
JURISDICTION : CORONER'S COURT OF WESTERN AUSTRALIA
ACT : CORONERS ACT 1996
CORONER : ROBYN MARY HARTLEY, CORONER
HEARD : 22 – 25 SEPTEMBER 2025
DELIVERED : 2 OCTOBER 2026
FILE NO/S : CORC 1224 of 2023 & CORC 2746 of 2023
DECEASED : DI BIASE ANDRÉ JOSEF
DODD BRYAN JEFFREY

Catchwords:

Nil

Legislation:

Coroners Act 1996 (WA)

Counsel Appearing:

Ms S Markham appeared to assist the coroner.

Mr D Harwood and Mr T Oliver (State Solicitor's Office) appeared on behalf of the East Metropolitan Health Service.

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

Nil

*Coroners Act 1996
(Section 26(1))*

RECORD OF INVESTIGATION INTO DEATH

*I, Robyn Mary Hartley, Coroner, having investigated the deaths of **André Josef DI BIASE** and **Bryan Jeffrey DODD** with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, PERTH, from 22 to 24 September 2025, find that the identity of the deceased persons was as follows:*

***André Joseph DI BIASE** and that death occurred at Royal Perth Hospital, Victoria Square, Perth on 8 May 2023 from multiple injuries; and*

***Bryan Jeffrey DODD** and that death occurred at Royal Perth Hospital, Victoria Square, Perth on 15 September 2023 from multiple injuries; in the following circumstances:*

Table of Contents

INTRODUCTION	3
MR DI BIASE	4
BACKGROUND	4
ADMISSION TO RPH	4
CAUSE AND MANNER OF DEATH	7
ISSUES	7
MR DODD	18
BACKGROUND	18
ADMISSION TO RPH	18
CAUSE AND MANNER OF DEATH	20
ISSUES	20
ISSUES COMMON TO BOTH DEATHS	23
CONCLUSION	27

INTRODUCTION

1. André Josef Di Biase was being detained involuntarily pursuant to the *Mental Health Act 2014* (WA) (MHA) when he died on 8 May 2023 after breaking the window and jumping from the ninth-floor balcony while being treated for physical health concerns in the General Medical Ward 9A at Royal Perth Hospital (RPH).
2. Due to his involuntary status, Mr Di Biase came within the definition of a person held in care as set out in the *Coroners Act 1996* (WA) (the Act).
3. The Act requires that the death of a person in care be investigated by way of inquest and that the Coroner who holds the inquest must comment on the quality of the supervision, treatment and care of the person while in care.
4. Bryan Jeffrey Dodd was admitted to RPH on 12 September 2023 after presenting to the Emergency Department with unmanageable pain in association with metastatic cancer. He was also being treated in Ward 9A when he broke the window in his hospital room and fell to his death from the ninth-floor balcony on 15 September 2023.
5. An inquest into Mr Dodd's death was not mandatory. However, due to the similarities in the circumstances of Mr Di Biase and Mr Dodd's deaths, a decision was made to hold a discretionary inquest into his death. The State Coroner ordered a joint inquest into the two deaths pursuant to section 40 of the Act.¹
6. I held the joint inquest at the Perth Coroner's Court from 22 to 25 September 2025.

¹ Email from State Coroner Fogliani dated 18 September 2024.

MR DI BIASE

BACKGROUND

7. Mr Di Biase was born in Western Australia on 3 March 1991. He was a much-loved son and brother.
8. At the time of his death, Mr Di Biase was living with his parents and employed as a Youth Support Worker. He was 32 years old. Mr Di Biase was an intelligent young man who studied law until his mental health began to decline.
9. In about 2010, Mr Di Biase began to develop a severe psychotic illness with grandiose delusions and ideas of reference. He was diagnosed with schizophrenia.
10. In 2014, his symptoms worsened due to illicit drug use. From 2017 onwards Mr Di Biase had multiple admissions to hospital for psychiatric treatment, both as a voluntary and involuntary patient. Mr Di Biase's family were always extremely supportive throughout his battle with his mental health challenges. When giving evidence at the inquest, the consultant psychiatrist who treated Mr Di Biase at RPH noted that the Di Biase family struck him as exceptionally supportive, with the entire family attending a meeting he arranged.
11. In July 2018, Mr Di Biase was hospitalised for treatment of a pneumothorax caused by self-inflicted stab wounds to his chest. He was hospitalised again from September to December 2018 with serious injuries after he intentionally drove a car into a wall at high speed after having command auditory hallucinations telling him to kill himself.

ADMISSION TO RPH

12. On 26 April 2023, Mr Di Biase was referred to RPH for assessment by a psychiatrist under the MHA on the basis that his mental health had declined, due to suspected non-compliance with his clozapine medication.
13. On 29 April 2023, Mr Di Biase was made an involuntary patient in the Mental Health Unit (MHU) at RPH. That same day, a Code Black was called when Mr Di Biase violently assaulted a security guard and attempted self-harm. It required restraint, seclusion and intramuscular sedative medication to manage this incident.

14. On about 1 or 2 May 2023, Mr Di Biase developed high fevers, a sore throat, dry cough, runny nose and raised CRP, the latter being a general indicator of inflammation.
15. On Friday, 5 May 2023, he was seen by an Internal Medicine Unit (IMU) Registrar and diagnosed with a viral respiratory tract infection with superimposed bacterial tonsillitis. Following a discussion between the IMU Registrar and the IMU Consultant, Mr Di Biase was prescribed intravenous (IV) antibiotics four times per day. He was transferred to Ward 9A for medical care until such time as he was medically stable and no longer needing IV therapy.
16. After discussion with the Psychiatric Registrar, the IMU Registrar noted that Mr Di Biase would require a “special (nurse or security)”, meaning one on one care upon arrival to Ward 9A and that the MHU were to organise this on transfer. The IMU Registrar noted that Mr Di Biase was alert, calm and cooperative but guarded about his thoughts.
17. While awaiting transfer to Ward 9A, Mr Di Biase was cannulated by a doctor and given his first dose of IV antibiotics in the MHU. He had a 1:1 nurse special while he waited to be moved. The reason for Mr Di Biase’s transfer to Ward 9A, a medical ward, was that IV antibiotics were not usually administered in the MHU. While there was no policy in place regarding transfer in such circumstances, it was considered best practice by RPH.

Transfer to Ward 9A

18. Mr Di Biase arrived in Ward 9A at about 4.30pm on 5 May 2023. At the point of handover, Mr Di Biase’s mental state was reported to be much improved from 29 April 2023, the day of the Code Black incident. However, a 1:1 nursing special was recommended to continue.
19. Once on the ward, Mr Di Biase was relatively settled but had continuing fever and urinary retention.
20. By the afternoon and evening of 6 May 2023, Mr Di Biase was reported to be having episodes of staring into space. When asked what he was doing, Mr Di Biase replied that he was just looking out the window. He reportedly denied any risk to himself or others but was guarded and suspicious when asked about his mental state.

21. At 1:00pm on 7 May 2023, Mr Di Biase had dressed and packed his belongings, stating he was ready for discharge. He was reviewed by a psychiatric Registrar at 4:30pm, who noted that Mr Di Biase presented as pleasant, vague and guarded about his beliefs. The Registrar recommended that the 1:1 special, preferably by a nurse, was to continue.
22. At about 5:30am on 8 May 2023, a Safety All-hours for Everyone (SAFE) Resident Medical Officer (RMO) reviewed Mr Di Biase. Nursing staff had reported that Mr Di Biase had been awake all night, standing in the corridor, punching objects and refusing to go to bed. This behavioural change was not escalated for medical or psychiatric attention at the time.
23. It was not until Mr Di Biase spoke to the SAFE RMO, that he revealed that he had been having auditory hallucinations, but these had now ceased. The SAFE RMO discussed with Mr Di Biase the option of having oral or IV medication to help him settle, which he declined. The nursing staff advised that Mr Di Biase seemed more settled when his special nurse was male, rather than female, with a view to this occurring in the future. The SAFE RMO recommended PRN medication as necessary and to call security if required.
24. Nursing notes entered at 6:00am, after the SAFE RMO notes that morning, recorded that Mr Di Biase had not slept that night and by 4:00am was sitting up in bed with a glazed look on his face. The 6:00am nursing entry described him as agitated, pacing the room and appearing as if he was going to punch through the window. He told staff he was “seeing and hearing things”. Mr Di Biase was pushing furniture around the room and was apparently “fixated” on the outside window of his room. Staff were not able to give Mr Di Biase his scheduled IV antibiotics due to his agitation. He also refused all offers of medication except for paracetamol.
25. At 6:55am, Mr Di Biase punched a wall and removed his clothes. He was persuaded to partially re-dress.
26. At 8:45am, Mr Di Biase was reviewed by the IMU medical team RMO, who noted that he was sitting in bed, calm comfortable and reportedly feeling well.
27. However, at 9:45am, Mr Di Biase was again pacing around his room and

trying to move furniture around. He told a registered nurse who was present while his 1:1 Assistant in Nursing (AIN) was on a break, that he was trying to perform a handstand. He was told there wasn't enough room to do that.

28. Mr Di Biase then moved to the window and banged on the glass until it broke. He climbed through the window, cutting himself on the jagged glass, and onto the locked balcony area where he subsequently plunged to his death over the balcony railing.
29. A Code Black was called but by the time security and the SAFE Team arrived, Mr Di Biase was no longer on the balcony.

CAUSE AND MANNER OF DEATH

30. Following a post mortem examination conducted on 15 and 16 May 2023 the forensic pathologist formed the opinion that the cause of death was multiple injuries.² I accept and adopt this cause of death.
31. Given the circumstances of Mr Di Biase's death and his history of self-harm, I have concluded that he jumped from the balcony outside Ward 9A with the intention of ending his life. Therefore, I find that the manner of death was suicide.

ISSUES

Decision to transfer Mr Di Biase from the MHU to Ward 9A³

32. Dr Nathani, Mr Di Biase's treating consultant psychiatrist for his admission to RPH, explained that, during the first week of May 2023, Mr Di Biase developed persistent fevers exceeding 38.3°C, together with abnormal inflammatory markers, which caused significant concern about a serious underlying infection and possible sepsis.
33. The psychiatric team examined Mr Di Biase regularly over approximately 48 hours and undertook investigations, including blood tests and blood cultures, but initially could not identify the source of his infection.
34. Eventually, when Mr Di Biase reported pain on swallowing, examination of his throat led to the diagnosis of tonsillitis.

² Exhibit 1, Volume 1, Tab 8 Post Mortem reports.

³ Exhibit 1, Volume 3, Tab 7 Statement of Dr Nathani; T85 – 98.

35. Dr Nathani explained that the seriousness of the fever and abnormal blood results meant that Mr Di Biase's physical health concerns could not simply be observed in the hope that they would resolve on their own. Conservative treatment was also unlikely to be sufficient. There was no doubt in his mind that expeditious, active medical treatment was required.
36. A significant factor in Dr Nathani's decision-making was that Mr Di Biase urgently needed to be recommenced on clozapine, which Dr Nathani regarded as the key treatment for his severe psychotic illness and for reducing his risk of suicide. However, clozapine could not be restarted while Mr Di Biase remained febrile and medically unwell. Clozapine itself can cause serious adverse effects, including fever, myocarditis and agranulocytosis, making it impossible to distinguish drug-related complications from infection if it was recommenced prematurely. Accordingly, Dr Nathani regarded resolution of the infection as a necessary prerequisite to restarting clozapine.

Medical team's decision to administer IV ABs⁴

37. Having determined that Mr Di Biase needed treatment for his medical issues, the psychiatric team sought input from the Internal Medicine Unit by way of an internal referral.
38. An IMU Registrar assessed Mr Di Biase in the MHU in the morning on 5 May 2023. The Registrar conducted a thorough physical examination and review of numerous investigations in diagnosing Mr Di Biase with a viral upper respiratory tract infection with super imposed bacterial tonsillitis.
39. Due to the severity of the infection, the high inflammatory markers, ongoing fevers and the need for rapid treatment, the Registrar, in conjunction with the IMU Consultant, considered IV antibiotics necessary to quickly control the infection and reduce the risk of serious deterioration, including progression to sepsis and potentially fatal consequences.
40. IV antibiotics have the capacity to deliver a higher dosage and take effect faster than oral antibiotics. Oral antibiotics are also difficult for a patient to swallow when they have a sore throat. Antibiotics are not routinely

⁴ Exhibit 1, Volume 3, Tab 8 Statement of Dr Mallal; T125 – 135; Exhibit 1, Volume 3, Tab 3 Statement of Dr Chee.

administered intramuscularly in the treatment of bacterial tonsillitis as they are less likely to be effective.

41. Dr Nathani accepted the medical team's assessment that IV antibiotics were clinically required. He made inquiries as to the duration and frequency of the treatment and was informed that Mr Di Biase would require IV antibiotics four times daily for more than 48 hours and potentially several days.

Consideration as to whether treatment could occur in the MHU

42. Dr Nathani gave evidence about the consideration given and discussions had about whether the required treatment could be administered to Mr Di Biase in the MHU. He noted that there had been occasions where limited IV treatment was administered in psychiatric wards, but generally only where one or two doses were required, additional staffing was available and specialist medical nursing support could be provided.
43. However, Mr Di Biase's anticipated treatment consisted of repeated IV antibiotic administration four times daily for multiple days.
44. Dr Nathani considered that this fell outside what was ordinarily manageable in the MHU. He identified several concerns about administering prolonged IV treatment within the MHU:
 - a) IV lines presented ligature risks;
 - b) IV poles could potentially be weaponised by other patients;
 - c) mental health nurses were not routinely trained or practised in administering ongoing IV therapy; and
 - d) the MHU lacked the infrastructure and expertise to manage significant physical deterioration or medical emergencies.
45. Having concluded that active medical treatment was required for his severe bacterial infection and that treatment would consist of a course of IV antibiotics over a period of days, it was agreed between the psychiatric and medical treating teams that Mr Di Biase needed to be transferred to Ward 9A.
46. The intention was always that the transfer to the medical ward would be temporary. Once the IV antibiotic course was completed and Mr Di Biase's physical condition improved sufficiently to allow conversion to oral antibiotics, he was expected to return to the MHU where clozapine

could then be recommenced.

47. Dr Nathani noted that, by the morning of 8 April 2023 there was an expectation that this return might occur soon because his infection appeared to be improving.

Consideration of the risks associated with transfer out of the MHU

48. Dr Nathani gave evidence that the decision to transfer Mr Di Biase was not solely a medical one. Both psychiatric and medical considerations were taken into account. He accepted that moving an involuntary psychiatric patient to a ninth-floor medical ward created environmental risks, particularly given Mr Di Biase's longstanding suicide risk, psychosis and history of erratic behaviour. He confirmed that psychiatric units are often located on ground floors precisely because such risks are recognised.
49. However, he also explained that Mr Di Biase's psychiatric condition remained serious irrespective of the transfer. In his view:
- a) Mr Di Biase's mental state had not substantially improved because clozapine had not yet been reinstated;
 - b) he remained at risk of suicide and misadventure;
 - c) the infection itself created an additional risk of delirium, which could further worsen his mental state; and
 - d) if sepsis were to develop, a medical ward would be the appropriate environment in which to manage that deterioration
50. Dr Nathani therefore considered that there were competing clinical risks and that the situation reflected a broader systemic challenge of caring for patients with both significant psychiatric and significant medical illness. The transfer reflected an effort to balance acute medical needs against acute psychiatric risks rather than a decision based on physical illness alone.
51. Dr Nathani ultimately maintained that, based on the information available at the time, Mr Di Biase required active medical treatment for his bacterial tonsillitis and IV antibiotics were clinically appropriate. The MHU was not considered capable of safely delivering repeated IV therapy over several days such that transfer to a medical ward was appropriate.

52. Importantly, Dr Nathani provided a comprehensive handover to a doctor from RPH's Consultation Liaison Psychiatry Service when Mr Di Biase was transferred to Ward 9A. There was also a handover from the MHU to the medical ward.
53. The expectation was that Mr Di Biase would remain under psychiatric oversight with daily reviews by the Consultation Liaison Psychiatry Service with one-to-one observation while temporarily accommodated on the medical ward.
54. At the time of transfer from the MHU Mr Di Biase had been under a 1:1 nurse special. Dr Nathani advised that patients under the MHA would ideally be subject to a 1:1 nurse special while receiving treatment on a medical ward.

EMHS' position on decision to transfer and subsequent system improvements⁵

55. Dr Yeates, Director of Medical Services for the Royal Perth Bentley Group, accepted that the decision to prescribe IV antibiotics for Mr Di Biase was clinically appropriate and consistent with the Australian Therapeutic Guidelines. He agreed with the evidence provided by the treating clinicians that alternative methods of administration would not have been as effective.
56. Dr Yeates explained that, at the time of Mr Di Biase's admission in May 2023, there was no formal policy prohibiting IV antibiotics in the MHU. Rather, there was a longstanding clinical practice that transfer to a medical ward was generally preferred where ongoing IV treatment was required for a mental health patient
57. Confirming the information provided to the Court by Dr Nathani, he identified several reasons why IV treatment was not routinely provided within the MHU:
 - a) concerns that IV equipment, tubing and poles could be used as weapons or create ligature risks;
 - b) the fact that many mental health nurses, while highly trained, did not routinely practise IV therapy and therefore may not have maintained recent experience in its administration; and

⁵ Exhibit 1, Volume 3, Tab 1.2 EMHS Report dated 9 June 2025; T229 – 232; Exhibit 1, Volume 3, Tab; Letter to Court from EMHS dated 24 November 2025.

- c) broader concerns regarding the suitability of the mental health environment for prolonged IV treatment.
58. Dr Yeates acknowledged that the administration of IV antibiotics was not absolutely prohibited in psychiatric wards and that there had been occasions where it had occurred. However, this was not a common occurrence.
59. Following Mr Di Biase's death EMHS undertook a SAC1 investigation which recommended that there be a policy/process review on the provision of general health needs in the secure MHU at RPH.
60. This resulted in a team of clinical experts including mental health specialists undertaking an extensive review with the following mandate:
- a) specify the parameters for the safe delivery of physical (general) health care to patients on mental health wards;
 - b) set out a process for determining the most suitable care location for patients with concurrent mental and physical health needs on an individual patient basis; and
 - c) optimise the delivery of mental health care to patients who have been determined to require care on physical health care areas.
61. Arising from the review, the *Royal Perth Bentley Group Physical Health Care Escalation for Patients in a Mental Health Setting Standard Operating Procedure* was created to provide structured guidance on the escalation of physical health care needs for people receiving care in a dedicated mental health inpatient setting. The standard operating procedure (SOP) includes a decision making flowchart to guide clinical risk assessment, care escalation and appropriate care location to ensure patient safety from a mental and physical health point of view.
62. Under the SOP, clinicians treating mental health patients with physical care needs must specifically consider:
- a) the type of medical treatment required;
 - b) whether equipment needed to administer the treatment presents a risk and how those risks might be mitigated;
 - c) whether appropriate medical expertise is available within the mental health unit;
 - d) whether mental health nursing staff possess the necessary

- skills and experience;
 - e) whether environmental risks can be mitigated; and
 - f) whether additional resources or staffing can safely support the physical health treatment being provided within the psychiatric setting.
63. Dr Yeates described the new SOP as creating more opportunities to allow patients to remain on the mental health unit while receiving physical medical care, where safe to do so. He agreed that the process contained in the SOP is substantially more detailed and rigorous than the informal arrangements that existed in May 2023 when Mr Di Biase was transferred from the MHU to Ward 9A.
64. Importantly, the SOP recognises that there will be instances where a treatment for physical health concerns cannot be safely delivered in a mental health unit and the patient will need to be transferred to a medical ward for treatment. Where transfer is proposed, it must now be formally considered and approved through multiple levels of review with the reasons for transfer recorded at each stage.
65. Having carefully considered the evidence of those clinicians involved in the decision to transfer Mr Di Biase to a medical ward for administration of IV antibiotics to treat his bacterial tonsillitis, I have determined that it was appropriate in the circumstances. At the time, none of the clinicians were aware that the windows on Ward 9A were made of a type of glass that Mr Di Biase would be able to smash to allow him to escape onto the balcony. They were concerned for his deteriorating physical health, which they knew needed to be resolved not just because he risked developing life-threatening sepsis but also because the much-needed re-titration of clozapine could not commence until Mr Di Biase no longer had an infection. I accept the unrefuted evidence that administration of IV antibiotics four times daily for multiple days was essential medical care that was unable to be safely provided to Mr Di Biase in the MHU.

Supervision on Ward 9A

66. Mr Di Biase's treating team on the MHU completed a handover to both the Consultation and Liaison Psychiatry Service, who were taking over his psychiatric care, and the team overseeing his physical treatment on Ward 9A.
67. Dr Nathani gave evidence about the comprehensive verbal handover he

gave to the Consultation Liaison Psychiatry Service by way of telephone call to Dr Hearn in the late afternoon on Friday 5 May 2023. He was aware that Dr Hearn was the Consultation Liaison Psychiatry Service Registrar covering the weekend⁶

68. Dr Nathani conveyed his assessment that Mr Di Biase was a high-risk psychiatric patient due to prior serious suicide attempts, suffering from treatment-resistant schizophrenia requiring clozapine, repeated non-adherence with clozapine, recent rebound psychosis after stopping clozapine and the risk of impulsive self-harm or misadventure. Additionally, there was the possibility of Mr Di Biase developing delirium in association with his infection which would worsen his mental state.
69. Dr Nathani advised Dr Hearn that Mr Di Biase had required seclusion in late May in the context of assaulting security staff but that his mental state had improved since then.
70. He recalls Dr Hearn asking all the right questions during their conversation and him feeling comfortable that he had conveyed all the necessary information about Mr Di Biase's mental state to her.
71. Dr Hearn's notes of the conversation record that Dr Nathani advised that Mr Di Biase no longer required a security special.⁷
72. Although Dr Nathani was not involved in the Ward 9A nursing handover, he said his understanding was that when a patient being detained involuntarily under the Mental Health Act was transferred to a non-secure environment like Ward 9A they would generally be managed with a 1:1 special, usually a nurse special where the concern was self-harm or misadventure rather than violence.
73. The *Royal Perth Bentley Group Special and Supportive Observations Policy*⁸ states that a 1:1 mental health registered nurse special should be provided (**where available**) [emphasis added] when a patient detained under the Mental Health Act is being treated in a general health area.
74. From the time Mr Di Biase was transferred to Ward 9A late in the afternoon on Friday 5 May 2023 he was allocated a 1:1 special.

⁶ T89 – 90.

⁷ Exhibit 1, Volume 3, Tab 8.2 Inpatient e-referral.

⁸ Exhibit 1, Volume 3, Tab 1.2.4.

75. From 7:00am on 8 May 2023 Mr Di Biase's special was an AIN. The AIN providing the 1:1 special was relieved by a Registered Nurse at 9:45am to do the morning tea rounds. It was during this time that Mr Di Biase began banging against the window leading out to the balcony from his room. His allocated AIN heard the bang and returned to Mr Di Biase's room. The AIN asked Mr Di Biase not to bang on the window. He stepped outside the room briefly to write some notes, while still keeping Mr Di Biase in his line of sight. Mr Di Biase hit the glass again twice in quick succession and the top panel of the window smashed. Mr Di Biase escaped through the broken window onto the balcony and jumped to his death.⁹
76. It will never be known whether allocation of a registered mental health nurse as Mr Di Biase's special in the lead up to and/or on the day of his death would have changed the tragic outcome. I do not seek to level criticism towards any individuals who undertook 1:1 specials for Mr Di Biase during his time on Ward 9A.
77. However, the *Royal Perth Bentley Group Special and Supportive Observations Policy* clearly recognises that the best approach to risk management is for an involuntary mental health patient on a medical ward to have a registered mental health nurse as their 1:1 special.
78. While giving evidence at the inquest, Dr Yeates was asked how RPH determines which patients are prioritised for a mental health nurse special, given need must often outstrip supply. He informed the Court that the hospital was 27 nurses short at the start of the morning shift on 8 May 2023. There was an identified need for four mental nurse specials, but only one available.¹⁰
79. Subsequent to the inquest EMHS provided information about the process at RPH for determining all nurse specials, including mental health nurse specials. It was noted that nurse specials constitute an extra staff member in addition to standard ward staffing profiles.
80. Assignment of specials, whether they be mental health nurses, registered nurses or AINs, is the responsibility of the Work Allocation Officer. If there are deficits and all requests cannot be fulfilled the Work Allocation Officer will liaise with the areas needing additional staff to ascertain

⁹ Exhibit 1, Volume 1, Tab 22 Statement of Richard Ting Kah Ing.

¹⁰ T254 – 254; T270 – 271.

whether any of the requests can be safely modified. If insufficient registered mental health nurses are available, then the possibility of using a general registered nurse is considered. If there are no general nurses, then consideration is given to allocating an AIN to conduct the 1:1 special.¹¹

81. Immediately following Mr Di Biase's death, EMHS reinforced with staff the importance of allocating Psychiatric Nurse Specialists, where available, for mental health patients in non-mental health wards.¹²
82. It remains the case that where more mental health nurse specials are needed than mental health nurses available on any particular shift, an involuntary mental health patient like Mr Di Biase may be on a general ward for medical treatment without a mental health nurse as their special.

External facing windows on Ward 9A¹³

83. At the joint inquest, the Court heard a large amount of evidence about the annealed glass on the external facing windows on Ward 9A. The glass was installed when the building was built in the late 1940s. It is thin and fragile, thereby breaks easily. The modern-day standard requires 6.38 mm laminated safety glass. This glass can still be broken, although it is much harder to do. Importantly, if it is smashed it does not break into shards like the annealed glass on Ward 9A. The laminated safety glazing means that even if the glass breaks the pieces are still held together.
84. In March 2019 there was an incident on Ward 10A, a level above Ward 9A, where an outward facing window was broken and glass fell onto the Wellington Street side of the hospital, creating a public safety risk.
85. As a result, the balcony-facing windows on Ward 10A were upgraded. The original annealed glass was replaced with 6.38 mm laminated safety glass. This was completed within about eight weeks of the incident.
86. The remediation following the 2019 incident was limited. Other external windows in A Block were not upgraded at that time and largely remained fitted with the original annealed glass.
87. I see this as a missed opportunity on the part of EMHS to conduct a

¹¹ Letter to Court from EMHS dated 24 November 2025.

¹² Exhibit 1, Volume 3, Tab 1.2 EMHS Report dated 24 June 2025.

¹³ T277 – 291; Exhibit 1, Volume 3, Tab 1.2.2 Royal Perth Hospital, Review of Windows in A-Block.

hospital-wide review of window strength and the risks posed by the weakness of the existing annealed glass.

88. It was clear from the evidence that the clinicians making the decision to transfer Mr Di Biase to Ward 9A had no comprehension of the possibility the window could be broken in the way he was able to on the date of his death.
89. Significantly, immediately after Mr Di Biase's death a direction was made that high risk mental health patients requiring treatment on a general ward were not to be transferred to Ward 9A. Instead, they needed to be transferred to Ward 10A where the outward facing windows had been upgraded to safety compliant glass.

MR DODD

BACKGROUND

90. Mr Dodd was born in South Australia on 30 July 1962. He was happily married to his wife of 11 years and had three siblings. Mr Dodd was 61 years of age when he died.
91. Mr Dodd was diagnosed with metastatic colorectal cancer in 2022 and, as his condition deteriorated, he had applied and been accepted to access Voluntary Assisted Dying (VAD). Mr Dodd's wish was to have an assisted death in his own home. He signed his VAD declaration on 6 September 2023 and was cleared to undertake this process when he chose to do so. At that time, there was no issue with Mr Dodd's cognition or capacity to consent. However, by 7 or 8 September 2023, Mr Dodd's wife reported her concerns about her husband's changing behaviour to the VAD clinician.
92. Due to his elevated pain levels, Mr Dodd was prescribed multiple medications including oxycodone and medicinal cannabis. He was also prescribed alprazolam for panic attacks and anxiety. As his cancer metastasised, Mr Dodd's pain had become unbearable and he reportedly used increasing quantities of his usual pain medication, oxycodone. It is likely that he was also using his medicinal cannabis to excess. Mr Dodd's use of medication, in a desperate bid to ease his terrible pain, almost certainly contributed to the decline in his physical health and cognition.

ADMISSION TO RPH

93. Early on 12 September 2023, Mr Dodd attended the Emergency Department at RPH with a referral from his GP practice. Mr Dodd presented with unmanageable pain levels, problems with mobility, recurring falls and confusion. He was initially admitted to the Acute Medical Unit (AMU) for care and assessment by the Palliative Care Team and found to be suffering from metastatic colorectal cancer and delirium of unknown origin. Due to his condition, an Assistant in Nursing was assigned as a 1:1 companion for Mr Dodd.
94. Over the next few days, staff observed that Mr Dodd was agitated and confused and wanting to go home to his wife. However, there were concerns for Mrs Dodd's wellbeing if she were to try and care for him at home while he was still delirious.

95. On 14 September 2023, the medical team determined that Mr Dodd was not to be discharged at his own request against medical advice. Instead, he was to be held under a duty of care because it was deemed unsafe for him not to be in hospital.
96. At 9:30pm on 14 September 2023, Mr Dodd's agitation increased, necessitating the calling of a Code Black emergency. He agreed to take an oral dose of haloperidol and settled to bed with the assistance of security staff.
97. However, at 2:30am on 15 September 2023, Mr Dodd tried to break the window in his room with a chair, necessitating a second Code Black being called. A further dose of intra-muscular haloperidol was given, and Mr Dodd was moved to a single occupancy room.

Transfer to Ward 9A

98. At about 4:00pm on 15 September 2023, Mr Dodd was transferred to Ward 9A. At the point of transfer, it appears that the incident in which Mr Dodd tried to break his window with a chair, was not handed over to the staff on Ward 9A.
99. The comprehensive care plan completed for Mr Dodd indicated that he would require a 1:1 Assistant in Nursing special due to his behaviour and absconding risk. Mr Dodd was also on the SAFE list, meaning that he would be monitored by the SAFE Team.
100. Initially, Mr Dodd was settled, however at about 9:00pm that evening, he became restless, agitated and confused. He told staff he wanted to go home to his wife.
101. Despite staff attempts to reassure him, Mr Dodd became increasingly agitated. His level of agitation was such that the AIN allocated as his 1:1 companion, moved her chair out of the room because his "energetic and paranoid" behaviour made her fearful.
102. Shortly after this, Mr Dodd broke the window in his room and started to climb out. When two AINs tried to stop him, Mr Dodd picked up a shard of glass and held it up towards them in a threatening manner. He climbed out of the window onto the balcony.
103. A Code Black was called, which resulted in two security officers arriving

on the ward within about a minute. One tried to talk to Mr Dodd through the broken window while the other interacted with staff in a bid to deescalate the situation.

104. Approximately a minute after the first two security officers arrived Mr Dodd went over the balcony railing, falling to his death just metres from where Mr Di Biase had died in May 2023.

CAUSE AND MANNER OF DEATH

105. Following an external post mortem examination conducted on 20 September 2023 the forensic pathologist formed the opinion that the cause of death was multiple injuries.¹⁴ I accept and adopt this cause of death
106. I do not believe that Mr Dodd went off the balcony outside his hospital room with the intention of ending his life. I believe he was delirious and confused at the time, and simply trying to get home. I find that death occurred by way of accident.

ISSUES

Response to infrastructure issues following Mr Di Biase's death¹⁵

107. In an immediate response to Mr Di Biase's death, a direction was made that involuntary mental health patients transferred to medical wards should not be placed in Ward 9A but rather go to Ward 10A, where the balcony-facing windows had already been upgraded following the 2019 incident.
108. Tragically, Mr Dodd was not captured by this direction as he was not a mental health patient.
109. EMHS also began developing a broader response to the issue of the annealed glass in windows on wards in the A Block at RPH.
110. By July 2023, quotes had been sought for a technical review of the windows. An architect was appointed in August 2023 to assess the problem and recommend solutions.

¹⁴ Exhibit 1, Volume 2, Tab 5 Post Mortem reports.

¹⁵ T277 – 310; Exhibit 1, Volume 3, Tab 1.2.2 Royal Perth Hospital, Review of Windows in A-Block; Exhibit 1, Volume 3, Tab 13 Overview of Timeline of Window Incidents and Remediation Actions – Infrastructure with Diagrammatic Representation.

111. The next month Mr Dodd broke the same type of annealed glass that Mr Di Biase had and fell to his death from the Ward 9A balcony.
112. It is extremely unfortunate that Mr Di Biase's death did not result in the Ward 9A windows being upgraded in the same way that the Ward 10A windows were within eight weeks of the March 2019 incident.
113. The evidence from Acting Executive Director of Infrastructure at RPH, Ms Hiyare-Hewage, was that following Mr Di Biase's death the hospital did not simply replicate the 2019 Ward 10A solution but instead a decision was made that a comprehensive review was required because:
 - a) Mr Di Biase's death was seen as the second major window-related incident in A Block after the 2019 Ward 10A event;
 - b) it became clear the issue was not limited to one ward or one balcony-facing window;
 - c) the A block building contained multiple different window designs, requiring different solutions; and
 - d) the hospital wanted a whole-of-building assessment rather than another isolated fix.
114. There was a desire to understand the full scope of the risk, determine which remedial options would work for different window types, ensure any solution was compatible with the ageing building fabric and avoid introducing new risks or impractical solutions in occupied hospital wards.
115. In order to achieve this a technical review was required before funding and construction could proceed. An architect had to be engaged, a procurement process had to occur, costings had to be prepared and funding secured before major replacement works could commence.
116. After Mr Dodd's death, remediation action accelerated dramatically with the assessment of the windows beginning almost immediately.
117. By 5 October 2023, a quote had been obtained for replacing the Ward 9A balcony-facing windows and a purchase order was issued the same day.
118. The windows were replaced with 6.38 mm laminated safety glass by 19 October 2023.

119. I acknowledge that the apparent speed of this work was in part made possible because much of the investigative and planning work had already been undertaken in the months following Mr Di Biase's death.
120. While accepting the evidence presented by EMHS as to the merits of a comprehensive review, I see the failure to replace the annealed glass on Ward 9A immediately following Mr Di Biase's death as a missed opportunity to protect patient safety.

ISSUES COMMON TO BOTH DEATHS

Ability to call Code Black¹⁶

121. The AIN who was allocated as Mr Di Biase's special on the day of his death was asked about emergency responses available to him in that role and he advised that he could call for help or he could use a personal duress alarm if supplied with one.
122. The AIN explained that, in his experience, duress alarms are issued by the Shift Coordinator to staff who are expected to have close contact with potentially volatile patients. He had been issued with a personal duress alarm on other occasions where there was significant risk to his own safety from patient behaviour but was not given one for the shift with Mr Di Biase on 8 May 2023.
123. It is important to note that Mr Di Biase had not been deemed a security risk since a Code Black was called in the MHU on 29 August 2023. When he was transferred from the MHU to Ward 9A on 5 May 2023 his treating consultant psychiatrist from the MHU conducted a handover advising that Mr Biase's mental state was much improved and he no longer required a security special.
124. In these circumstances, I am not certain that the AIN allocated to Mr Di Biase on 8 May 2023 would have been issued a personal duress alarm even if they were being used on Ward 9A at that time. We know from evidence provided by Dr Yeates at the inquest that personal duress alarms were only in use on the MHU and Ward 2K at RPH in 2023.
125. Further, I did not get the sense from the evidence before me that Mr Di Biase posed a threat to anyone but himself in the lead up to him breaking the window and escaping onto the balcony on 8 May 2023.
126. However, submissions provided to the Court on behalf of EMHS in November 2025 advised that, as part of the *Royal Perth Bentley Group Comprehensive Mental and Physical Inpatient Care Plan*, the hospital will investigate the feasibility of providing personal duress alarms to staff caring for patients with mental health needs on physical health wards. This would appear to capture the circumstances of Mr Di Biase's

¹⁶ T36 – 37; T168 – 169; T189 – 206; Exhibit 1, Volume 2, Tab 8 Handwritten notes and stamen of Ms Sokiri, Tab 10 Statements of Nurse Chacko and Tab 11 Handwritten notes and statement of Nurse Thoman.

admission to Ward 9A. Further on I will detail the updated situation at RPH in terms of the roll out of personal duress alarms beyond their mental health wards.

127. Various witnesses who gave evidence about the terrifying moments before Mr Dodd went off the balcony on 15 September 2023 assisted in clarifying the steps taken to call the Code Black once he began smashing the window.
128. I was struck by the care and kindness provided to Mr Dodd by Ms Sokiri, his allocated AIN that night. He hadn't paid for access to the television in his room and she thought it might settle him if he was able to watch something. So, Ms Sokiri paid out of her own funds for Mr Dodd to have television access.
129. Ms Sokiri and the Shift Coordinator for the night shift on 15 September 2023, Ms Thoman, both assisted Mr Dodd in his repeated attempts to call his wife. When they were unable to get through to Mrs Dodd they reassured him that she was likely sleeping given the late hour and that she would be in to see him the next day. Mr Dodd seemed happy when he was told this.
130. The evidence about the incident also revealed bravery on the part of Ms Sokiri and her fellow AIN Ms Habtue who risked their personal safety in an attempt to stop Mr Dodd from climbing out the broken window.
131. In this instance, the Code Black was called when one of the two AINs trying to restrain Mr Dodd screamed out for help. A nurse within earshot heard the shouting and ran to Mr Dodd's room. She turned to the Shift Coordinator who was running behind her and told her to call a Code Black. The Shift Coordinator then ran back to the nurses' station and called a Code Black on the phone there.
132. It became clear at the inquest that the only way Mr Dodd's AIN could have called a Code Black herself as soon as Mr Dodd began attempting to break the window would have been if she had been issued with a personal duress alarm.
133. Ms Sokiri gave evidence that she was aware of AINs at RPH being issued with a personal duress alarm if the patient has a history of Code Blacks.

134. Ms Sokiri also advised that when she was allocated to be Mr Dodd's AIN for the night shift on 15 September 2023 she was unaware that a Code Black had been called in the early hours of that morning when he had tried to smash a window with a chair while on the AMU.
135. In fact, two Code Blacks had been called due to Mr Dodd's presentation in the 24 hours before he broke the window on Ward 9A. At 9:30pm on 14 September a Code Black was called because Mr Dodd was agitated and attempting to discharge against medical advice. The Psychiatric Registrar was contacted and a decision was made that Mr Dodd needed to be kept in hospital under the doctrine of necessity due to his confusion.
136. Given these circumstances, I believe it would have been entirely appropriate for Ms Sokiri to be issued with a personal duress alarm for her night shift as Mr Dodd's AIN special on 15 September 2023 had they been in use on Ward 9A at the time.
137. While I expect access to a personal duress alarm may have allowed for the Code Black to be called just very slightly earlier, I think it is unlikely that it would have changed the outcome for Mr Dodd.
138. However, this issue raised concerns for me from a death prevention perspective. It may be that there are instances where a 1:1 special who has a personal duress alarm is able to activate a Code Black surreptitiously, thereby not heightening a patient's distress unnecessarily. It also allows the specialists in de-escalation and safety, namely security officers and the SAFE team, to get to the incident without delay and, potentially, save a life. Whether that be a patient or a staff member or both.

EMHS' position on personal duress alarms¹⁷

139. During his evidence as an overarching witness for EMHS, Dr Yeates explained the distinction between the various emergency response buttons and alarms used at RPH:
 - a) fixed emergency buttons are located in patient rooms and produce a loud alarm audible throughout the ward when activated. They alert nurses to attend to ascertain what sort of emergency is occurring before calling a Code Blue, Code

¹⁷ T244 – 248; Letter to Court from EMHS dated 24 November 2025; Emails to Court from State Solicitor's Office dated 23 and 24 September 2026.

Black or taking other action;

- b) fixed duress alarms are located in selected concealed locations, such as under the desk at a nurses' station. They activate a silent alarm which alerts security that a Code Black response is needed; and
- c) personal duress alarms, like fixed duress alarms, activate a silent alarm which immediately triggers a Code Black response.

- 140. Dr Yeates confirmed that currently, personal duress alarms were only being used on the MHU and the other mental health ward at RPH, Ward 2K. He advised that consideration was being given to expanding the use of personal duress alarms across all wards at the hospital.
- 141. In submissions filed subsequent to the inquest, EMHS confirmed that handheld personal duress alarms are not standard issue to all staff within inpatient areas or controlled hospital environments.
- 142. Through their counsel, EMHS has recently advised that personal duress alarm deployment to the Acute Medical Unit in A Block at RPH is near completion. This unit was considered the highest risk non-mental health ward and, therefore, deployment to this area was determined to provide the greatest benefit.
- 143. EMHS went on to assert that the AMU installation will facilitate deployment to other wards in A Block. Decisions on such deployment will be taken on a risk prioritisation basis.
- 144. I am heartened to learn of the expansion of the use of personal duress alarms and urge EMHS to extend the roll out to the balance of the medical wards.

Access to the balcony on Ward 9A

- 145. The evidence at the inquest was that the doors that open out onto the balcony outside Ward 9A are locked and only security staff carry the keys.
- 146. This inevitably led to a delay in ward staff being able to access the balcony when Mr Di Biase and later Mr Dodd broke a window and escaped onto it.

EMHS' submissions on Ward 9A balcony access¹⁸

147. EMHS advised that balcony access is a controlled measure due to safety risks to both patients and staff and there is no requirement for any clinical staff member to access the balcony in normal circumstances.
148. Given the balcony is a restricted area, any unauthorised access requires the calling of a Code Black. The security staff that respond to a Code Black emergency carry master keys allowing access to the balcony.
149. While all ward staff including doctors, nurses, AINs, ward clerks and cleaners are trained in Aggression Prevention and Intervention, they are not the specialists with the training required to deal with a person who is behaving in a way that places themselves or others at imminent and significant risk. When such a circumstance arises, ward staff are expected to call a Code Black so that security staff can attend.
150. Importantly, general ward staff are not trained in the application of physical restraint. If an emergency arises where restraint may be required, a Code Black must be called.
151. I accept these submissions.

CONCLUSION

152. The deaths of Mr Di Biase and Mr Dodd occurred in strikingly similar circumstances within a period of only four months. Both men were vulnerable patients being treated on Ward 9A at Royal Perth Hospital. Both were able to break the annealed glass window in their room, gain access to a locked balcony and jump or fall to their deaths.
153. While their underlying medical and psychiatric conditions were very different, the common factor in both deaths was the existence of an environmental hazard that neither treating clinicians nor ward staff appreciated at the time they were caring for the men.
154. I am satisfied that the clinical decisions made in relation to both men were appropriate when viewed in light of the information available to their treating teams at the time. The decision to transfer Mr Di Biase to Ward 9A for treatment of a serious infection was clinically justified, as

¹⁸ Letter to Court from EMHS dated 24 November 2025.

was the management of Mr Dodd's delirium and confusion in a medical ward environment. I make no adverse findings against any individual clinician, nurse, assistant in nursing or member of staff involved in the care of either man. The evidence demonstrated that they all acted with professionalism, compassion and a genuine desire to help their patients.

155. However, this joint inquest identified important systemic issues. In particular, the failure to remediate the annealed glass windows on Ward 9A following Mr Di Biase's death represented a missed opportunity to reduce the risk of a further tragedy. Equally, the evidence revealed challenges in caring for patients with concurrent mental and physical health needs, the allocation of appropriately trained specials, and the mechanisms available to staff responding to rapidly escalating behavioural emergencies. It is encouraging that EMHS has since undertaken substantial work to address these issues through infrastructure upgrades, revised transfer and escalation processes, and the introduction of additional behavioural response supports.
156. Nothing in these findings can undo the profound loss suffered by the Di Biase and Dodd families. I hope, however, that the examination of these deaths, and the changes that have flowed from them, will contribute to safer care for vulnerable patients in the future. Both families have approached these proceedings with dignity, insight and determination. Their contribution to this inquest has been invaluable and has ensured that the circumstances of these deaths have been considered thoroughly and openly.

RM Hartley
Coroner
2 October 2026