JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	BRENDYN DEAN NELSON, CORONER
HEARD	**:**	17 & 18 JUNE 2026
DELIVERED	**:**	28 JULY 2026
FILE NO/S	**:**	CORC 252 of 2023
DECEASED	**:**	WALDER, TRAVIS JOHN

Catchwords:

Nil

Legislation:

Coroners Act 1996 (WA)

Guardianship and Administration Act 1990 (WA)

Mental Health Act 2014 (WA)

Counsel Appearing:

Ms E Lynch assisted the Coroner

Ms H Millar SC (instructed by Meridian Lawyers) appeared for Dr M Nasr

Mr L Nicholls (instructed by Avant Law) appeared for Dr J Halewood

Mr T Pontre (instructed by MDA National) appeared for Dr A Senthi

Mr C Madondo and Ms P Femia (State Solicitor's Office) appeared for the WA Country Health Service

Cases referred to in decision:

Nil

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Brendyn Dean Nelson, Coroner, having investigated the death of ***Travis John WALDER*** *with an inquest held at Bunbury Magistrates Court, 3 Stephen Street, BUNBURY, on 17 and 18 June 2026, find that the identity of the deceased person was* ***Travis John WALDER*** *and that death occurred on 24 August 2023 at the railway crossing on Robertson Drive, Picton, from multiple injuries in the following circumstances:*

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Introduction

1 Travis John Walder died on 24 August 2023 from multiple injuries he sustained after he ran in front of an oncoming passenger train at the rail crossing on Robertson Drive in Picton. He was 32 years old.

2 Travis[1] had been diagnosed with schizophrenia and had a history of issues arising from his polysubstance use.

3 The night prior to his death, Travis had been conveyed from his parents' home in Withers to the Emergency Department at Bunbury Regional Hospital (**BRH**) by ambulance. The ambulance had been called by Travis's father after Travis had become agitated and non-responsive.

4 Ambulance officers considered that Travis was hyperalert, confused, and experiencing visual and auditory hallucinations, but not aggressive. Travis's father advised that Travis had used methylamphetamine earlier that day, and cannabis that evening. Travis was transported to hospital, remaining agitated but manageable enroute. At the hospital, he was assessed as being agitated, elevated and likely highly impaired. The impression was that Travis was under the influence of an illicit drug toxidrome, likely methylamphetamine.

5 Travis was sedated for therapeutic sleep, with a re-assessment to be undertaken in the morning to determine if he was suffering a relapse of his schizophrenia or a drug-induced psychosis, or both. Travis woke shortly before midnight and insisted on leaving the hospital. He was assessed by medical staff, and a determination was made that there was no basis to detain him under the *Mental Health Act 2014* (WA).

6 Despite a recommendation that he remain in the ED overnight; Travis left the hospital on foot at about 12.20am on 24 August 2023. The critical incident causing his death occurred about five hours later.

7 Travis was a much-loved member of his family. I am grateful to Travis's parents and his sister for engaging with the coronial process, including by their attendance throughout the course of the inquest. I have carefully considered their concerns, identified in materials in the coronial brief, about Travis's care and treatment prior to his death.

8 Based on my review of the evidence, I also reiterate the view, expressed by several witnesses, that Travis enjoyed the consistent and unwavering

[1] Travis's family asked that he be referred to by his first name at the inquest, and I have adopted that approach in these findings.

support of his family in the management of his mental health issues over a long period of time, including in times of crisis.

Jurisdiction

9 About a month prior to his death, and after a period of voluntary inpatient treatment at BRH's Acute Psychiatric Unit (**APU**), Travis was made the subject of a community treatment order (**CTO**) to be managed by the Bunbury Community Mental Health Team (**BCMHT**).[2]

10 That team operates within the Southwest Adult Mental Health Service, which forms part of the WA Country Health Service (**WACHS**).

11 A community treatment order is an involuntary treatment order.[3] As a consequence, had the CTO been in effect as at Travis's death, he would have been an involuntary patient under the *Mental Health Act*[4] and therefore a '*person held in care*' as defined in the *Coroners Act 1996* (WA).[5] In that event, an inquest would have been mandatory.[6]

12 The CTO was made by Dr Vineetha Edirisooriya by a Form 5A on 28 July 2023 at 9.25 am. The stated intention was that it remain in effect until 27 October 2023. However, s 76 of the *Mental Health Act* provides that a community treatment order must be confirmed in an approved form within 72 hours of it having been made. That section falls within Pt 6 subdiv 5 of the Act, which applies where a person is examined by a psychiatrist other than in specified circumstances, none of which applied to Dr Edirisooriya's examination of Travis.

13 The CTO was not confirmed within 72 hours of it having been made, and by operation of s 76(4) of the *Mental Health Act*, it ceased to be in force.

14 In those circumstances, the A/State Coroner directed that an inquest should be held to investigate Travis's death. I held the inquest on 17 and 18 June 2026 in Bunbury.

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[2] Exhibit 1, tab 19.
[3] *Mental Health Act 2014* (WA) s 21(2)(b).
[4] *Mental Health Act* s 21(1).
[5] *Coroners Act 1996* (WA) s 3.
[6] *Coroners Act* s 22(1)(a).

15 In addition to making findings as to Travis's cause and manner of death, if possible,[7] I may also comment on any matter connected with Travis's death, including public health or safety or the administration of justice.[8]

Issues raised at the inquest

16 To make findings as to the manner of Travis's death, the inquest focused on the quality of the treatment of his mental health leading up to his apparent suicide, including:

(a) the manner of his discharge from the APU in July 2023;

(b) his post-discharge management by the BCMHT which, at all relevant times, understood Travis to remain subject to the CTO despite it having ceased to be in force, including after his failure to present on 21 August 2023 for a depot injection; and

(c) his treatment at BRH on 23 and 24 August 2023, including:

(i) the quality of his assessment upon presentation at the ED, and the treatment plan that was developed;

(ii) the quality of his assessment upon waking up from the therapeutic sleep and what steps were taken following his stating that he wanted to leave the hospital;

(iii) the interaction between medical and nursing staff, including the psychiatric liaison nurse (**PLN**) on duty at the time; and

(iv) the decision not to detain Travis under the *Mental Health Act* after he had awoken from therapeutic sleep and been assessed by an emergency physician.

17 WACHS conducted a SAC 1 Clinical Incident Investigation into Travis's death which examined the above matters.

18 Further, Dr Adam Brett, an independent expert consultant psychiatrist was instructed by Counsel Assisting to provide his opinion on the quality of the psychiatric and mental health care that Travis received in the lead-up to his death. Dr Brett produced an opinion dated 4 February 2026 which addresses the issues identified above.

[7] *Coroners Act* s 25.
[8] *Coroners Act* s 25(2).

19 To address the matters identified at pars [15]-[15] above, I received the documentary evidence contained in the coronial brief, and the following witnesses gave oral evidence:

(a) Ms Jane Akusoba, a registered nurse and Travis's case manager within the BCMHT;

(b) Dr Daniel de Klerk, Travis's supervising psychiatrist and treating practitioner under the CTO;

(c) Dr Jon Halewood, the registrar who treated Travis when he presented to the ED on 23 August 2023 and developed his treatment plan;

(d) Dr Anand Sethi, the ED consultant who supervised Dr Halewood;

(e) Dr Mohamed Nasr, the ED registrar to whom Travis's care was handed over by Dr Halewood, and who assessed Travis when he woke from therapeutic sleep around midnight on 24 August 2023;

(f) Ms Alexis Briggs, a registered nurse who was involved in Travis's treatment at the ED on 23 and 24 August 2023;

(g) Ms Susana McKiernan, the PLN on shift on 23 and 24 August 2023;

(h) Dr Brett, regarding his expert opinion produced to the Court; and

(i) Dr Samir Heble, Executive Director, Medical Services, WACHS, who gave evidence in relation to, amongst others, the outcomes of the SAC 1 investigation, and matters arising from Dr Brett's opinion.

Materials received after the inquest

20 During the inquest, evidence was identified which raised specific concerns about the planning for Travis's discharge from the APU, and how its quality may have impacted the ability of the BCMHT to manage him in the community under the CTO.

21 As I consequence, at the end of the oral evidence I afforded WACHS an opportunity to provide further evidence in relation to Travis's discharge.

22 WACHS subsequently filed:

(a) a witness statement from Dr Edirisooriya, which became exhibit 3;

(b) a summary of the records of engagement between staff at the APU and Travis's family between 22 July 2023 and 28 July 2023, which became exhibit 4; and

(c) a witness statement from Ms Tori Mincham, who performed the role of Discharge Liaison Nurse in the APU at the relevant time, which became exhibit 5.

23 I will address the content of those exhibits when I make factual findings in relation to the relevant issues below.

Factual findings

24 In this part, I make factual findings about the circumstances leading up to and including Travis's death, including any findings necessary to make comment on the matters identified at par [15] above.

Travis's personal background

25 Travis was born in 1991.[9]

26 He lived in Boyup Brook with his parents and sister, before the family moved to other towns in the South-West region and closer to Perth, before eventually returning to Bunbury.[10]

27 He attended primary school in Withers and Harvey, and secondary school in Harvey, leaving high school in Year 9.[11]

28 Travis struggled academically, particularly with literacy.[12] He enjoyed playing team sports and being outdoors.[13]

29 Travis started his first job at Harvey Fresh at 14 years of age, working there until he was 18. He had short periods of employment after that, which generally ended due to behavioural issues. He stopped working in 2017 due to the onset of paranoid psychosis and commenced receiving a Centrelink pension.[14]

30 In early 2021, when Travis was 16 years of age, he was living with his parents in Harvey when he began to use morphine taken from his mother

[9] Exhibit 1, tab 1.
[10] Exhibit 1, tab 7, p 5; tab 8 pars [5]-[7].
[11] Exhibit 1, tab 8, pars [9]-[10].
[12] Exhibit 1, tab 7, p 5.
[13] Exhibit 1, tab 7, p 5; tab 8 par [11].
[14] Exhibit 1, tab 7, p 5.

who was prescribed the medication as part of her cancer treatment. Travis started using intravenous drugs which continued until he was about 24 years of age, when he commenced the suboxone program.[15]

31 In about June 2021, Travis began living with his great-aunt in Usher, before moving into a caravan park in Harvey, although he would return to his parents' home for assistance.[16]

32 At the inquest, Dr Heble noted that Travis expressed that exercise, conversations with his family, walking his dog, gardening and fishing were all things he believed kept him well.

33 In his own words, the most important thing to Travis was his relationship with his father, mother and sister.[17]

Diagnoses

34 Travis had a long history of mental illness, including schizophrenia and a substance use disorder. He had variable engagement with mental health services and was not always consistently compliant with treatment.[18]

35 As is often seen in cases involving severe treatment-resistant illness complicated by drug use, Travis's insight, judgment and capacity to consistently engage with treatment fluctuated, particularly during times of deterioration of his mental state associated with acute intoxication.[19]

36 However, as Dr Heble appropriately recognised, Travis demonstrated resilience in managing distressing experiences and sought support from health services when he was capable, reflecting a determination to engage with care despite the complex challenges he faced.[20]

Schizophrenia

37 Travis had a long history of psychosis exacerbated by drug use, including methylampthetamine, opioids, cannabis and other sedating drugs. He told his family that using drugs helped dull the noise in his head.[21]

[15] Exhibit 1, tab 7, p 6.
[16] Exhibit 1, tab 7, p 6.
[17] Ts 165.
[18] Exhibit 1, tab 32, par [47].
[19] Exhibit 1, tab 32, par [49].
[20] Exhibit 1, tab 32, par [79].
[21] Exhibit 1, tab 7, p 6.

38 Travis also had a history of prior suicide attempts and ongoing thoughts of self-harm.[22] He was also diagnosed with adjustment disorder, Cluster B personality traits, anxiety and depression.[23]

39 Travis was engaged with the BCMHT sporadically from 2016, being referred to and discharged from the service multiple times.[24]

40 In September 2016, Travis's parents referred him to the BCMHT based on concerns about his worsening depression, increased frequency of suicidal ideation, and suboxone use.[25]

41 Travis exhibited symptoms of auditory hallucinations and paranoia. He had been hearing voices since he was about 16 years of age.[26] He was initially managed in the community,[27] before being brought to Harvey Hospital by his parents after cutting his wrist with a knife.[28]

42 This led to a voluntary admission to the APU for two weeks between 27 December 2016 and 10 January 2017, during which Travis was diagnosed with schizophrenia.[29]

Opioid use disorder

43 Travis was a patient of Harvey Medical Group from 2007 to about 2022, with a history that included opioid use disorder, gastro-oesophageal reflux, neuropathic pain and insomnia.[30]

44 He subsequently saw a general practitioner, Dr Simpson, at Leschenault Medical Centre in Australind, who had initially treated him as part of the Community Program for Opioid Pharmacotherapy (**CPOP**) in 2021.

45 Travis had been prescribed medications including oxazepam, diazepam and paliperidone.[31] From November 2021 to 3 January 2022, Travis fulfilled the criteria for the Prescription Shopping Programme, and his general practitioner in Harvey was notified. He was deemed to meet the criteria for opioid dependence after Dr Simpson received documentation

[22] Exhibit 1, tab 7, p 11.
[23] Exhibit 1, tab 7, p 10.
[24] Exhibit 1, tab 7, p 14.
[25] Exhibit 1, tab 7, p 10.
[26] Exhibit 1, tab 7, p 6.
[27] Exhibit 1, tab 7, p 11.
[28] Exhibit 1, tab 7, p 13.
[29] Exhibit 1, tab 7, p 13.
[30] Exhibit 1, tab 7, p 7.
[31] Exhibit 1, tab 7, p 7.

regarding the immediate cessation of Norspan (buprenorphine) authority prescriptions to Travis in May 2022.

46 Travis was registered for the Buprenorphine program in June 2022 and treated with a monthly Buvidal injection, to act as a substitute for opioids and assist with withdrawal symptoms.[32]

Admissions to APU from February 2017 to October 2022

47 Travis had several subsequent admissions to the APU, as well as presentations to the EDs in Harvey and Bunbury.[33] He was admitted to the APU again for 15 days in early 2017, having threatened to kill himself with an axe and attempting to hang himself using a belt over a door at home, following non-compliance with prescribed medication. He was suffering acute exacerbation of psychotic symptoms, worsening auditory hallucinations and persecutory delusions.[34]

48 In May 2018, Travis was voluntarily admitted to the APU for five days following an overdose. He was diagnosed with schizophrenia with a differential diagnosis of depression with psychotic features.[35]

49 Travis was admitted again in December 2018, due to medication non-compliance, worsening derogatory auditory hallucinations, and suicidal ideation. He was initially admitted voluntarily, but after declining to accept treatment, he was made an involuntary patient and depot injections were recommended. He was discharged after 22 days, with follow up by the BCMHT planned.[36]

50 It appears that Travis's treatment in the community through the Harvey outreach clinic worked well, at least initially. He received regular home visits, and his depot medication at the family home. He was considered by staff to be polite, cooperative and well-engaged.[37]

51 In April 2019, Travis's father reported that he had attempted to hang himself using a belt following an argument. He was hospitalised and voluntarily admitted to the APU for 32 days.[38]

[32] Exhibit 1, tab 7, p 8.
[33] Exhibit 1, tab 7, p 11.
[34] Exhibit 1, tab 7, p 13.
[35] Exhibit 1, tab 7, p 11.
[36] Exhibit 1, tab 7, p 17.
[37] Exhibit 1, tab 7, p 17.
[38] Exhibit 1, tab 7, p 17.

52 Travis experienced a further episode of suicidality with planning in January 2020, by which time he was using a combination of substances and had been refused suboxone by the local pharmacy. He experienced chronic visual and auditory hallucinations.[39]

53 In October 2020, Travis engaged with the Southwest Community Alcohol and Drug Service and was accepted into the CPOP.[40]

54 In April 2021, Travis jumped out of a vehicle being driven by his father and ran into the path of an approaching tow truck. He reported that he was hearing voices and feared that he would be killed if he did not kill himself first.[41] He was admitted to the Psychiatric Intensive Care Unit. Following a 37-day admission, he was released on a community treatment order.[42]

55 In September 2022 during a presentation to the ED at BRH, Travis was identified as being at chronic risk of acting impulsively due to persistent suicidal ideation, particularly when affected by illicit substances. While staff were attempting to organise transport, he left the hospital. He was later visited at home, where it was apparent that his mental health had deteriorated, and he was admitted to the APU until 27 September 2022.[43]

56 During a further admission to the APU in October 2022, he resumed depot injections and engaged in therapy. Prior to discharge, his mental state was described as the best observed in recent months. He was monitored by his care coordinator and continued receiving the depot injections.[44] He was eventually discharged from the BCMHT in February 2023.

Incident in July 2023 and admission to APU

57 On 15 July 2023, Travis deliberately ran in front of a flatbed truck while under the influence of cannabis [45] He struck the side of the truck and was thrown to the side of the road. He was taken to Harvey Hospital, where he rejected that he had intended to self-harm. He was transferred to BRH and evaluated by the psychiatric liaison nurse, who noted Travis's history of past suicide attempts.[46] He denied any suicidal ideation or intent.

[39] Exhibit 1, tab 7, p 18.
[40] Exhibit 1, tab 7, p 18.
[41] Exhibit 1, tab 7, p 19.
[42] Exhibit 1, tab 7, p 20
[43] Exhibit 1, tab 7, p 22.
[44] Exhibit 1, tab 7, p 23.
[45] Exhibit 1, tab 9.2.
[46] Exhibit 1, tab 7, p 29.

58 Travis was discharged from hospital the following day, and he refused to engage in any follow up with the BCMHT after his discharge.[47]

59 On 21 July 2023, Travis expressed suicidal thoughts and was brought to BRH by his father, who was concerned about his decompensating mental state and risk to himself.[48] He was triaged at the ED and staff identified psychotic and affective symptoms associated with ongoing illicit drug use. He was medically cleared[49] and admitted to the APU voluntarily.[50]

60 Upon admission, Travis was diagnosed with a relapse of schizophrenia in the context of cessation of the depot and ongoing drug use.[51] He reported chronic auditory hallucinations, and that he had intentionally run into the path of the truck due to paranoia and fear of being followed.[52]

61 Early in the admission, Travis refused a psychiatric review and physical examination.[53] He eventually agreed to resume the depot medication,[54] but declined a referral to alcohol and drug counselling, stating that he did not want or need any assistance in this regard.[55] In his discharge summary, it was noted that Travis would minimise his substance use, which was generally the trigger for relapses.[56]

62 According to Travis's family, he did not seem to make much progress after inpatient admissions.[57] I infer they felt the same in relation to this, his last, inpatient admission at the APU. By 24 July 2023, he had consented to review by the treating team and stated that he was still experiencing voices commanding him to kill himself, but that he did not feel safe at hospital.[58]

63 Travis was visited by his father on 22 and 23 July 2023 without issue. The records do not indicate any discussion between Travis's father and staff about any treatment plan for Travis.[59]

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[47] Exhibit 1, tab 7, pp 29-30.
[48] Exhibit 1, tab 11.
[49] Exhibit 1, tab 11.
[50] Exhibit 1, tab 7, p 30.
[51] Exhibit 1, tab 7, p 31.
[52] Exhibit 1, tab 7, p 30; tab 11.
[53] Exhibit 1, tab 11.
[54] Exhibit 1, tab 7, p 31.
[55] Exhibit 1, tab 7, p 32; exhibit 4.
[56] Exhibit 1, tab 11.
[57] Exhibit 1, tab 7, p 6.
[58] Exhibit 1, tab 7, p 31.
[59] Exhibit 4.

64 A progress note from 24 July 2023 suggests an intention by the treating team to obtain collateral information from Travis's family, but there is no record of that having occurred, despite his having been visited by his father again on that date.[60]

65 Travis took escorted leave with his father on 25 July and with his sister on the afternoon of 26 July. It is not apparent from the records that any staff spoke with either Travis's father or sister about the plan for his future treatment, which by that stage was clearly documented in a note from earlier in the day as to '*likely*' include the CTO.[61]

66 Travis reluctantly attended a discharge planning meeting with his father and Ms Dalton on 27 July, during which Travis's father expressed concern about his son's poor self-care, decompensating mental state and suicide risk. Travis indicated an unwillingness to engage with the BCMHT, but an acceptance that this would be necessary.[62]

67 The clinician's notes from that occasion indicate that the plan was to clarify the proposed plan for a depot and CTO as appears to have been formulated at a multi-disciplinary team meeting the previous day.[63]

68 There is no indication that the plan, including the proposed CTO, was discussed with Travis's father during or after the meeting.

69 A psychiatric registrar within the APU treating team consulted Dr de Klerk on 27 July 2023.

70 Dr de Klerk agreed that a continuing treatment order would be worthwhile on discharge, to promote ongoing support and depot administration.[64]

71 At discharge on 28 July 2023, it was noted that Travis was continuing to suffer ongoing command hallucinations. He was considered by his treating team to be chronically elevated but a lower acute risk if treated with antipsychotics and abstinent from drugs.[65]

72 A progress note indicates that, on the date of Travis's discharge, '*referral to community for case manager remained outstanding'*.[66] At that time,

[60] Exhibit 4.
[61] Exhibit 4.
[62] Exhibit 1, tab 7, p 32.
[63] Exhibit 4.
[64] Exhibit 1, tab 7, p 33.
[65] Exhibit 1, tab 7, p 31.
[66] Exhibit 1, tab 7, p 33.

Travis was understood to be living in a caravan park in Harvey, was identified by APU staff as being at a risk of homelessness and was known not to have a mobile phone.[67] Further, it was expressly recognised in the care transfer summary between the APU and the BCMHT that his living circumstances and not having a mobile phone were '*barriers to follow up in the community*'.[68] Notwithstanding this recognition, his discharge plan included '*follow up phone call 4 August (?call parents*)'.[69]

73 Travis received a paliperidone injection on 27 July 2023.[70] He was also given a prescription for 5mg of olanzapine to be taken twice daily. His prescriptions for pregabalin, diazepam and oxazepam had been ceased during the admission.[71] An appointment with his GP was scheduled for 8 August, with the recommendation he recommence CPOP.[72]

74 A copy of the CTO was given to Travis, and its terms were read out to him.[73]

75 The care transfer summary indicates that an unsuccessful attempt was made to contact Travis's next of kin.[74]

76 Ms Dalton appears to have attempted to call Travis's father at about 9.45 am on 28 July 2023,[75] although she is unable to recall the attempt.[76]

77 Notes record two further attempts by a welfare officer to call Travis's father on 28 July, although the notes indicate that the purpose of the calls was related to organising transport for Travis. There is no indication that the intention of these two calls was to communicate the fact of the CTO.[77]

78 The CTO required that Travis comply with all of Dr de Klerk's directions about the treatment to be provided to him under the order, with the specific directions:

- *To continue Paliperidone monthly injection*

[67] Exhibit 1, tab 7, p 34.
[68] Exhibit 1, tab 7, p 34; tab 20, p 1.
[69] Exhibit 1, tab 7, p 34.
[70] Exhibit 1, tab 7, p 32.
[71] Exhibit 1, tab 7, p 32; tab 11.
[72] Exhibit 1, tab 7, p 33.
[73] Exhibit 1, tab 7, p 33.
[74] Exhibit 1, tab 20.
[75] Exhibit 4.
[76] Exhibit 5, par [16(g)], [20].
[77] Exhibit 4.

- *monitor metabolic parameters and prolactin levels*

- *continue work on motivation to abstain from polysubstance use*[78]

79 Travis attended an appointment with Dr Simpson on 8 August 2023 post-discharge. He advised that he was living at the caravan park in Harvey, and that he was using Norspan patches, as well as any other opioid he could obtain. Dr Simpson advised that he needed to go back onto the CPOP, which he was prepared to do. He was refused benzodiazepines, but consideration was given to starting Buvidal again shortly.[79]

80 He attended another appointment with Dr Simpson on 11 August for the purposes of the buprenorphine program. That was the last time he was seen by Dr Simpson.[80]

Management by BCMHT in August 2023

81 Travis was 'reactivated' with the BCMHT on 28 July 2023, and his case was allocated to Ms Akusoba, with a request for her to contact Travis and the APU to discuss the discharge plan and confirm further follow up arrangements.[81]

82 The CTO recorded Travis's address as the caravan park in Harvey. Ms Akusoba recalls that Travis had no contact details, including no telephone number.[82] She recalls trying to reach Travis on his mother and father's phone several times, but was not successful.[83]

83 On 2 August 2023, Ms Akusoba was able to contact Travis by calling his father's mobile phone. He advised Ms Akusoba that he was still living at the caravan park in Harvey (although, by that time, Ms Akusoba had received information independently as part of her management of another case to suggest that he was not, in fact, living there anymore).[84]

84 Travis made it very clear to Ms Akusoba that he would not comply with the CTO and would not receive the depot.

85 Ms Akusoba tried to reassure Travis, but he remained adamant that he would not receive treatment, or any follow up from BCMHT. Travis ended

[78] Exhibit 1, tab 19, p 3.
[79] Exhibit 1, tab 23, p 34.
[80] Exhibit 1, tab 23, p 35.
[81] Exhibit 1, tab 7, p 34; tab 21, p 3.
[82] Exhibit 2, tab 8, par [34].
[83] Exhibit 2, tab 8, par [35].
[84] Exhibit 2, tab 8, par [34]; ts 11.

the call before Ms Akusoba could perform any mental state examination,[85] and he did not answer when she tried to call him back.[86]

86 Ms Akusoba's evidence was that although Travis was direct and used some abusive language, she did not consider that Travis was exhibiting any symptoms of psychosis or '*busy*' thought patterns,[87] and he did not verbalise any suicidal ideation during the telephone call.[88]

87 The records indicate that Ms Akusoba intended to raise the substance of this conversation with Dr de Klerk.

88 Dr de Klerk has no independent recollection of whether that discussion occurred,[89] but Ms Akusoba can recall a conversation taking place,[90] and Dr de Klerk confirmed that he has no cause to doubt the content of Ms Akusoba notes.[91] I find that the discussion took place and proceeded in accordance with Ms Akusoba's notes and independent recollection.

89 Ms Akusoba recalls speaking with Dr de Klerk on or about 8 August, and relaying what had occurred during the phone call on 2 August, including Travis's indication that he was unwilling to engage with the service.[92]

90 The decision was made by Dr de Klerk to proceed to the first review meeting, which had already been scheduled.[93]

91 Travis did not attend the appointment on 15 August as scheduled but did attend the following day, unscheduled, so the BCMHT took the opportunity to conduct the first review which had been scheduled for the previous day.[94] Dr de Klerk saw Travis via videoconference. Ms Akusoba and another staff member were present, in person, with Travis.[95]

[85] Exhibit 2, tab 8, par [48].
[86] Exhibit 1, tab 7, p 35; tab 21, p 4; exhibit 2, tab 8, par [49].
[87] Exhibit 2, tab 8, par [58].
[88] Exhibit 2, tab 8, par [60].
[89] Exhibit 1, tab 31, par [18].
[90] Ts 19-20.
[91] Ts 25.
[92] Exhibit 2, tab 8, par [50].
[93] Exhibit 2, tab 8, par [51].
[94] Exhibit 2, tab 8, pars [61]-[62]; ts 15.
[95] Exhibit 1, tab 31, par [19].

92 Dr de Klerk recalls that the consultation was brief and challenging.[96] At the inquest, he described it as short, uncomfortable and unpleasant.[97] He estimates the consultation lasted less than ten minutes.[98]

93 Travis immediately demanded certain medications, and then abruptly left when Dr de Klerk was unwilling to give a prescription.[99] Dr de Klerk recorded that Travis had not demonstrated any psychotic symptoms during the short interview, and his impression was that Travis's major issue was his sedation seeking but unwillingness to engage with alcohol and drug services. Dr de Klerk decided to continue with the CTO although he doubted that Travis suffered from a mental illness that would benefit from treatment in the absence of drug and alcohol intervention.

94 Dr de Klerk indicated a plan of potential release from the *Mental Health Act* after review in four weeks' time.[100]

95 I interpose that in his witness statement, Dr de Klerk noted that the medications that Travis was seeking were not only contra-indicated, but potentially causative of harm.[101] I accept that evidence.

96 Following the interview, it was noted that Travis came back into the premises and was in the waiting room, visibly upset.[102] After discussion with the staff present, Dr de Klerk maintained the view that Travis was not exhibiting any symptoms of serious mental illness or psychosis. He suggested that Travis present to the ED if distressed, and if he presented with psychotic symptoms needing treatment then readmission to the APU could be considered.[103]

97 In his witness statement, Dr de Klerk noted that he considered Travis's distress at the time to be primarily in response to his refusal to prescribe sedative medication, rather than due to any active psychotic symptoms. Dr de Klerk did not consider the latter to be likely, given Travis had been able to articulate a request for medication, and then leave the interview when that was refused, indicating a logical chain of thought on his part.[104] I accept that Dr de Klerk held that view, and find that it was reasonable. I

[96] Exhibit 1, tab 31, par [20].
[97] Ts 25-26.
[98] Ts 26.
[99] Exhibit 2, tab 8, pars [68]-[74].
[100] Exhibit 1, tab 7, p 35; tab 21, p 5.
[101] Exhibit 1, tab 31, par [20].
[102] Ts 16.
[103] Exhibit 1, tab 7, p 35, tab 21, p 6.
[104] Exhibit 1, tab 31, par [25].

also accept Dr de Klerk's evidence that had he formed the view during or after the meeting that Travis's distress was due to active psychotic symptoms relating to his schizophrenia, he would have considered changing the CTO to an inpatient treatment order.[105]

98 Dr de Klerk contacted the psychiatric liaison nurse at BRH to provide an update, in the event Travis presented to the ED and was displaying psychotic symptoms.[106] It is not clear if the nurse Dr de Klerk spoke to on that occasion was Ms McKiernan or another member of staff,[107] although he recalls them being familiar with Travis.[108]

99 Travis did not attend for his depot injection on 21 August. Staff attempted to call his parents, but there was no answer.[109]

100 Ms Akusoba noted that she would continue to attempt to contact Travis and would feed back his non-compliance to Dr de Klerk when he returned from leave the following day.[110]

101 Dr de Klerk was informed when he returned to work that Travis had not attended his depot appointment as scheduled.[111]

102 Ms Akusoba does not recall Travis or anyone else contacting the clinic in relation to Travis between 16 and 21 August 2023.[112]

103 I interpose that around this time, Travis's mother had suffered a stroke, and she was discharged home on 22 August 2023 following treatment and rehabilitation.[113]

Events of 23 August 2023

Prior to admission to BRH

104 In the afternoon of 23 August, Travis was at his parents' home and talking with his sister.[114]

[105] Exhibit 1, tab 31, par [26].
[106] Exhibit 1, tab 7, p 36; tab 21, p 7.
[107] Exhibit 1, tab 21, p 7.
[108] Ts 31.
[109] Exhibit 1, tab 21, p 9; exhibit 2, tab 8, par [85].
[110] Exhibit 1, tab 7, p 36; tab 21, p 9.
[111] Exhibit 1, tab 31, par [33].
[112] Exhibit 2, tab 8, par [88].
[113] Exhibit 1, tab 7, p 36.
[114] Exhibit 1, tab 8, par [39].

105 Later in the day, Travis's behaviour began to escalate. His father believed that he had used methylamphetamine, smoked cannabis, and may have also taken pregabalin.[115]

106 Travis started shouting and began crying out and was extremely agitated. His father had not seen him in such a state before,[116] and he could not be calmed. He was shouting certain phrases repeatedly[117] and positioned himself into a foetal position, rocking back and forth.[118]

107 At just before 7.00 pm, Travis's father called for an ambulance. Travis was yelling so loudly by this stage that the operator had difficulty hearing what was being said.[119]

108 Travis's father informed the operator that Travis had severe schizophrenia and had used drugs earlier that day and was experiencing a convulsion.

109 The operator remained on the phone with Travis's father for about 18 minutes.[120] At one point, as his father was trying to reassure him, Travis yelled '*I'm telling them to kill me*'.[121]

110 Travis then began hyperventilating and letting out high-pitched screams. His speech was incoherent and disorganised.[122]

111 Upon their attendance, ambulance officers were advised that Travis was not compliant with his medications and had injected methylamphetamine and used cannabis earlier that day.[123]

112 Police officers attended to assist with transport, and observed Travis suffering tremors, muscle spasms and involuntary movements.[124] He was hyperalert, confused, irrational, and experiencing visual and auditory hallucinations.[125]

[115] Exhibit 1, tab 7, p 37; tab 8, pars [43]-[44].
[116] Exhibit 1, tab 8, par [46].
[117] Exhibit 1, tab 8, par [49].
[118] Exhibit 1, tab 7, p 37; tab 8, par [50].
[119] Exhibit 1, tab 8, par [51].
[120] Exhibit 1, tab 7, p 38.
[121] Exhibit 1, tab 7, p 38.
[122] Exhibit 1, tab 7, p 38.
[123] Exhibit 1, tab 7, p 39; tab 11.1, p 2.
[124] Exhibit 1, tab 7, p 39.
[125] Exhibit 1, tab 7, p 39; tab 11.1, p 2.

113 Travis was not considered to be violent or aggressive towards any of the attending staff or his parents, but they were unable to converse with him.[126]

114 At 7.20 pm, Travis was given 10 mg of droperidol intramuscularly, which took effect after about three minutes.[127]

115 Travis was transported to BRH by ambulance, leaving his parents' home at 7.28 pm.

116 Travis's father believed, at that time, that he would undergo a mental health review including to determine if Travis required admission for further treatment.[128]

Initial treatment by Dr Halewood

117 Travis remained agitated in the ambulance but manageable enroute to BRH,[129] and upon arrival he was triaged as category 2.[130] He was observed to be making choreoathetoid movements.[131]

118 Dr Halewood was on the evening shift at the ED,[132] and recalls seeing Travis soon after he arrived.[133]

119 In his witness statement, Dr Senthi recalls that the paramedics advised that Travis's behaviour had escalated at home, and he had become very agitated and erratic on background of known schizophrenia and substance abuse, including consumption of methylamphetamine and potentially cannabis, and that Travis's father had called for the ambulance.[134] Dr Senthi notes that there was no reference to any suicidal ideation or the existence of the CTO during the handover.[135]

120 Dr Halewood was initially Travis's treating doctor in the ER.[136] His note of Travis's initial treatment was written in retrospect on 24 August 2023 at 6.00 pm, given the notes he made electronically during provision of

[126] Exhibit 1, tab 7, p 39; tab 10, par [19]; tab 11.1, p 2.
[127] Exhibit 1, tab 7, p 39; tab 11.1, p 2.
[128] Exhibit 1, tab 7, p 40; tab 8 par [58].
[129] Exhibit 1, tab 10, pars [23]-[24]; tab 11.1, p 2.
[130] Exhibit 1, tab 7, p 40.
[131] Exhibit 2, tab 9, par [5].
[132] Exhibit 2, tab 3, par [31].
[133] Exhibit 2, tab 9, par [7].
[134] Exhibit 2, tab 3, par [31].
[135] Exhibit 2, tab 3, par [32].
[136] Ts 40.

treatment did not save on the electronic system as intended.[137] Although it is never ideal for notes to be made retrospectively, particularly following such a serious outcome as the death of a patient, I have no cause to doubt the accuracy of Dr Halewood's note, including where it was made relatively close in time. I accept that he did make notes at the time of his shift, but that they did not save due to a system issue.

121 Dr Senthi also made a retrospective note, in which he recorded his observation that Travis was yelling, and waving his arms vigorously.[138] Dr Senthi observed that Travis appeared unable to understand or communicate information.[139] I infer that these observations were likely made later, during the second time Dr Halewood assessed Travis.

122 Upon initial assessment by Dr Halewood, Travis was elevated but remained in bed. He had profound motor tics and some intermittent yelling. He was able to speak but was non-conversant and Dr Halewood was unable to take a history. Dr Halewood's recollection is that Travis was incoherent and when he did respond to any questions, it was '*gibberish*' or in nonsensical short sentences.[140]

123 Dr Halewood's initial impression was that Travis was intoxicated, which was consistent with the history that had been provided by paramedics. His view was that immediate intervention was not warranted at that time because Travis was not presenting as a risk to himself, and visual observation by nursing staff was sufficient, with redirection if required.[141]

124 Dr Halewood left to attend to other patients but returned to Travis after being informed that there had been an increase in his agitation.[142] Dr Halewood observed that Travis's agitation had in fact increased, and that he was screaming and flailing, which caused Dr Halewood to conclude that he posed an imminent risk to himself and anyone nearby, including staff and other patients.[143]

125 Dr Halewood consulted with Dr Senthi, and it was agreed that Travis lacked capacity and required sedation for his own protection pursuant to the power conferred by s 110ZI of the *Guardianship and Administration*

[137] Exhibit 1, tab 22, p 2; exhibit 2, tab 9, pars [30], [34]-[35].
[138] Exhibit 1, tab 22, p 4.
[139] Exhibit 1, tab 22, p 4.
[140] Exhibit 2, tab 9, par [11].
[141] Exhibit 2, tab 9, pars [13]-[14].
[142] Exhibit 2, tab 9, pars [18]-[19].
[143] Exhibit 2, tab 9, par [20].

Act 1990 (WA).[144] Travis was administered 10 mg of midazolam intramuscularly at about 7.50 pm,[145] which had a good sedating effect.[146]

126 Dr Halewood stayed with Travis until he fell asleep, to ensure there was no respiratory compromise.[147]

127 Travis was then moved to an area in the department referred to as Mental Health Room 2 (**MH2**) for monitoring,[148] being the area usually used for monitoring of sedated patients.[149]

128 Due to the report of drug use earlier that day, blood samples were taken for the purposes of the Emerging Drugs Network of Australia (**EDNA**). Subsequent analysis of the sample detected methylamphetamine at approximately 0.2 mg/L and amphetamine at 0.07 mg/L.[150]

129 Dr Halewood's impression following his assessment was that Travis appeared to be under the influence of an illicit drug toxidrome, likely a sympathomimetic (stimulant drug) like methylamphetamine.[151]

130 At that stage, Dr Halewood considered that intoxication was more likely than some form of relapse of Travis's schizophrenia,[152] but that it was critical for Travis to be reassessed once he woke up, and once there had been an opportunity for any intoxicating agent to have metabolised.[153] Dr Halewood was cognisant that although intoxication was his impression at that time, there was a need to consider what other illness may be at play upon Travis becoming more settled and capable of being assessed.[154]

131 Dr Senthi considered that methylamphetamine toxicity with psychotic features was more likely than a relapse of schizophrenia based on the relatively acute nature of Travis's deterioration, according to the history provided at admission.[155]

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[144] Exhibit 2, tab 3, par [36]; tab 9, par [22]; ts 41.
[145] Exhibit 1, tab 22, p 15.
[146] Exhibit 2, tab 3, par [38]; tab 9, par [24].
[147] Exhibit 2, tab 9, par [24].
[148] Exhibit 1, tab 22, p 7.
[149] Exhibit 2, tab 1, par [36].
[150] Exhibit 1, tab 12.
[151] Exhibit 1, tab 22, p 2.
[152] Ts 42.
[153] Ts 43.
[154] Ts 43.
[155] Ts 53.

132 Dr Halewood's plan was for Travis to have therapeutic sleep overnight, with any potential substance having time to '*wash out*' and then be re-assessed on waking to determine if the cause of his presentation was drug-induced psychosis or a relapse of schizophrenia.[156] Dr Brett agreed, as part of his review of the treatment, that this was a reasonable plan.[157]

133 Travis was asleep when Ms Briggs commenced her shift.[158] He awoke, mildly agitated, around 10.20 pm and Ms Briggs administered 5 mg of diazepam intravenously which caused him to settle and go back to sleep.[159] Ms Briggs did not speak with Travis at that time.[160]

134 Ms McKiernan recollects that when she commenced her night shift, she was informed during handover that there were two patients in the ED who had required sedation, one being Travis.[161] She recalls going into the ED to inform the doctor in charge and the nurse shift coordinator that she was available, and seeing that Travis was in bed and appeared to be asleep.[162]

135 Ms McKiernan's recollection is that in anticipation of a referral, she perused Travis's medical records and notes.[163]

136 In her witness statement, she indicated it would be her usual practice to review the medical records and notes for a patient, as well as the record on the Psychiatric Services On-Line Information System (**PSOLIS**),[164] but at the inquest she noted that she could not recall accessing PSOLIS in relation to Travis's case at the time. Her evidence was that she would usually access PSOLIS when a patient had been referred.[165] It was clear from the evidence that Travis was not the subject of such a formal referral at any stage of his treatment on 23 or 24 August.

Treatment by Dr Nasr and discharge

137 Dr Nasr was working the night shift in the ED, from 10.30 pm on 23 August 2023 to 8.00 am on 24 August 2023.[166] He recalls that the shift

[156] Exhibit 1, tab 22, p 3.
[157] Ts 90.
[158] Exhibit 2, tab 5, par [39].
[159] Exhibit 1, tab 7, p 49; tab 12.1; exhibit 2, tab 5, par [41].
[160] Ts 129.
[161] Exhibit 2, tab 7, par [6].
[162] Exhibit 2, tab 7, pars [8]-[9].
[163] Exhibit 2, tab 7, par [15].
[164] Exhibit 2, tab 7, par [16].
[165] Ts 119.
[166] Exhibit 2, tab 1, par [16].

was relatively busy, and he was the senior registrar in charge.[167] Dr Nasr's note of Travis's treatment was also written in retrospect, given competing priorities in the ED,[168] but it was relatively contemporaneous given it was made on 24 August 2023 at 7.12 am. I have no reason to doubt the accuracy of that note, and find that it, along with the nursing records, is the best record of what occurred.

138 Dr Nasr states that Travis's case was handed over to him as potential drug induced agitation and delusion, resulting from methylamphetamine use earlier in the day, with a known background of schizophrenia.[169] Travis was sleeping in his room at the time of handover.[170]

139 Dr Nasr noted that handover is usually conducted by the junior doctors with the consultants overseeing the process and adding in any additional information as required.[171] Dr Senthi recalls being part of the handover to Dr Nasr, at around 10.30 pm, of all patients within the ED.[172]

140 Dr Nasr noted that nothing in the handover suggested that Travis was potentially suicidal.[173]

141 Where Dr Halewood's notes had not saved, there was no formal clinical documentation in either the digital medical record or the Emergency Department Information System (**EDIS**) for Dr Nasr to be able to access.[174]

142 Dr Nasr understood that the treatment plan developed by the outgoing team was for Travis to be observed overnight and then for him to be reassessed in the morning.[175]

143 Travis woke up and sat up in his bed at about 11.30 pm and began to unwrap the bandage securing his canula before laying back down.

144 At about 11.53 pm, Travis sat up again and propped himself up.[176] It was at this point that Ms Briggs spoke to him for the first time.

[167] Exhibit 2, tab 1, pars [20]-[21].
[168] Exhibit 1, tab 22, p 5.
[169] Exhibit 2, tab 1, par [27].
[170] Exhibit 1, tab 11, p 1.
[171] Exhibit 2, tab 1, par [19].
[172] Exhibit 2, tab 3, par [65].
[173] Exhibit 2, tab 1, par [28].
[174] Exhibit 2, tab 1, par [29].
[175] Exhibit 2, tab 1, par [30].
[176] Exhibit 1, tab 7, p 49.

145 Ms Briggs recalls that when Travis awoke, he wanted to leave the ED immediately, and she explained to him that it was late at night and she was concerned about his safety if he were to leave at that time, particularly given he did not have a clear plan for accommodation or transport.[177]

146 Ms Briggs offered further medication, before offering to make Travis a coffee and provide him some food, to keep him in the ED, to which Travis agreed.[178]

147 Ms Briggs was concerned with making Travis offers that might encourage him to stay in hospital and convince him not to leave.[179]

148 Ms Briggs recalls that Travis was giving direct answers to her questions, demonstrating an understanding of what he was being asked.[180] Although he was wanting to leave, Ms Briggs noted that he was willing to wait on a couple of occasions, including for her to speak to Dr Nasr, to get him something to eat, and to allow her to contact his father.[181]

149 Ms Briggs got Travis some food and juice and continued to talk to him.[182]

150 Ms Briggs also recalls contacting the psychiatric liaison nurse. She cannot recall who she spoke to, other than that the person was female.[183] Given the timing, I find that the person was Ms McKiernan. Ms Briggs recalls being advised that Travis was not under the care of the mental health team, before going to speak to Dr Nasr.[184] Ms McKiernan cannot recall receiving this call; however, it was apparent from her written and oral evidence that Ms Briggs had a superior independent recollection of events, and I accept her evidence that this phone call occurred as she described. I also accept that the purpose of Ms Briggs's call was to essentially '*clear*' Travis leaving the ED with the PLN, and to ascertain if there was any mental health plan in place.[185]

[177] Exhibit 2, tab 5, pars [43]-[44].
[178] Exhibit 2, tab 5, par [46], ts 129.
[179] Ts 129.
[180] Ts 129-130.
[181] Ts 130.
[182] Exhibit 2, tab 5, par [46].
[183] Ts 131.
[184] Exhibit 2, tab 5, pars [52]-[53].
[185] Ts 131-132.

151 At about midnight, Travis got out of bed, removed monitoring equipment and stood at the door of MH2, before Dr Nasr entered at about 12.05 am.[186]

152 Dr Nasr recalls being informed that Travis wanted to leave the ED, and going to review Travis in MH2 promptly.[187] He introduced himself to Travis and performed a physical examination consisting of a quick head-to-toe check, which was unremarkable in the sense that Dr Nasr did not identify any physical findings including any self-inflicted injuries.[188] While he was examining Travis, Dr Nasr asked him a range of questions to check his capacity, including whether he had any thoughts of harming himself or harming others.[189]

153 Dr Nasr maintained eye contact and engaged with Travis, including to identify whether he appeared intoxicated or had any features suggestive of psychosis.[190]

154 Dr Nasr states that Travis was communicating with him rationally and did not demonstrate any delusions. He presented as calm and cooperative, and denied suicidal or self-harm thoughts.[191] He responded coherently to Dr Nasr's questions and did not provide responses which appeared to be nonsensical, disorganised or suggestive of an inability to understand the information being discussed.[192]

155 Dr Nasr spoke to Travis specifically about where he planned to go and recalls him saying that he wanted to leave and go to his family home.[193]

156 In terms of sedation, Dr Nasr determined that Travis was fully conscious and was not suffering any lingering effects of the sedating medication.[194]

157 Ms Briggs was able to hear parts of the examination and recalls Dr Nasr asking Travis about where he planned to go, and whether Travis felt safe within himself.[195]

[186] Exhibit 1, tab 7, p 49.
[187] Exhibit 2, tab 1, par [36].
[188] Exhibit 2, tab 1, par [38].
[189] Exhibit 2, tab 1, par [39].
[190] Exhibit 2, tab 1, par [40].
[191] Exhibit 1, tab 11.
[192] Exhibit 2, tab 1, par [42].
[193] Exhibit 2, tab 1, par [43].
[194] Ts 85.
[195] Exhibit 2, tab 5, par [55].

158 Ms Briggs also noted that Travis's responses and manner of engagement with Dr Nasr were consistent and the same as when he had been speaking with her, in circumstances where a patient's response can vary including upon questioning by a doctor or by a nurse.[196]

159 Her recollection is that Dr Nasr's assessment was not rushed.[197]

160 Based on the assessment, Dr Nasr formed the view that Travis was not clinically intoxicated. Dr Nasr also determined that Travis was not exhibiting any signs of psychosis or suicidality, and as such he had decision-making capacity regarding his care.[198]

161 After the examination, Dr Nasr went to review the available test results, all of which were unremarkable.[199]

162 He also reviewed the drug chart, nurses' notes and the hard copy notes made by the paramedics.[200] I am satisfied that part of Dr Nasr's approach in reviewing these materials included looking for any potential signs of risk of self-harm or suicidality, cognisant of the fact that a patient may express suicidal thoughts at an earlier time, and then deny them later as part of an examination.[201]

163 In Dr Nasr's view, the fact that Travis's symptoms appeared to have resolved after therapeutic sedation supported a diagnosis of substance intoxication rather than relapse of schizophrenia or primary psychosis.[202]

164 This included normalisation of Travis's vital signs which had been highly elevated at admission.[203]

165 In his retrospective note, Dr Nasr states that he contacted '*the PLN, who [was] happy for [Travis] to go home as he didn't warrant any indications for psych assessment involuntarily*'.[204]

166 In his witness statement, Dr Nasr recalls contacting Ms McKiernan at about 12.10 am by phone. He says he did so out of an abundance of caution

[196] Ts 134.
[197] Ts 134.
[198] Exhibit 2, tab 1, par [41].
[199] Exhibit 2, tab 1, par [44].
[200] Exhibit 2, tab 1, par [45].
[201] Ts 75.
[202] Exhibit 2, tab 1, par [47].
[203] Ts 84.
[204] Exhibit 1, tab 11.

and because, in his experience, psychiatric liaison nurses often provide additional useful information about a patient's mental health history.[205]

167 Dr Nasr believes he did not have access to PSOLIS,[206] and as such he was reliant on Ms McKiernan to inform him of any current management plans or concerns identifiable from that system that could inform his clinical decision-making.[207]

168 Dr Nasr recalls that Ms McKiernan did not advise him of any current management plans or concerns in respect of Travis, including any prior issues with Travis's medication compliance.[208]

169 I find, including based on the evidence of an audit of access to the PSOLIS system during the shift undertaken by WACHS, that Ms McKiernan did not access PSOLIS as part of her communication with Dr Nasr.[209] I find that Ms McKiernan must have based any response to Dr Nasr on the contents of EDIS and the handover that she had been provided.

170 Ms McKiernan has a recollection of having a conversation with '*the ED doctor*' who called '*to let me know that [Travis] had left or was leaving the ED*', but she was unable to recall if this conversation took place before or after Travis had left the ED.[210] Ms McKiernan is unable to recall the questions she was asked by Dr Nasr, or any specifics of the conversation including the purpose of the call.[211]

171 To the extent there is any real discrepancy between the evidence of Dr Nasr and Ms McKiernan, I prefer the evidence of Dr Nasr who appeared from the written and oral evidence to have a much stronger recollection of the events from that night. For the avoidance of doubt, I do not accept the possibility that the call was made after Travis had already left the ED, as a courtesy.[212] That is inconsistent with the other evidence,

[205] Exhibit 2, tab 1, par [49].
[206] This belief may have been inaccurate. Dr Heble's evidence is that practitioners may not have '*global*' access to PSOLIS, but all practitioners should have '*read-only*' access, including at the time of Travis's treatment: ts 156-157. However, in any event, I accept that given the role performed by emergency physicians and the likelihood that they would not use PSOLIS frequently, it is reasonable for them to rely on psychiatric liaison nurses, who will be more conversant with the system, which is not the easiest to navigate: ts 156.
[207] Exhibit 2, tab 1, par [51].
[208] Exhibit 2, tab 1, pars [52]-[53].
[209] Ts 153.
[210] Exhibit 2, tab 7, par [20].
[211] Ts 123, 126.
[212] 126-127.

including the recollections of both Dr Nasr and Ms Briggs, but more critically the tense used by Dr Nasr in his more contemporaneous note.

172 Dr Nasr recalls that at around the same time as he was speaking to the PLN, he was informed by Ms Briggs that she had contacted Travis's father about the possibility of discharge, and that Travis's father had expressed his concern about Travis returning to the family home that night.[213]

173 Dr Nasr is unable to recall if he spoke to the PLN before receiving this information, but can recall that he did not relay anything said by Travis's father to the PLN. He is confident that the discussion with the PLN occurred before he returned to see Travis the second time.[214] I accept that evidence, including because it accords with Ms Briggs's evidence.

174 I interpose that Ms Briggs's evidence (which I accept) is that there was a high level of communication amongst nurses, doctors and clinical staff in the ED at BRH at the relevant time, communication was well organised, and that doctors were approachable and communication with nurses was open.[215]

175 On that basis, I conclude that the information being provided to Ms Briggs was being conveyed to Dr Nasr in a timely way throughout.

176 Following receipt of that information from Ms Briggs, Dr Nasr went back to Travis and recommended that he stay overnight so that a social worker could carry out a review in the morning with possible input from the drug and alcohol nurse. Dr Nasr encouraged Travis to take the opportunity to rest.

177 Travis declined that recommended course.[216]

178 Dr Nasr believes, based on his interactions, that Travis understood that he could stay in the ED if he wanted to, but that he decided against it.[217]

179 Dr Nasr determined that there was no current indication to hold Travis under the *Mental Health Act* or the *Guardianship and Administration*

[213] Exhibit 2, tab 1, par [58].
[214] Ts 81-82.
[215] Exhibit 2, tab 5, pars [14]-[18].
[216] Exhibit 2, tab 1, par [59].
[217] Exhibit 2, tab 1, par [61].

Act,[218] including where any acute risk had resolved and his behaviour appeared to have normalised after therapeutic sedation.[219]

180 At about 12.08 am, Travis's cannula was removed, and his property was returned to him, and he began walking towards the ED main entry.[220]

181 Ms Briggs made a note at 12.15 am, stating that she had called Travis's father to notify him that Travis wanted to leave, and that Travis had been medically discharged and planned to walk to his parent's home.[221]

182 I find that this note, although made at 12.15 am, relates to the conversation that Ms Briggs had with Travis's father between Dr Nasr's two discussions with Travis,[222] and relates to events which occurred before 12.08 am.

183 Travis's father was shocked that, as he understood it, Travis was being discharged from the hospital. I acknowledge that from the perspective of the clinicians, Travis was not being discharged in the sense that he was not being directed to leave the hospital.[223] Their view was that although he had been medically cleared, Travis was leaving against their advice. Travis's father may not have understood this. There is no evidence that it was communicated to him in those terms at the time.

184 Ms Briggs spoke to Travis's father about recalling the ambulance, or calling police, if Travis were to arrive back at home and become unsafe again.[224] According to Ms Briggs, the purpose of the call was not simply to advise that Travis was about to leave and to see if his father was willing to pick him up, but part of her ongoing attempts to find ways to negotiate with Travis to stay at the hospital. I accept this evidence, including where it is consistent with Ms Briggs's actions from the time that Travis woke up, and which are verifiable including by reference to CCTV footage.

185 I accept Ms Briggs's evidence that the call to Travis's father served the function of providing potential safety netting but also gathering

[218] Exhibit 1, tab 11.
[219] Exhibit 2, tab 1, par [62].
[220] Exhibit 1, tab 7, p 50; exhibit 2, tab 5, par [57].
[221] Exhibit 1, tab 22, p 8.
[222] Ts 81.
[223] Exhibit 2, tab 5, par [62].
[224] Ts 132.

information in the hope of being able to work with Travis to get him to stay at the hospital.[225]

186 Ms Briggs's evidence was that the phone call was not rushed, but she cannot recall its length.[226] It was very clear from Ms Briggs's oral evidence that she has a strong recollection of the phone call, including by virtue of how often she has reflected on it since. I accept her evidence that the phone call with Travis's father was not rushed, or cursory in any way.

Events in the early morning of 24 August 2023

187 At about 12.15 am, Travis left BRH on foot, and eventually arrived at his parents' home in Withers, on foot at about 1.00 am.

188 His exact movements between BRH and his parents' home are unknown.

189 Travis spoke with his father, who advised that he did not want him to come inside the house, including to avoid upsetting Travis's mother who remained bed-bound at that time.[227]

190 According to his father, Travis looked exhausted and was still behaving erratically and was not '*speaking straight*'.[228]

191 Travis's father gave him the keys to his vehicle (which was not operational due to a flat battery) and some blankets, instructing him to rest in his car which was parked in the driveway.[229]

192 Later that morning, Travis was observed by the neighbour who lived directly across the street from Travis's parents. She estimated the time was about 5.00 am, although she was not certain.[230] He was wearing the same clothes as he was wearing earlier that morning.[231]

193 Travis waved to her and then walked down the street towards Stallard Place.[232] She did not notice anything unusual about Travis at that time, and he seemed to be walking normally.[233]

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[225] Ts 132.
[226] Ts 133.
[227] Exhibit 1, tab 8, par [70].
[228] Exhibit 1, tab 7, p 46; tab 8, par [71].
[229] Exhibit 1, tab 7, p 46; tab 8, par [74].
[230] Exhibit 1, tab 13, par [5].
[231] Exhibit 1, tab 7, p 46.
[232] Exhibit 1, tab 7, p 59; tab 13, pars [9], [12].
[233] Exhibit 1, tab 13, par [15].

194 There is no evidence of Travis's actions between 5.00 am, and 5.25am.

Critical incident

195 The train involved in the incident was enroute to the Bunbury Passenger Terminal to collect passengers.[234] It was two carriages in length.,[235] and travelling about 44 km/hr at the relevant time.[236]

196 The rail crossing at Robertson Drive is a dual carriageway in both directions, and is controlled by boom gates, red flashing lights and an audible warning bell when in operation.[237]

197 At the relevant time, the crossing lights were active, the boom gates were lowered, and the headlights on the train were on high beam.[238]

198 The driver of the train first saw Travis at about 5.25 am as he ran in front of the train and lay down on the tracks, about 10 metres away.[239]

199 The driver engaged the full-service emergency brake,[240] but Travis was hit by the front railcar and pulled underneath.[241]

200 After the collision, the train was stopped adjacent to the median strip on Robertson Drive.[242] Despite the shock he had experienced, the driver maintained sufficient composure to be able to call the fact of an emergency through to his control room.[243]

201 At 5.28 am, a call was made to the Police Operations Centre advising that the Australind Train had struck a pedestrian at the rail crossing at Robertson Drive in Picton.[244]

202 Police officers arrived on the scene at about 5.35 am and began providing immediate medical assistance to Travis.[245] He was removed from underneath the train by two police officers, who commenced CPR and

[234] Exhibit 1, tab 7, p 3.
[235] Exhibit 1, tab 7, p 3.
[236] Exhibit 1, tab 17, p 1.
[237] Exhibit 1, tab 7, p 3.
[238] Exhibit 1, tab 7, p 51; tab 14, pars [5]-[7].
[239] Exhibit 1, tab 14, pars [10]-[13].
[240] Exhibit 1, tab 7, pp 47, 52; tab 17, p 2.
[241] Exhibit 1, tab 7, p 4.
[242] Exhibit 1, tab 7, p 3.
[243] Exhibit 1, tab 7, p 51; tab 14, par [19].
[244] Exhibit 1, tab 7, p 1.
[245] Exhibit 1, tab 7, p 1.

applied torniquets to both legs.[246] Ambulance officers were called, and police officers continued to perform CPR for about 13 minutes before paramedics arrived.[247]

203 Paramedics assessed Travis, noting that he had sustained catastrophic injuries to his head, chest and limbs which were not survivable.[248]

204 A paramedic certified that Travis was deceased at 5.45 am.[249]

205 Main Roads attended and took over management of road closures and traffic given the location and time of the incident.[250]

Subsequent investigations

206 Subsequent investigation confirmed that the driver of the train had adhered to all relevant policies and procedures.[251] The railcars were inspected and found to be free of any mechanical failure or malfunction.[252]

207 WACHS conducted a SAC 1 investigation into Travis's treatment at APU, post-discharge by the BCMHT, and at the ED on 23 and 24 August. The panel identified the following matters of concern (noting that these views were reached without the benefit of all the evidence that I have been provided with, including the oral evidence of the clinicians at the inquest):

(a) The lack of follow up with Travis or his next of kin once he did not attend for the appointment on 21 August and was uncontactable.[253]

(b) The lack of contemporaneous documentation in EDIS from 23 and 24 August.[254]

(c) The absence of sufficient documentation to evidence that a comprehensive risk assessment was undertaken, or a safety plan developed for Travis, or any assessment by the PLN of the progress notes or PSOLIS, including while Travis was sedated.[255]

[246] Exhibit 1, tab 7, p 4.
[247] Exhibit 1, tab 7, p 4.
[248] Exhibit 1, tab 7, p 4; tab 11.2, p 2.
[249] Exhibit 1, tab 2.
[250] Exhibit 1, tab 7, p 4.
[251] Exhibit 1, tab 7, p 51.
[252] Exhibit 1, tab 7, pp 51-52; tab 15; tab 161.
[253] Exhibit 1, tab 24, p 4.
[254] Exhibit 1, tab 24, p 4.
[255] Exhibit 1, tab 24, pp 5, 7.

(d) That Travis did not have satisfactory discharge planning, factoring in transportation to his home address or to his parents' home, or any follow up care planning.[256]

208 The SAC 1 process resulted in recommendations including the co-location of psychiatric liaison nurses within the ED at BRH near other clinical staff to enable early awareness of people presenting with a mental health or alcohol or other drug related presentation.[257]

Opinion of Dr Brett

209 As identified above, Dr Brett was instructed by Counsel Assisting to provide an opinion on the quality of Travis's supervision, treatment and care at BRH and by the BCMHT from 21 July to 24 August 2023.

210 At the time of his instructions, Dr Brett was provided with copies of the postmortem report, including toxicology, the medical record, witness statements obtained by police, the SAC 1 report and CCTV footage. As is often the case, Dr Brett was asked for his opinion prior to the Court being furnished with detailed witness statements from the clinicians who were summonsed to give evidence. In any event, Dr Brett recognised in his written report that the medical records can never reflect the totality of patient care, including in busy emergency departments.[258]

211 In his report to the Court, Dr Brett observed, in summary:

(a) that there was no documentation from the PLN, and no apparent knowledge or recognition in the ED that Travis had been recently discharged from the APU, was supposed to be receiving a depot, or that he was understood to be subject to the CTO;

(b) that Travis was part of a high-risk population, where people with schizophrenia have a 10% lifetime risk of suicide;[259]

(c) that the BCMHT should be working in tandem with alcohol and drug services for patients like Travis, within the same team and under the same roof;[260]

[256] Exhibit 1, tab 24, p 5.
[257] Exhibit 1, tab 24, pp 11-12.
[258] Exhibit 1, tab 27, p 9.
[259] Exhibit 1, tab 27, p 10.
[260] Exhibit 1, tab 27, p 11.

(d) that placing Travis on the CTO was appropriate, given his chronically poor insight and long history of non-compliance,[261] and that depot medication was a sound approach;[262]

(e) that Travis's family should have been advised of the fact of the CTO and its conditions, particularly where they were his primary carers and directly involved in most of his admissions;[263]

(f) that the fact that the CTO was not confirmed did not impact on Travis's management, where all his treating team operated on the belief that he was subject to the conditions of the order;[264]

(g) that consideration should have been given to a breach notification of the CTO when Travis refused his depot in August 2023, and attempts should have been made to involve his parents;[265] and

(h) that Travis should have had a mental health review before his discharge on 24 August 2023, and there was inadequate discharge planning.[266]

Cause of death

212 A forensic pathologist conducted an external postmortem examination, including a CT scan, which showed severe injuries to the head, spine, chest, pelvis and limbs.[267]

213 Toxicological analysis of a postmortem sample showed a blood methylamphetamine level of 0.3 mg/L, with a low amphetamine level.[268]

214 As identified above, the methylamphetamine level detected from the EDNA testing at admission to BRH on 23 August was 0.2 mg/L. I accept the opinion expressed by Dr Heble that the antemortem level is consistent with recent use by Travis, and likely methylamphetamine intoxication.[269]

215 Information was sought from the ChemCentre as to possible explanations for the difference in concentrations between the two samples, aside from

[261] Exhibit 1, tab 27, p 11.
[262] Exhibit 1, tab 27, p 11.
[263] Exhibit 1, tab 27, p 11.
[264] Exhibit 1, tab 27, p 11.
[265] Exhibit 1, tab 27, p 11.
[266] Exhibit 1, tab 27, p 12.
[267] Exhibit 1, tab 5.3.
[268] Exhibit 1, tab 6.
[269] Exhibit 1, tab 32, par [46].

further use. The response demonstrates that there are multiple explanations for the marginal increase in the level between the antemortem and postmortem samples unrelated to further use, including analytical factors, and the potential for postmortem distribution.[270]

216 I consider it unlikely, given the timing, that Travis was able to source and use further methylamphetamine between his discharge from BRH and prior to his death.

217 Therapeutic levels of the benzodiazepines diazepam and oxazepam and the opioid analgesic were detected. Buprenorphine, another opioid analgesic, and paliperidone, an antipsychotic, were also detected. Tetrahydrocannabinol was also present at the level of 1.9 mcg/L.[271]

218 The forensic pathologist formed the opinion that Travis's cause of death was multiple injuries.[272]

219 I respectfully agree with and adopt that conclusion as my finding for the purposes of s 25(1)(c) of the Act.

Manner of death

220 The evidence demonstrates that Travis, in the setting of his serious mental illness and recent substance use, deliberately placed himself in the path of an oncoming train with the intention that it should hit and kill him.

221 For the purposes of s 25(1)(b) of the Act, I find that Travis's death occurred by way of suicide.

Comment on matters connected with Travis's death

Quality of Travis's inpatient treatment at the APU

222 On my review of the materials, Travis's acute symptoms were treated upon his admission to the APU in July 2023, and it is apparent that he experienced some improvement over the course of the admission.

223 I note that at the inquest, Dr Heble was asked questions about whether it was appropriate for Travis to be discharged, and his opinion was that Travis's acute symptoms had fully resolved.[273]

[270] Exhibit 1, tab 28.
[271] Exhibit 1, tab 6.
[272] Exhibit 1, tab 5.1, p 1.
[273] Ts 152.

224 I am cautious about accepting this opinion, where it is apparent that Travis was reported to still be experiencing some hallucinations as at the date of discharge. The assessment by the treating team of his acute risk being low was also questionable, given it was predicated on Travis being treated with antipsychotics, which could at least be enforced through the CTO, but also remaining abstinent from drugs, which was not enforceable.

225 Notwithstanding, I accept that a treating psychiatrist could reach the view that the less restrictive treatment option of a CTO was open and appropriate, as against an involuntary inpatient treatment order (noting that Travis was at APU voluntarily at that stage).

226 In that regard, I accept that the CTO was a reasonable approach. It was clearly more robust than a voluntary discharge with no order under the *Mental Health Act*, allowed some measure of enforcement, and ensured some ability to monitor for any relapse. I accept that the approach was also open in circumstances where although Travis was clearly not enthused about engaging with the BCMHT, he was openly willing to engage with his GP and resume the CPOP.

227 I also accept, in this context, that there were previous occasions, particularly when his family were living in Harvey, when Travis was managed well in the community, and had been prepared to engage and on occasions pro-actively seek treatment.[274] That history militated in favour of the CTO and community treatment.

228 The primary observation to be made is whatever the standard of treatment provided in the APU, it should have been abundantly clear to all involved before and at discharge, based on his refusal to be referred to drug services during the admission and his stated view that his depot lacked efficacy, that Travis was going to be highly unlikely to accept the depot or engage with any drug or alcohol counselling services.

229 These factors, along with Travis's known itinerant lifestyle, meant that issues in the implementation of the CTO were inevitable. Consequently, strong discharge planning was critical. I agree with Dr Brett that a clear discharge plan should have been made, involving Travis's family.[275]

[274] Exhibit 1, tab 8, pars [28]-[29].
[275] Ts 102.

Quality of the discharge planning

230 In summary, I consider that the planning of Travis's discharge from the APU was poor.

Validity of the CTO

231 The quality of the discharge planning is reflected, in part, by the issue concerning the absence of the confirmation of the CTO.

232 Dr Edirisooriya is unable to recall why the CTO was not confirmed within 72 hours as required.[276] All of the witnesses agreed that it was incumbent on the practitioner who made the CTO to ensure that it is confirmed.[277]

233 I find that the absence of confirmation was a clear administrative lapse,[278] and something that should have been checked at the time of handover.[279]

234 I find that the absence of confirmation was, at least in part, because the CTO was planned and made very late in the admission. As Dr de Klerk observed, in addition to the fact that it did not follow an inpatient treatment order, the CTO was made very late in the piece and was therefore made in usual circumstances and outside of the norm.[280]

235 It was clear from the evidence that both Dr de Clerk and Ms Akusoba were under the impression, at all relevant times, that Travis was subject to the CTO and treated him accordingly.[281] Therefore, I am prepared to accept Dr Heble's evidence that the administrative lapse resulting in the cessation of the CTO did not, in this case, materially affect the continuity of Travis's care, which proceeded accordingly to professional judgment.[282]

236 However, the failure to confirm the CTO would have had a tangible impact had a check of PSOLIS been undertaken by the PLN on 23 or 24 August, as the CTO would have appeared as invalid or expired.[283]

[276] Exhibit 3, par [22].
[277] Ts 23; 149,
[278] Ts 149.
[279] Ts 99, 149.
[280] Ts 24.
[281] Exhibit 1, tab 31, par [17]; exhibit 2, tab 8, par [99].
[282] Exhibit 1, tab 32, par [26].
[283] Exhibit 1, tab 32, par [27].

237 While, as observed by Dr Brett,[284] that might have been the only tangible effect, I consider that the absence of confirmation of the CTO is reflective of the fact that Travis's discharge was not well planned.

Engagement with Travis's family

238 The quality of the discharge planning is also reflected in the fact that the treatment plan was not understood by Travis's family.

239 According to Travis's father, his family was not aware of the CTO until they were going through Travis's belongings after his death.[285]

240 Section 139(1) of the *Mental Health Act 2014* (WA), as enacted at the time Travis was discharged from the APU, provided that, subject to s 142, any close family member of Travis's was entitled to be notified, as soon as practicable, that a notifiable event had occurred in respect of Travis.

241 Schedule 2 of the Act makes plain that the making of the CTO was a notifiable event, and that the practitioner who made the order was ultimately responsible for the notification of the notifiable event. Given what was recorded at the APU upon Travis's admission and observed during the admission, Travis's father was clearly a close family member for the purposes of s 139, if not his carer.

242 None of the disentitling provisions in s 142 of the Act applied.

243 Section 141 of that Act required reasonable efforts to be made to notify any close family member until either at least one close family member had been notified, or it was reasonable to conclude that no close family member could be notified.

244 Subsection 141(2) required that if no close family member was notified, a record be made of the reasons for that and any effects made to notify the close family member.

245 Dr Edirisooriya has no recollection of speaking with Travis's family about his discharge or the CTO.[286]

246 I note that there was a discharge planning meeting with Travis and his father on 27 July 2023. This appears to have been the extent of direct engagement with Travis's family about future treatment. As such, it would

[284] Ts 98.
[285] Exhibit 1, tab 8, par [63].
[286] Exhibit 3, par [15].

have been appropriate for the likely existence of the CTO to have been raised at that conference.[287] Clearly, it should have been confirmed later, according to the statutory requirement.

247 Dr Heble initially expressed a belief during his oral evidence that Travis's family would have been made aware of the CTO given it represented a significant change in Travis's circumstances, and due to the requirement under the *Mental Health Act*.

248 That may be so, but I find no evidence in support of the belief that it was raised to Travis's family's attention. Such a belief is:

(a) inconsistent with Travis's father's written evidence;

(b) not supported by any record expressing that it was communicated to Travis's family, including during the meeting with Travis's father on 27 July 2023, or supported by any implication capable of being drawn from any contemporaneous documents; an0064

(c) inconsistent with the evidence the CTO was raised as a possibility late in the discharge and was only determined as being part of the plan on the date of discharge.

249 I find that Travis's family was not aware of the CTO until after his death.

250 The questions then arising is whether reasonable attempts were made, and whether those attempts were recorded, as required.

251 There appeared to be an implication from some of the evidence that Travis's mother's health and recovery may have resulted in Travis's family being less contactable than usual around this time. To the extent that was suggested as a reason for the CTO not being brought to the family's attention,[288] it was clear that Travis's father and sister were generally available, not least because they were visiting Travis every day in the lead up to his discharge. As Dr Heble recognised, these visits were opportunities for conversations around discharge planning to take place.[289]

252 From the evidence, I find that a single attempt was made to call Travis's family to notify them of the CTO. I am not satisfied that constituted a reasonable attempt for the purposes of the statutory requirement.

[287] Ts 101.
[288] Ts 147.
[289] Ts 147.

253 Travis's family not being aware of the CTO had a real impact.

254 I accept Travis's father's evidence that had he been aware of the existence of the CTO, he may have been more forceful when speaking with staff at BRH during his admission to the ED.[290] Clearly, as Dr Brett observed, Travis's father had no difficulty in taking difficult steps when Travis needed help and care, and he was clearly involved.[291]

255 Travis's father ought to have had knowledge of the existence of the CTO to be able to advocate on behalf of his son.

Other issues

256 Putting aside the notification issue, the quality of the discharge planning was also reflected in the seeming absence of the participation of others who would have added value to the process and, relatedly, the absence of well-considered plans to address the known issues around communication that were going to inevitably arise.

257 There is no evidence of any attempt to directly involve Travis's GP.[292]

258 I accept that a social worker engaged with Travis during his admission. However, it is not apparent that a social worker, or carer support workers, or even the Mental Health Advocacy Service were engaged in any way to assist in formulating a plan to address the issues that were clearly going to arise given Travis's itinerance and lack of easy means of contact.

259 Given that it was identified that maintaining contact with Travis was going to be an issue, carer support workers should have been engaged while he was still in the APU, including to try and make plans with his family about initiating and maintaining contact.[293]

260 Dr de Klerk expressed that it was frustrating to receive a referral without the means of engaging with the patient.[294]

261 There was also no clear collaboration between the APU and community team regarding discharge. Dr de Klerk acknowledged receiving a handover call from the inpatient treating team but observed that those calls do not ordinarily descend to specifics of where a patient is going to live

[290] Exhibit 1, tab 8, par [62].
[291] Ts 101.
[292] Ts 20.
[293] Ts 97, 98.
[294] Ts 32.

and is usually a more high level discussion of clinical condition and the need and purpose of the CTO.[295] It is clear from the APU records that there was no handover to Ms Akusoba.

262 In this case, there was inadequate discharge planning, which made management under the CTO more difficult than it ought to have been.

Quality of Travis's treatment and management under the CTO

263 There is some force to Dr Brett's observation that the utility of a continuing treatment order is questionable when it is clear from the outset that it will be ignored.[296]

264 Travis made it abundantly clear, at an early stage, that he did not intend to comply with the CTO, and he followed through on that stated intention.

265 Dr de Klerk's evidence is that when Travis failed to attend for his depot on 21 August, he considered initiating a breach of the CTO but did not.

266 In his view, a breach process is warranted for a pattern of non-engagement or non-compliance that is not reasonably remediable, particularly for patients treated for schizophrenia where effective management cannot rely solely on medication alone.[297]

267 Dr de Klerk was also mindful that breach processes may damage any therapeutic relationship,[298] and breach action in this case would have risked causing damage to an already fragile therapeutic relationship.[299]

268 Dr de Klerk's ordinary practice would be to direct the care coordinator to contact the patient, discuss rescheduling and allow short delays where clinically appropriate.[300]

269 His next steps would be to contact family members or other supports where appropriate. He considered that such an approach could be undertaken in Travis's case for up to a week.[301]

270 I accept that, in the circumstances, Dr de Klerk's decision not to proceed to a breach immediately is defensible. Although I question whether there

[295] Ts 32.
[296] Ts 96.
[297] Exhibit 1, tab 31, pars [36]-[37].
[298] Exhibit 1, tab 31, par [38].
[299] Exhibit 1, tab 31, par [46].
[300] Exhibit 1, tab 31, par [39]-[40].
[301] Exhibit 1, tab 31, par [43].

was any real potential for damage given the absence of any apparent therapeutic relationship at that stage and Travis's expressed views about his willingness to engage with the BCMHT, I accept that moving immediately to a breach had the capacity to alienate Travis entirely, and would not have allowed any ability for Travis to be able to change his mind within a reasonable timeframe.

271 However, to the extent it is suggested by Dr Heble in his report,[302] I cannot see how a home visit, including to Travis's parents, would have been counterproductive to the establishment of trust.

272 In this case, a home visit was clearly indicated and more likely to either establish, or allow some progress towards the formation of, an ongoing therapeutic relationship rather than be detrimental to longer-term management. A home visit was indicated where it was clear that any further follow up by phone was not going to be successful, given the way Travis spoke to Ms Akusoba on 2 August[303] and the quality of the conference with Dr de Klerk.

273 In this case, the barriers to communication were not only well known, but had been expressly recognised at the time of discharge. A line of communication with both Travis and the family needed to be established.

274 Ms Akusoba's view was that a home visit was not capable of occurring because Travis had no fixed address and appeared to be homeless.[304] She also believed that Travis's parents' address was not on their system,[305] and the BCMHT did not have information regarding Travis's GP.[306]

275 It is apparent that staff in WACHS did have the address and phone number for Travis's father, including within webPAS.[307] In any event, I anticipate the information could have been readily attainable had attempts been made to liaise with Dr Simpson, who clearly identifiable as Travis's GP from existing records.[308]

276 In my view, an attempted home visit to Travis's parents was warranted – both because his answering his father's mobile phone indicated that he might have been at their residence, and also because there was utility in

[302] Exhibit 1, tab 32, par [52].
[303] Exhibit 2, tab 8, par [44].
[304] Exhibit 2, tab 8, par [103].
[305] Ts 20.
[306] Ts 20.
[307] Exhibit 5, par [21].; ts 146-147.
[308] Exhibit 5, par [24].

the BCMHT engaging with the family directly in any event to try and resolve the issues that they were immediately facing in engaging with Travis. Although it was not the responsibility of the BCMHT under the *Mental Health Act* to provide the notification, a home visit might have also ameliorated the issue of Travis's family being unaware of the CTO.

277 I accept that Travis's case was challenging including because there was an absence of other services within the community with whom Travis was engaged. As such, there were fewer sources for the BCMHT to be able liaise and cooperate with, including to obtain collateral information.[309]

278 However, it is precisely that difficulty that meant that the initiative in identifying the home address of Travis's parents and attempting a home visit there, and engaging with the GP, was even more essential.

Quality of Travis's management at BRH on 23 August 2023

279 From my own assessment of the evidence, I accept Dr Nasr's view that, on his assessment at the time, he did not have a basis to detain Travis under the *Mental Health Act* including for a further assessment under that Act.[310]

280 This conclusion is consistent with the opinion of Professor Anthony Brown,[311] and the opinion expressed by Dr Brett at the inquest.[312]

281 Putting that issue to one side, this is a case where there was no failure on behalf of any individual clinician involved in Travis's management at BRH on 23 and 24 August. However, processes did not operate optimally to ensure the provision of all relevant information to Dr Nasr.[313]

Adequacy of engagement with PLN service and knowledge of the CTO

282 Nearly all the witnesses were asked at the inquest what relevance knowledge of the (presumed) existence of the CTO, the missed depot and recent discharge from the APU would have had, in circumstances where it is clear from the evidence that none of these matters were known to any of Travis's treating team.

[309] Ts 20.
[310] Exhibit 2, tab 1, par [70].
[311] Exhibit 2, tab 2.
[312] Ts 92-93.
[313] Ts 103.

283 Dr Heble's opinion is that neither awareness of the recent discharge from the APU, nor the CTO, would have altered the clinical response or decision making on 23 August and in the early hours of 24 August.[314]

284 I accept, as Dr Senthi says, that awareness of the CTO or the missed depot injection would not have changed the approach of inducing therapeutic sleep and reassessing Travis upon his waking.[315]

285 However, I consider that a distinction can and should be drawn between the likely impact on the treatment plan (which I accept would have been none), and the likely impact on the approach taken by Dr Nasr and Ms Briggs had they been made aware. As Dr Halewood in my view properly agreed, awareness would have further reinforced the importance of the reassessment of Travis when he was awake and presumably sober.[316]

286 It cannot be said, definitively, that Dr Nasr's assessment would have changed in any material way. I say that where I accept Dr Nasr's view that upon his assessment Travis did not present as an acute risk, so he did not contact the PLN demanding a review.

287 However, the evidence is clear that the absence of that knowledge precluded Dr Nasr and Ms Briggs from being able to engage with Travis and his father, as well as with the PLN, in a fully informed way about the nature of any chronic risk.[317]

288 Dr Nasr's considers it a possibility that had the fact of Travis being understood to be subject to a CTO been identified and that he had missed a depot injection, the mental health team may have considered undertaking a review prior to Travis self-discharging.[318]

289 I accept that evidence. It is consistent with Dr Senthi's evidence that had he become aware of the CTO, he may have advised Dr Halewood to contact the PLN to seek some information about the CTO and to advise them that Travis was in the ED.[319]

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[314] Exhibit 1, tab 32, par [59(g)].
[315] Exhibit 2, tab 3, par [55].
[316] Ts 46.
[317] Ts 80-81.
[318] Exhibit 2, tab 1, par [77].
[319] Exhibit 2, tab 3, par [56]. I note that even if there had been a possibility to arrange for administration of the overdue depot during the ED admission, the slow onset nature of the paliperidone depot means it would not have clinical effect until several days post-administration: exhibit 2, tab 3, par [59].

290 Ms McKiernan's view was that awareness of the CTO and the overdue depot would have been useful for the registrar conducting the examination upon waking to know.[320]

291 Dr Halewood accepted that contacting a psychiatric liaison nurse for collateral information on a patient while they are having therapeutic sleep can be useful, and having his discharge summary would have been helpful.[321] Dr Senthi ultimately accepted that it would have been useful for ED clinicians to be aware of the CTO to engage the PLN.[322]

292 Dr Brett's opinion is that awareness of the CTO would more likely have resulted in further contact with Travis's father and further collateral history being obtained.[323] His view is that knowledge of those facts would have resulted in greater questioning as to whether this was purely a case of methylamphetamine toxicity, or a case of that as well as a relapse in his schizophrenia.[324]

293 In his view, the assessment by Dr Nasr was necessarily a cross-sectional assessment in an ED, and knowledge of those matters but would have at least increased the prospect of a longitudinal assessment or at least consideration of the same.[325]

294 I accept that, as Dr de Klerk notes, assessment of patients with dual diagnoses of schizophrenia and substance use disorder is clinically challenging, and on any presentation, it may be difficult to distinguish symptoms attributable to schizophrenia from those related to substance use, as well as learned coping behaviours or a patient's way of managing interactions with clinicians.[326]

295 In those circumstances, I consider that the additional information would have been helpful to Dr Nasr in undertaking his assessment, and in deciding how he would liaise with the PLN.

296 Dr Nasr noted that awareness of the CTO and the missing depot would have changed the nature of his conversation with the PLN – particularly

[320] Ts 122.
[321] Ts 44, 46.
[322] Ts 59.
[323] Ts 92.
[324] Ts 92.
[325] Ts 92.
[326] Exhibit 1, tab 31, par [23].

to address the chronic nature of his illness rather than, necessarily, any acute issues.[327]

297 Along with Dr Nasr, Ms Briggs was perhaps the most direct in her answer to the question.

298 According to Ms Briggs, had she been aware of the CTO she would have been more insistent on the PLN attending to review Travis before he left the hospital.[328] She acknowledged that she had no ability to direct the PLN to attend, but she would have requested attendance directly and in a more forward manner.[329]

299 Ms McKiernan's evidence is that she would have attended, if asked to attend.[330]

300 If nothing else, this evidence demonstrates incontrovertibly that the absence of that information coming through to Ms Briggs, at least, meant that an opportunity was lost. This does not mean that the outcome would have been different for Travis, but it is a demonstration of how knowledge of key information about an existing community mental health patient can impact on clinical pathways during an ED presentation.

Adequacy of the discharge

301 Dr Nasr maintains that there was no decision to discharge Travis, in the sense that Travis elected to discharge himself and refused the recommendation that he remain in hospital overnight and engage with services the following day.[331] Dr Brett accepted that in that circumstance Travis had discharged against medical advice.[332]

302 Dr Heble accepts that there were missed opportunities to further engage with the family and the PLN.[333] Those are both matters I expected would have occurred had Dr Nasr and Ms Briggs been aware that there was a CTO in place and that a depot injection had been missed.

303 In terms of the quality of the discharge, to the extent it was within the control of staff given Travis's firm intention to leave, I accept that staff

[327] Ts 86.
[328] Exhibit 2, tab 5, par [69].
[329] Ts 137.
[330] Ts 123.
[331] Exhibit 2, tab 1, pars [75], [76(e)].
[332] Ts 101.
[333] Exhibit 1, tab 32, par [60].

were in a very difficult position. Dr Brett recognised during his oral evidence at the inquest that this was all occurring in the middle of the night, so it was inherently difficult.[334]

304 Ultimately, it was not the preference of anyone treating him that Travis should leave the ED at the time that he did.

305 As Ms Briggs said, she simply would not send anyone home from the ED on their own in the middle of the night.[335]

306 I accept that Ms Briggs was also in an invidious position, in that organising a taxi voucher to transport Travis from the hospital would have been difficult, given the absence of any confirmed address and having been told by Travis's father about his concerns regarding Travis returning to the family home that night.

307 In my view, Ms Briggs took all reasonable steps available to her to try and ensure that Travis was as safe as he could be. Further, Dr Nasr did what was within his power to try and keep Travis safe, by recommending he stay overnight. In my view, both Dr Nasr and Ms Briggs are to be commended for their caring approach toward Travis and his welfare. The inadequacy of the discharge planning was not the result of any fault or failing by any ED staff, but more directly a consequence of Travis's firm desire to leave the ED notwithstanding the offer he stay overnight.

Engagement with Travis's family

308 In my view, the absence of an understanding of the existence of the CTO and the missed depot meant that the engagement between clinicians in the ED and the PLN was less than it would otherwise have been had that information been recognised. The consequence of that is that Travis's family was also likely not engaged in the way that they would have been had the PLN been more directly engaged.

309 Dr Heble agrees that Travis's family should have been further involved.[336] I agree, to the extent it likely would have assisted in closing the gap in the understanding between his presentation while at home with what was ultimately handed over to the staff treating the acute symptoms. For example, if the fact of the CTO and missed depot was known, a call to the family might have better identified the nature of the auditory

[334] Ts 94.
[335] Ts 130.
[336] Ts 159-160.

hallucinations that Travis was experiencing at home, particularly those referred to at par [109] above.[337]

310 Dr Nasr accepted that with the benefit of hindsight, he might have called again but there was no apparent indication at the time.[338] Again, I accept that evidence, based on what he knew at the time.

311 I understand that there was reassurance from Travis's apparent de-escalation from his presentation when he arrived at the ED. However, it remains the fact that it would have been difficult to interpret whether Travis's change in presentation was simply due to '*wash out*', or partly attributable to Travis's learned coping behaviours and ability to understand how to best placate concerns of those treating him. Travis's family would be better placed to understand those nuances. Dr Brett noted that Travis appeared to be someone who was well aware of the processes, and able to give the answers required to ensure that he did not remain in hospital.[339] Dr Brett disagreed that this ability, alone, is proof that someone is not suffering a relapse in schizophrenia – patients can deny symptoms when suffering symptoms.[340]

312 As Dr Brett noted, families generally know their children better than clinicians, and when they are unwell. I accept that it is much harder, if not impossible, for a clinician like Dr Nasr to be able to identify such nuances in a cross-sectional examination in a busy ED. For that reason, I accept Dr Brett's opinion that the outcome of an assessment may have been different if it were undertaken by a psychiatric liaison nurse, during the day, with further history from Travis's father.[341]

Recommendations

313 There were matters raised during the inquest that I am satisfied have been addressed by steps implemented by WACHS, and which do not need to be the subject of any recommendation by this Court.

314 In relation to the absence of confirmation of the CTO, although it is not clear from the evidence how, exactly, it was missed, I am satisfied that there are checks in place. There is also now, because of the SAC 1 process,

[337] Ts 77.
[338] Ts 76.
[339] Ts 93.
[340] Ts 93.
[341] Ts 94.

greater tracking of CTOs at both a regional and local level.[342] I am satisfied that these measures are sufficient.

315 This case is further demonstration of the importance of minimising fragmentation in provision of mental health and alcohol and drug services.[343] Travis's willingness to engage with counselling was variable, but his engagement with the CPOP shows that he was not closed off entirely to alcohol and drug services. I agree with Dr Brett that during his engagement with the BCMHT he should be able to get drug and alcohol services within that team.[344]

316 I accept, as Dr de Klerk suggested, that there is utility in external services also being available, including where a referral to a different treatment team is something the patient wants. However, as Dr Brett notes, '*the more weapons in your armoury, the better*'.[345]

317 In my view, co-location of these services is not just to the benefit of the patients but also the clinicians. It is an additional resource for them,[346] and readily compliments the work of peer support workers within the community mental health teams.[347]

318 At the inquest, Dr Heble confirmed that the Southwest Alcohol and Drug Service will be embedded in the Bunbury and Busselton Community Health Services from July 2026.[348] I strongly commend this step, and as a result a recommendation is not required.

319 Dr Heble's evidence also made plain that there has been an expansion in the number of peer and family support workers,[349] and that they clearly already well embedded in the service.[350]

320 In my view, the only area arising from the evidence that warrants a recommendation relates to the engagement between the ED and psychiatric liaison nurses at BRH.

[342] Exhibit 1, tab 32, par [77].
[343] Ts 100.
[344] Ts 95.
[345] Ts 100.
[346] Ts 95.
[347] Ts 95.
[348] Ts 157.
[349] Exhibit 1, tab 32, par [73(f)].
[350] Ts 161.

321 I accept that there have been significant improvements in this regard, as a direct result of this case,[351] namely physical co-location of the psychiatric liaison nurse in the ED.

322 I accept that this step, alone, ensures prompt oversight and care of all mental health patients in the ED and more robust collaboration with ED staff,[352] simply by increased face-to-face communication and psychiatric liaison nurses seeing what the clinicians are seeing (rather than operating based on information by telephone).[353] I note that this change in addition to an increase in bed capacity in the Mental Health Observation Areas at Bunbury.[354]

323 I also note the adoption of the parallel assessment model,[355] which decreases the risk that symptoms are assessed in isolation and supports collaborative decision making.[356]

324 Dr Nasr noted in his evidence that the psychiatric liaison nurse service has adopted a more proactive approach to identifying and reviewing patients with known mental health histories and communicating relevant information to ED clinicians, even in the context of intoxication.[357] Dr Senthi also referred to this change following the SAC 1 report.[358]

325 I consider this is a clear improvement, where the evidence was that at the time of Travis's case, the PLN would not have gone into the PSOLIS notes by virtue of the mere fact that the patient was in the ED on the off chance they might be referred.[359] In this case, Travis was one of only two patients who may have required a mental health assessment upon waking, so he was clearly 'earmarked' as a potential referral.

326 According to Dr Nasr, this approach is '*informal*',[360] and driven by the individual.[361]

[351] Ts 154.
[352] Exhibit 1, tab 32, par [73(g)], [75].
[353] Ts 88.
[354] Exhibit 1, tab 32, par [73(a)]; ts 163.
[355] Ts 154-155.
[356] Exhibit 1, tab 32, par [73(b)].
[357] Exhibit 2, tab 1, par [83].
[358] Exhibit 2, tab 3, par [51].
[359] Ts 116.
[360] Ts 81.
[361] Ts 88.

327 When asked whether this approach has been formalised, Dr Heble advised the Court that it was '[*being*] *considered as a policy moving forward*'.[362]

328 I accept that these measures may be seen as current standard practice. However, I am mindful that changes in staff can have a consequence of such improvements being overlooked or lost over time.

329 In that event, I see no reason why the parallel assessment model and this pro-active approach by psychiatric liaison nurses at BRH should not be embedded in existing policies and procedures.

330 As such I recommend as follows:

The WA Country Health Service embed the parallel assessment model, and the practice of psychiatric liaison nurses proactively identifying and reviewing patients with known mental health histories and communicating relevant information to ED clinicians, into existing policies and procedures at Bunbury Regional Hospital.

Conclusions

331 Travis's death is an important opportunity to reflect on the challenging and difficult issues that face patients coping with serious, treatment-resistant mental illness and struggling with substance use, and the clinicians who seek to treat them.

332 I hope the inquest and these findings have brought greater clarity for Travis's family about the events of 23 and 24 August and assured them that the individual clinicians and WACHS have all reflected on Travis's care to try and identify all opportunities for improvement, for the benefit of future patients.

BD Nelson
Coroner
28 July 2026

[362] Ts 154.