JURISDICTION	:	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	:	CORONERS ACT 1996
CORONER	:	SARAH HELEN LINTON, ACTING STATE CORONER
HEARD	:	30 JUNE 2026
DELIVERED	:	17 SEPTEMBER 2026
FILE NO/S	:	CORC 3394 of 2024
DECEASED	:	MADDAMS, DAVID WILLIAM

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:

Ms E Lynch assisted the Coroner

Mr L Lasko (SSO) appeared on behalf of the North Metropolitan Health Service and the Osborne Park Community Mental Health Team

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

Nil

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Sarah Helen Linton, Acting State Coroner, having investigated the death of ***David William MADDAMS*** *with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, PERTH, on 30 June 2026, find that the identity of the deceased person was* ***David William MADDAMS*** *and that death occurred on* ***4 November 2024*** *at* ***Unit 4, 9 Ken Street, Wembley Downs****, from* ***pulmonary thromboembolism*** *in the following circumstances:*

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INTRODUCTION

1 David Maddams[1] was a military veteran who suffered serious injuries, including a head injury, while serving in the Australian Army. He was medically discharged and received ongoing support from the Department of Veteran Affairs, including assistance with health care.

2 David had a significant psychiatric condition, for which he was prescribed antipsychotic medication. He also had a number of significant physical health conditions, including obesity, obstructive sleep apnoea and a history of pulmonary thromboembolism. David had periods of hospitalisation for his health conditions and received ongoing medical management from psychiatrists, GP's and specialists. He wasn't always compliant with his recommended treatment, which elevated his level of risk.

3 In mid-2024, David decided to cease taking his prescribed anti-psychotic medication. His primary reason for doing so was to try to lose weight for other health reasons. David's psychiatrist warned David that he was at risk of relapsing into psychosis once he stopped taking the medication, but he was considered to have capacity to make that choice.

4 After a period of time off his medication, David relapsed into psychosis. He was hospitalised as an involuntary psychiatric patient and recommenced on antipsychotic medication. Once stabilised, David was discharged home on a Community Treatment Order (CTO) to ensure he continued to receive his psychiatric medication via an injection. David refused to take oral medications, including a medication that reduced his risk of thromboembolism, at that time it was hoped that, with a bit more time and after his mental state improved a bit more, David's GP would be able to persuade him to start taking it again. In the meantime, his risk of developing pulmonary thromboembolism was elevated.

5 On 4 November 2024, while still subject to the CTO, David's parents found him deceased in his home. Following a post-mortem examination, a forensic pathologist concluded David's cause of death was pulmonary thromboembolism and expressed the opinion his death was due to natural causes.

6 By virtue of being on a CTO at the time of his death, David comes within the definition of a 'person held in care' under the *Coroners Act 1996* (WA). In such circumstances, an inquest is mandatory and a

[1] I will refer to David Maddams as David, at the request of his parents.

coroner must comment on the quality of his supervision, treatment and care.[2] I held an inquest on 30 June 2026 in order to undertake that task.

7 To assist me in that regard, I received into evidence a considerable amount of documentary material, including information provided by David's parents about his history and the events leading up to his death, David's medical records and a report from his usual treating psychiatrist, Dr Michael Woodall.[3] Oral evidence was also received at the inquest from:

- Dr David Garside, who was responsible for David's psychiatric care during his last hospital admission prior to David being placed on the CTO, and
- Dr Kasia Frydrych, the Head of the Osborne Community Mental Health Service that was assigned to manage David on the CTO at the time of his death.

BACKGROUND

8 David was born in 1970. After finishing school he completed a degree in business and hospitality management and then he joined the Australian Army at the age of 22 years. He was 26 years old when he was involved in a motor vehicle accident in an Army Land Rover. He suffered head trauma and a neck injury.[4]

9 David was medically discharged from the Army a couple of years later. David found it hard to work due to his injuries and he received a Permanent Disability Pension and Military Superannuation through the Commonwealth Department of Veteran Affairs.[5]

10 For around 10 years prior to his death, David lived in a unit on his own, in a suburb near to his parents' home. David's parents had contact with him daily. David's mother would visit him often to help with his meals and laundry, amongst other things.[6]

[2] Section 22(1)(a) and s 25(3) *Coroners Act.*
[3] Exhibit 1.
[4] Exhibit 1, Tab 8, Tab 13 and Tab 17.
[5] Exhibit 1, Tab 8.
[6] Exhibit 1, Tab 8.

11 Other than spending time with his parents, David appears to have largely kept to himself. He was reported to spend a lot of time at home playing computer games and he told his GP that he also liked to write.[7]

12 David had given his parents Enduring Power of Guardianship and as a result they had a good understanding of his health issues and medication requirements. They were an important point of contact between David and his treating doctors.[8]

13 David was first diagnosed with organic psychosis following his head injury, which was later revised to paranoid schizophrenia. David was managed on anti-psychotic medication. The medication can have a side-effect of weight gain and one of David's physical health issues was obesity. He had also been diagnosed with severe obstructive sleep apnoea, possibly related to his weight, and venous thromboembolism. David was a long-term cigarette smoker and regular cannabis user, which complicated his other conditions.

14 For many years David received psychiatric treatment in the public mental health system, but in June 2015 Consultant Psychiatrist Dr Michael Woodall commenced treating David privately. Dr Woodall had begun working at Hollywood Private Hospital conducting veterans' clinics and David was entitled to treatment in the clinics through funding from the DVA.[9]

15 At the time of the referral, David had a long history of psychotic illness with multiple prior admissions to Graylands Hospital, significant compliance difficulties with medication, and a documented history of venous thromboembolism. David had been established on high-dose zuclopenthixol depot (a long-acting antipsychotic medication delivered by injection) following his last Graylands admission. Dr Woodall understood David had "shown his best response on this medication and he had then enjoyed a long period of relative stability in terms of his psychotic symptoms,"[10] although he could still hear voices.

16 David was not under the care of a community mental health team while under Dr Woodall's care. His psychiatric care was managed by Dr Woodall in conjunction with David's GP, Dr Jeff Veling. David was

[7] Exhibit 1, Tab 14.1.
[8] Exhibit 1, Tab 14 and Tab 17.
[9] Exhibit 1, Tab 14.4.
[10] Exhibit 1, Tab 14.5, p. 1.

prescribed his fortnightly depot medication by Dr Woodall, and it was administered by a practice nurse associated with the GP practice.[11]

17 As well as providing David with psychiatric care, Dr Woodall also assisted David to obtain appropriate entitlements through the DVA, including recognition and treatment for his obstructive sleep apnoea. David's GP, Dr Veling, monitored David's physical health, including his weight and metabolic parameters. He also received regular physiotherapy.[12]

18 David's parents considered David was fortunate to have these two doctors working closely together to care for him and seemed happy with the care he received. David would also often tell his parents how lucky he was to have them both as his treating practitioners.[13]

19 David's mother often attended clinics with him and Dr Woodall acknowledged that David's parents were an important part of David's safety net, given his limited insight. David's parents would advise Dr Woodall if they became aware he had ceased his medication or detected signs he was becoming unwell.[14]

20 When David was first referred to Dr Woodall in 2015, he had observed that David was morbidly obese and asplenic, having had his spleen surgically removed after a fall. Dr Woodall considered David's metabolic disturbance was primarily associated with his high dose of zuclopenthixol (on which he was already established), principally through its effect on appetite and weight. He noted David had also experienced a deep vein thrombosis in December 2014 and was at risk of further events. In that regard, Dr Woodall considered David's single greatest modifiable risk factor for thrombosis was his heavy smoking. David had taken up smoking when he joined the Army as a young man, and he had remained a heavy smoker since that time, estimating he smoked around 50 cigarettes per day. He was not open to the suggestion he should give it up.[15] David suffered further pulmonary embolisms as a result.[16]

21 Dr Woodall advised he was conscious of the metabolic burden of the zuclopenthixol dose, in particular the weight gain it caused, so he made

[11] Exhibit 1, Tab 14.1 and Tab 14.5.
[12] Exhibit 1, Tab 14.5.
[13] Exhibit 1, Tab 17.
[14] Exhibit 1, Tab 14.5.
[15] Exhibit 1, Tab 8 and Tab 14.5.
[16] Exhibit 1, Tab 11 and Tab 17.

genuine attempts to reduce it. A dose-reduction trial was undertaken over time, reducing the dose and increased the spacing between each dose from fortnightly to every three weeks. Unfortunately, this produced a flare-up of David's psychotic symptoms. Late in 2021, David's parents advised Dr Woodall that neighbours had reported David shouting at night, which indicated a deterioration in his mental state. Accordingly, Dr Woodall returned the dose to the previous level at fortnightly intervals.[17]

22 Because David's condition was never able to be stabilised on a reduced dose, Dr Woodall advised he was unable to reach the point at which he could safely attempt to cross-taper to a different injectable agent that might have fewer adverse effects. David's long history of poor compliance with oral medication meant that, in any event, treatment would have had to be by depot.[18]

23 The responsibility for monitoring and managing David's metabolic and thrombotic risk was shared between Dr Woodall and Dr Veling. David was being treated with anticoagulation to reduce his thrombotic risk. Unfortunately, he was not always compliant with his medication and although his cigarette smoking and cannabis use exacerbated his risk, as noted above he was reluctant to give up these habits.[19]

DAVID CEASES HIS ANTI-PSYCHOTIC DEPOT MEDICATION

24 In the early years, David was reviewed by Dr Woodall every four to six weeks. As their therapeutic relationship became established, the time period increased to every three to four months. The reviews were predominantly in person until the COVID-19 pandemic, after which they transitioned to mainly telephone consultations. Dr Woodall's last in-person review of David was in April 2024. His final four consultations were conducted by telehealth.[20]

25 At the last in-person review in April 2024, David reported to Dr Woodall that he had experienced pain when a nurse administered his depot injection and he seemed reluctant to continue with it. Dr Woodall discussed the matter with David's GP and it became apparent that David had decided he wished to cease his medication in order to lose weight.

[17] Exhibit 1, Tab 14.5.
[18] Exhibit 1, Tab 14.5.
[19] Exhibit 1, Tab 14.5.
[20] Exhibit 1, Tab 14.5.

David's parents understood he had been encouraged to lose weight so he could have an operation to remove two large hernias.[21]

26 David had also admitted to Dr Woodall that he was using cannabis more regularly than previously at that time, and Dr Woodall considered the increased cannabis use was likely having an adverse effect on David's mental state.[22]

27 David ceased his depot medication in May 2024. Dr Woodall spoke to him on 15 May 2024 to try to convince him to resume his injections, but David was adamant.[23] In his report, Dr Woodall indicated he told David directly "that this was a poor decision,"[24] in the context of the risk to his mental state. He reminded David of his history of hospitalisation when unwell and that both his cannabis use and compliance difficulties increased his risk of relapse. David made it clear he was certain about his decision, with his primary motivation articulated as a wish to lose weight.[25]

28 Dr Woodall commented that involuntary treatment under the *Mental Health Act 2014* (WA) would have required David to be demonstrably unwell (for example thought-disordered or troubled by auditory hallucinations) together with the necessary assessment of a lack of capacity. In his professional opinion, David had the capacity to make decisions about his medical care. Accordingly, Dr Woodall had to respect David's decision to cease treatment, even if he considered it was unwise from a psychiatric point of view. Given their good therapeutic relationship, built over many years, Dr Woodall had hoped that if David did become demonstrably unwell, he would be able to persuade him to accept treatment again, as had occurred in the past.[26]

29 Dr Woodall wrote to David's GP on 15 May 2024 to confirm his understanding that David was intending to stay off psychiatric treatment and try to manage his condition naturally, despite Dr Woodall's advice that he was at high risk of relapse. Dr Woodall mentioned in the letter that David was "more agitated than usual, rather pressured in his speech and slightly hostile" in their last conversation and noted there had been

[21] Exhibit 1, Tab 17.
[22] Exhibit 1, Tab 14.5.
[23] Exhibit 1, Tab 14.2.
[24] Exhibit 1, Tab 14.5 [13].
[25] Exhibit 1, Tab 14.5.
[26] Exhibit 1, Tab 14.5.

some complaints from neighbours about David shouting at night, so it was possible he might ultimately require involuntary admission.[27]

30 Although David was no longer receiving active psychiatric treatment, Dr Woodall continued to monitor David after he ceased treatment against advice. Dr Woodall chose to continue meeting with David, rather than discharge him from the service, so he could monitor him. Dr Woodall spoke to David on the telephone once a month in order to gauge whether David was deteriorating to the point of requiring admission, because there was no other means by which David would agree to be reviewed. During those subsequent consultations, Dr Woodall recalled David presented as well, denied hearing voices and reported he had lost weight just as he had hoped. David's parents also remained in contact with Dr Woodall, and he felt confident they would alert him if they saw signs that David was becoming unwell.[28]

31 Dr Woodall reported he did not consider referring David to a community mental health team at that time to try to monitor his mental state at home, as David's only psychiatric contact for a number of years had been with him and David had refused to engage with other practitioners. Therefore, Dr Woodall did not consider a referral at that stage was practical or likely to assist.[29]

Substance Use

32 Dr Woodall is the clinical lead for substance use at Hollywood Private Hospital so he has experience working in the area of substance use. As noted above, Dr Woodall considered David's cannabis use impacted on the severity of his symptoms. Dr Woodall reported he discussed this issue with David regularly, reinforcing on each occasion the impact on his psychosis and also his respiratory function. David did not accept that it exacerbated his hallucinations, believing instead that it relaxed him, and he politely declined assistance. The same pattern applied to his smoking. Each time aids to cessation were raised, David maintained he could simply stop of his own accord but chose not to do so.[30]

33 Dr Woodall therefore did not refer David for alcohol or other drug counselling as David did not identify this as a problem that he needed to

[27] Exhibit 1, Tab 14.2.
[28] Exhibit 1, Tab 14.5.
[29] Exhibit 1, Tabs 14.2, 14.5 and 14.5.
[30] Exhibit 1, Tab 14.5.

address. Insight and a willingness to change is generally a requirement for such counselling.[31]

Last Review on 12 August 2024

34 Dr Woodall's last review of David on 12 August 2024 was conducted by telehealth. David reported he had lost another 5 kg in weight, which was his main focus. He told Dr Woodall his mental health was 'okay' and the voices did not get to him too much. He felt his sleep was also okay and he reported he had been spending his time watching a lot of the Olympics. Nothing about those responses elevated Dr Woodall's level of concern.[32]

35 This was Dr Woodall's last contact with David. Dr Woodall did later speak to David's treating psychiatrist when he was hospitalised, to provide some background information, but he did not speak to David again before his death.

ADMISSION TO SIR CHARLES GAIRDNER HOSPITAL (SCGH)

36 David's mental state deteriorated further in the weeks after his last contact with Dr Woodall. David's parents saw signs he was becoming unwell, noting he was causing a disturbance at his unit complex by shouting and yelling and had become paranoid and irritable. Knowing his past history, they believed he might require hospitalisation again. They were aware Dr Woodall was away, so they sought help via the statewide Mental Health Emergency Response Line (MHERL) on 5 September 2024, hoping this would lead to David being urgently assessed. It seems the urgency of their request was not understood and so the relevant community mental health service was notified, but only to follow up at their convenience.[33]

37 The following afternoon, being 6 September 2024, David's father called the Subiaco Community Mental Health Service to enquire about when his son would be assessed. He was advised at that time that an urgent referral would be made. Clinicians from the North Metropolitan Health Service afterhours team then went to David's home that night to conduct an assessment. When they arrived David presented as settled and didn't want to engage with the clinicians. He was watching television with a friend and they considered overall his risk was low at the time, so they

[31] Exhibit 1, Tab 14.4.
[32] Exhibit 1, Tab 14.3.
[33] T 17 - 18; Exhibit 1, Tab 11.

referred him to the Subiaco Community Mental Health Service for follow up.[34]

38 An attempt was made by a registered mental health nurse (MHN) from the Subiaco Service to call David on his registered phone number on 11 September 2024, without success. The MHN rang David's parents, who explained David had ceased his depot medication and they had been receiving complaints from his neighbours. They also indicated David's private psychiatrist was away until the end of the month. David's parents provided a new mobile number for David, which the MHN tried, but David did not answer. A home visit was then planned.[35]

39 An initial home visit planned for 13 September 2024 was unable to be conducted due to other more urgent matters.[36]

40 The home visit took place on 16 September 2024. David was hostile and unwilling to engage with the community mental health team staff. He was believed to have experienced a relapse of his paranoid schizophrenia in the setting of having ceased his antipsychotic medication. Given his past history and presentation, it was determined that David appeared to lack capacity and presented with significant risks to himself and others, As a result, the MHN completed forms under the *Mental Health Act 2014* (WA) on 16 September 2024, so that David could be taken to hospital for psychiatric assessment and treatment. It was planned for police to assist with the transfer, given David's level of agitation, which created a potential safety risk for the mental health practitioners and St John Ambulance (SJA) staff.[37]

41 Given David's weight was believed at the time to be greater than 150 kg, based upon records, a specific bariatric bed had to be arranged for him in the Mental Health Unit before he could be admitted. An appropriate bariatric bed was arranged but there were logistical difficulties coordinating police officers to attend along with an appropriate bariatric ambulance in order to transfer David to hospital. In the meantime, the 72 hour time period for the forms lapsed and the bariatric bed was lost to another patient.[38]

42 David was re-formed on 20 September 2024 and, with the assistance of police, David was then transferred by ambulance to hospital on

[34] Exhibit 1, Tab 16.
[35] Exhibit 1, Tab 11 and Tab 16.
[36] Exhibit 1, Tab 16.
[37] Exhibit 1, Tab 11.
[38] T 7 - 8; Exhibit 1, Tab 15.

22 September 2024. David required sedation by SJA staff to bring him into hospital as he was verbally hostile and exhibited physically aggressive behaviour due to his deteriorated mental state. He presented to Sir Charles Gairdner Hospital (SCGH) Emergency Department at 10.47 am.[39]

43 On assessment by the psychiatry liaison team, David was noted to be dishevelled and disorganised in his thinking patterns and was still showing effects of the sedation at that time. He made it clear he didn't want to be on any medications and declined to speak about his history or generally engage in a medical review, but he was cooperative with the ED staff in terms of taking bloods and observations. Once he was medically cleared and a suitable bariatric bed became available, he was admitted to the Mental Health Unit on 23 September 2024.[40]

44 David was placed in the care of a multidisciplinary team, known as Green Team, under the management of Consultant Psychiatrist Dr David Garside. His care was managed by the treating team from 23 September 2024 until his discharge on 21 October 2024.[41]

45 During the early part of his admission, David was irritable and seemed frustrated that he was unable to smoke on the ward. He didn't like being interviewed and remained adamant he did not want to take his medications, oral or injectable, and did not want to engage in any other treatment.[42]

46 Dr Woodall had no contact with David or his family between his last review on 12 August 2024 and his death but after David was admitted to SCGH, Dr Woodall did have some conversations with David's treating team. He provided history about the background to David's decision to cease his medication. They also discussed the option of switching David to a depot agent less likely to cause weight gain. Aripiprazole was the preferred candidate.[43]

47 Following review by the treating team and discussion with Dr Woodall, David was placed on an Inpatient Treatment Order with a diagnosis of relapse of Chronic Paranoid Schizophrenia in the context of lack of insight into his illness and non-compliance with medication, complicated by cannabis use. Initially the plan was to offer an oral antipsychotic and

[39] Exhibit 1, Tab 11, Tab 13 and Tab 15.
[40] Exhibit 1, Tab 11, Tab 13 and Tab 15.
[41] Exhibit 1, Tab 13.
[42] Exhibit 1, Tab 13.
[43] Exhibit 1, Tab 14.5.

hopefully engage David in his treatment, but when this was not achieved, David was recommenced on Zuclopenthixol depot. The dose was initially set at 300 mg split over two weeks as he had been off his medication for a while. The dose was then uptitrated to 600 mg fortnightly dose. David was accepting of the depot medication, even though he did not voluntary choose treatment, and he tolerated the medication well.[44]

48 Because the anticoagulant that he was usually prescribed to reduce his risk of pulmonary thromboembolism only comes as a tablet, he was not recommenced on the medication in hospital. Dr Garside explained at the inquest there is an injectable form of blood thinning, which can be used on a daily basis and is sometimes used if patients are bed-bound. This option was discussed with the haematology team, given David's refusal to take oral medication. The haematology team felt that David had been off his medication for so long at the time, and noting he was not bed bound but was actively moving around, that it was not necessary to trial this other option.[45]

49 Initially, David was managed on a 2:1 nursing special to ensure his safety and the safety of others. As his agitation and irritability slowly settled, the nursing special was able to be ceased and he was transferred to an open ward in week two of his admission without issue.[46]

50 Intermittent insomnia was noted, which he indicated was a long-standing issue for him. He was trialled on an oral medication to reduce his nightmares, but he ceased it after a few days. It was suggested that he would likely benefit from a sleep study and then a CPAP machine but David declined any further investigation or intervention for this issue. Dr Garside indicated that they would not have attempted a formal sleep study while David was actively unwell, in any event, but he was not interested in partaking in this option at any stage.[47]

51 Despite psychoeducation and encouragement, David was adamant he would not take oral medications other than pain relief. Although David's medication may have been a factor in his weight gain, the other factors that impacted upon his weight were behavioural, including some of his dietary choices and his unwillingness to exercise. Attempts to engage

[44] Exhibit 1, Tab 13 and Tab 15.
[45] T 9 - 10.
[46] Exhibit 1, Tab 13.
[47] Exhibit 1, Tab 13 and Tab 15.

him with allied health staff such as a dietician, physiotherapist and alcohol and drug officer were, however, rejected.[48]

52 David was also offered a trial on a different antipsychotic medication, Aripiprazole, while in hospital, as this medication might have a better metabolic profile. David would have needed to be trialled on oral Aripiprazole first, to see whether a switch to this depot would be beneficial, but David declined so he remained on Zuclopenthixol. It was again planned that when his mental state improved, this option could be explored again once David was in the community.[49]

53 Dr Garside observed at the inquest that David had improved while in hospital, but it would probably take a couple of months on the full depot dose to get the full benefits of that stabilisation, and it was hoped at that stage that David might be persuaded to start taking oral medications again.[50]

54 David's involuntary treatment order was reviewed and extended on 15 October 2024 as he continued to be experiencing a psychotic illness which affected his decision-making capacity and no less restrictive alternative was appropriate at that time. However, he was given opportunities for regular escorted leave as his mood and behaviour improved.[51]

55 In the week leading up to his discharge, David denied any paranoia. He did admit to ongoing auditory hallucinations but he did not find them disturbing. He exhibited some ongoing emotional lability, primarily irritability at his ongoing hospital admission, but this improved as his opportunities for leave increased.[52]

56 David was granted a trial of unescorted leave over a weekend, commencing on 19 October 2024, as a prelude to discharge. The leave went well and his family provided positive feedback, but David returned a positive test for THC on return to hospital. The result was discussed with David's mother, who felt certain David had not consumed marijuana over the weekend. She wondered if it might have been an artefact from his use prior to his admission. The results were discussed by the Psychiatric Registrar with Dr Garside. On balance, it was

[48] T 10, 12; Exhibit 1, Tab 15.
[49] Exhibit 1, Tab 13 and Tab 15.
[50] T 10.
[51] Exhibit 1, Tab 15.
[52] Exhibit 1, Tab 15.

accepted David had not been using cannabis that weekend and it was agreed that David's planned discharge could continue.[53]

57 The plan was for David to be discharged on a Community Treatment Order (CTO) to ensure his compliance and clinical monitoring. He was in the recovery phase and it would take some further time on his medication for his mental state to stabilise. It was noted that David might consider transitioning back to Dr Woodall for his psychiatric care once his condition had stabilised, but Dr Woodall could not provide the initial care while David required involuntary treatment under the CTO. Therefore, David had to be referred to a community mental health team initially.[54]

58 David refused to participate in formal discharge planning but he was aware of what was planned. He had expressed a clear desire to leave hospital, so release on a CTO was aligned with his wishes. The option of release without a CTO was considered by the treating team, which would have been David's preference, but it was anticipated David would not comply with treatment once in the community, unless he was on a CTO.[55]

59 Options to manage his risk of thromboembolism were discussed with the haematology service at SCGH and his GP and a plan was formulated that his GP, Dr Veling, would try to re-engage David in his treatment and get him back on his anticoagulant medication after discharge as Dr Veling generally had a good working relationship with David.

DISCHARGE ON CTO

60 David was discharged from hospital on a CTO on 21 October 2024, to be managed by the Osborne Park Community Mental Health Team. As he was subject to the CTO, David was an involuntary patient under the *Mental Health Act*. The CTO had an expiry date of 20 January 2025, so it was expected he would need to remain on the order for at least a few months to ensure he received his depot medication for management of his schizophrenia. It was suggested in the discharge summary that during that period the treating team should explore an alternative antipsychotic with a better metabolic profile with David when he was more willing to engage and he should be encouraged to abstain from cannabis use.[56]

[53] Exhibit 1, Tab 12, Tab 13 and Tab 15.
[54] T 10; Exhibit 1, Tab 13.
[55] Exhibit 1, Tab 15.
[56] Exhibit 1, Tab 13 and Tab 16.

61 The discharge summary also noted that David required follow up with his GP about his ongoing anticoagulation as he was at future risk of recurrent thromboembolism while he was non-adherent to his anticoagulation. David had been non-compliant with this medication for around seven months at that time, so it pre-dated his hospital admissions. As noted above, it was hoped Dr Veling would be able to convince David to recommence his medication once his mental state improved.[57]

62 The medical records indicate David obtained a podiatry referral from Dr Veling on 28 October 2024. He also had a phone consultation with Dr Veling about a sore shoulder on 30 October 2024, after the receptionist was unable to find an appointment time that suited David. David told Dr Veling he thought the shoulder pain might be linked to an earlier dislocation and he was prescribed Panadeine Forte for his pain. It does not seem that Dr Veling saw David in person after his discharge and the possibility of getting him restarted on his anticoagulation therapy was, therefore, not explored.[58]

63 The CTO required David to comply with fortnightly depot injections of Zuclopenthixol and to attend scheduled outpatient appointments as directed by the community treatment team. The first review appointment date had not been confirmed at the time David left hospital, as that had to be arranged by the allocated community mental health service. His next depot injection wasn't due until 31 October 2024, so it was felt there was sufficient time for the service to contact David directly and it was deemed not therapeutic to delay discharge until those details were available. David's mother followed up with the SCGH treating team because she hadn't been given any details for a follow-up appointment, so the registrar, Dr Sullivan, contacted the Clinic to ensure the referral was in place.[59]

64 A referral was received by the Osborne Community Mental Health Service on 23 October 2024 and David was allocated to a case manager, who I will refer to as Sam in line with the documentation, and a treating psychiatrist. Sam tried to call David on 25 October 2024 and left a message outlining his role as a case manager and the role of the mental health service and encouraging David to call the Osborne Community Mental Health Clinic (the Osborne Clinic) to book a depot injection and

[57] Exhibit 1, Tab 13 and Tab 16.
[58] Exhibit 1, Tab 13.
[59] Exhibit 1, Tab 13 and Tab 15.

initial medical appointment. Sam left another message for David on 28 October 2024.[60]

65 When he did not hear back from David, Sam called David's mother on 29 October 2024. David's mother explained that David doesn't generally answer his phone. She believed he was stable on his medications and was doing reasonably well. David's mother agreed to facilitate David's attendance at the Osborne Clinic for his depot injection, which was due on 31 October 2024, and they could make a booking for his first medical appointment at that time.[61]

66 David attended the Osborne Clinic on 31 October 2024, but he did not receive his depot injection as planned. Instead, he was simply booked in for an initial medical appointment by the reception staff. The Clinical Head of the service, Dr Frydrych, explained that there appeared to have been some confusion at the time as David was at the clinic for two reasons: to book an appointment with the psychiatrist and to have his depot injection. The receptionist booked the appointment but was seemingly unaware that David also required his depot injection that day. The depot injection is not booked as an appointment in the PSOLIS diary system, so it would not have come up on the computer when the other appointment was booked, and it seems David did not mention it.[62]

67 The error was picked up after David left and his case manager, Sam, rang David's mother later that day to enquire about his missed depot injection. She confirmed David had attended the clinic but had not received his depot injection. Sam encouraged David's mother to bring him back to the clinic again the next day, as it was important he receive his depot. She was not available to escort David that day, but it was agreed David would be provided with a taxi voucher so he could attend on his own.[63]

68 David took a taxi to the clinic the next day, being 1 November 2024, and he received his depot injection without incident. He was noted to have been polite and warm with the staff during the visit. David also confirmed he was aware he needed to return for his medical appointment with his treating psychiatrist on 5 November 2024. Sadly, David died

[60] Exhibit 1, Tab 11.
[61] Exhibit 1, Tab 11.
[62] T 20 - 21; Exhibit 1, Tab 11 and Tab 16.
[63] Exhibit 1, Tab 11 and Tab 16.

suddenly the night before the appointment, so he was never reviewed by the psychiatrist.[64]

69 The notes generally suggested that David was doing well psychiatrically following his discharge from hospital but the allocated community mental health treating team staff did not get a chance to meet David, given the short period of time he was engaged with the service before his death. The person who administered his depot medication was not his case manager and he was still to attend his first psychiatric appointment. During his appointment with the psychiatrist, which would usually be a 90 minute appointment slot, it is expected aspects of his overall care would have been discussed with David, including his medications, etc. However, Dr Frydrych noted that the Osborne Clinic treating team were not afforded the opportunity to meaningfully engage with David, given the short time between his discharge from hospital and his unexpected death.[65]

70 Nonetheless, Dr Frydrych wished to pass on the condolences of the Osborne Clinic staff collectively to David's family for their loss.

LAST KNOWN EVENTS

71 David's mother last saw him on Saturday, 2 November 2024, at his unit. She visited him to drop off some food and help him with his washing. During the visit David appeared his normal self and was in a good mood.

72 On Monday, 4 November 2024, David sent a text to his mother at 2.32 pm and asked her a question about his clothing. She rang him in response at 2.35 pm and they had a brief conversation. Soon after, at 3.27 pm, David's mother called him from the shops but he didn't answer her call. She went to his unit after making the call, arriving at his home at about 3.30 pm.

73 When David's mother arrived at his unit, she found the front security screen door was closed and the front wooden door was open. She called out to David through the open screen door but he didn't respond. The screen door was unlocked, which was not unusual for David, so after getting no response she opened the door and entered the unit. David's mother looked for David inside the unit but couldn't find him. She noticed the television was on, although he was not in the lounge room.

[64] Exhibit 1, Tab 11 and Tab 16.
[65] T 22 – 23; Exhibit 1, Tab 11 and Tab 16.

She turned off the television and continued to search the house and then the exterior for her son.

74 After looking outside and seeing no sign of David, she returned inside and noticed the toilet door was closed. David's mother tried to open the door but felt some resistance. She could see a little through the crack in the door and observed David was inside the toilet, leaning against the door. He was not responding to her and she realised he had collapsed. David's mother called her husband and then emergency services to request help.[66]

75 David's father arrived quickly and brought tools with him, which he used to remove the toilet door from the hinges. Due to David's size they were unable to move him out into the corridor, but David's father was able to check for a pulse. He couldn't detect a pulse and they observed no signs of life. Ambulance officers arrived soon after and, with the help of a second SJA team, they were able to manoeuvre David out of the toilet and into a workable space. They commenced CPR at 3.50 pm. After 20 minutes of CPR, it was noted that David showed some minimal response, so active CPR continued for a further period of 10 minutes. All CPR was then terminated as it was agreed that further resuscitation efforts were not going to be successful. David's death was certified at the scene by a paramedic.[67]

76 Police officers attended the scene and David's mother was able to confirm that she had seen nothing suspicious upon entering the unit and it was noted David's wallet, mobile phone and car keys were all inside on a table near the kitchen. Police found no evidence of criminality or third person involvement.[68]

CAUSE AND MANNER OF DEATH

77 A post mortem examination showed evidence of CPR efforts. Internal examination showed enlargement of the heart and fibrosis around the heart. Abundant blood clot was present in lung vessels (pulmonary thromboembolism). The liver was enlarged and slightly fatty and the kidneys showed mild surface scarring. The forensic pathologist, Dr Kueppers, concluded it appeared David died as a result of pulmonary thromboembolism and it was noted he had a history of recurrent venous thrombosis and was reportedly not compliant with anticoagulation

[66] Exhibit 1, Tab 8.
[67] Exhibit 1, Tab 2, Tab 8 and Tab 9.
[68] Exhibit 1, Tab 7 and Tab 8.

therapy. Limited toxicology analysis detected David's antipsychotic medication Zuclopenthixol and tetrahydrocannabinol (cannabis).[69]

78 Dr Kueppers expressed the opinion the cause of death was pulmonary thromboembolism and the death was due to natural causes.[70]

79 David had no history of self-harm attempts and his mother had never known him to speak of suicidal thoughts or intention to harm himself.[71] His decision not to take his oral medications, including his prescribed anticoagulant therapy, was attributed to his psychiatric illness rather than any intention to put his life at risk.

80 Accordingly, I find David died from pulmonary thromboembolism and his death occurred by way of natural causes.

COMMENTS ON TREATMENT, SUPERVISION & CARE

81 Dr Garside observed that, in terms of David's treatment in hospital, they explored a number of options to improve his overall health, but David generally believed the SCGH staff were overreacting and he was "very, very opposed"[72] to the treatment options they suggested. Therefore, the primary focus was on recommencing David on the depot medication that was known to be effective in treating his schizophrenia and getting him to a stage where he was safe to be discharged into the community. It would generally take four to six weeks, at a minimum, for the depot level to become stable.[73]

82 David was very unhappy at being in hospital and was constantly wanting to be discharged. The treating team kept him in hospital for a bit longer than David wanted, due to concerns that David had been causing issues with his neighbours when unwell, which might put his accommodation at risk. In discussion with David's mother, it was agreed that keeping him in a bit longer, to make sure he was stable and would not be so disruptive at home, was necessary. However, once he was considered to be safely in the recovery phase, it was felt that discharge was the appropriate option given David's increasing irritability at remaining in hospital[74]

[69] Exhibit 1, Tab 5.
[70] Exhibit 1, Tab 5.
[71] Exhibit 1, Tab 8.
[72] T 10.
[73] T 12.
[74] T 10 – 11.

83 Dr Garside described David's admission as a "middle of the road admission"[75] in terms of length, in the end. The clinicians knew it would take quite some time for David's mental state to improve to a point where he would be able to engage more willingly in his treatment, but in the meantime he was becoming increasingly irritable, which might have created more opposition to his treatment.

84 Dr Garside mentioned at the conclusion of his evidence that he was not informed of David's death. He commented that the treating team had worked quite closely with David's parents, particularly his mother, and he felt it would have been lovely to have had a chat with her, offer his condolences and debrief about David's unexpected death. David's mother advised the community mental health service the day after his death, but that information does not appear to have been fed back to the SCGH psychiatric team.

85 Dr Garside's wish to be informed is a very understandable response. Unfortunately, in my experience it is not unusual for a psychiatrist not to be informed of a patient's sudden death in circumstances such as these. Where the death is a reportable death, it may be that the Court can play a role in informing the relevant treating practitioner, but in my view it would also be helpful and appropriate for the health service to provide that information to the treating practitioner, wherever possible. I have made similar observations in other inquests in the past, noting that it puts the medical practitioner in a much better position to reflect on the care provided and consider whether anything might have been done differently, as well as for the reasons Dr Garside has expressed. I do not consider it requires the formality of a recommendation, but I simply make the comment here that in this case, it would have been an easy task for someone at the community mental health service to feed the information back to Dr Garside or a member of his team after they were notified by David's mother. There seems to me to be no reason why it couldn't be done in future cases.

COMMENTS ON PUBLIC HEALTH

86 I note in this case that the first Form 1A that was completed for David's transfer to hospital for psychiatric assessment lapsed before police and SJA staff could be coordinated to attend his home, requiring a second Form 1A to be completed. Without commenting on the specific circumstances of David's case, Dr Frydrych gave general evidence this is

[75] T 11.

a common occurrence. Dr Frydrych observed that lining up police and ambulance staff to attend at the same time as mental health clinicians can often take days, and in her experience it is becoming increasingly difficult.[76]

87 Dr Frydrych observed that community mental health practitioners used to be able to arrange for police officers to attend home visits with them to assess a patient where there was a concern the patient might become aggressive, but that is "almost impossible"[77] now. Dr Frydrych attributed the difficulty to a change in WA Police Force policy. Dr Frydrych acknowledged that all government agencies are facing resource shortage, but she also noted that "community clinicians are completely vulnerable in the community going to people's homes and … conducting assessments."[78] The increased difficulty organising police to attend, along with the overall difficulty of coordinating police attendance along with SJA at the same time a bed is available at a mental health unit, means that it is not uncommon for people to be waiting in the community on forms until it can be arranged or for the patient to have to spend time in an ED once at hospital, like David did. Dr Frydrych noted it is, unfortunately, not uncommon for patients to be waiting two or three days in an emergency department before a bed becomes available, which is obviously not ideal.[79]

88 Following the inquest hearing, Dr Mark McAndrew, the Acting Executive Director of Mental Health Services and Dental Health Services at the North Metropolitan Health Service (NMHS) provided additional information to the Court about the current arrangements between Community Mental Health Services and the Western Australia Police Force (WA Police) when police assistance is required to refer a person for examination under the *Mental Health Act*.[80]

89 Dr McAndrew explained that when a Form 1A Referral for Examination by a Psychiatrist is completed, it usually specifies that the examination should take place at an authorised hospital. If the referring clinician believes it is not safe for the consumer to be taken to the place of examination by family members, mental health services staff or ambulance staff without assistance, another form under the *Mental Health Act* can be completed. This form, known as a Form 4A Transport

[76] T 18.
[77] T 18.
[78] T 18.
[79] T 18 – 19.
[80] Exhibit 2.

Order, allows a WA Police officer to take the person to the place for examination. There is no formal Memorandum of Understanding between NMHS and WA Police for how this service is provided. In practice, the request was traditionally made during weekday business hours by telephone from a Community Mental Health Service to the WA Police A/Superintendent of Custodial Services and Mental Health Division, providing details of the orders and making the request for transport assistance. Outside of business hours, the Community Mental Health Service After-Hours team would typically contact WA Police Central Communications to ask for assistance.[81]

90 On 16 April 2026, WA Police wrote to the Community Mental Health Services to provide an update on their processes for mental health transport requests. The update advised all requests for WA Police involvement in mental health transports, including those supported by a Form 4A (Transport Order) must now be submitted via a single, centralised email address and any requests directly to local police or via the State Operations Command Centre or Police Assistance Centre (PAC) will be redirected to the mailbox. All requests received via the email address will be reviewed by a PAC Senior Sergeant who will act as the primary decision-maker and will consider, amongst other things, whether "a clear justification exists for police involvement as distinct from a health-led transport response."[82]

91 If the request is accepted, a CAD job is created and the task is managed by State Operations Command Centre (SOCC) for dispatch. If a transport request is not approved, or the risk rating is assessed by WA Police as not supporting police involvement, the PAC Senior Sergeant will advise the requesting Health Service Provider of the decision and reasons. If there is disagreement or concerns about the decision, the matter may be escalated for review to the Duty Inspector at SOCC and the outcome of that review will be communicated back to the Health Service Provider.[83]

92 The Community Mental Health Services have reported that it has become increasingly challenging to obtain WA Police assistance for transport requests within the 72 hour validity period of a referral, consistent with Dr Frydrych's evidence. This has resulted in:[84]

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[81] Exhibit 2.
[82] Exhibit 2, p. 3.
[83] Exhibit 2.
[84] Exhibit 2, p. 2.

- delays in patient examination, hospital admission and commencement of treatment,
- increased risk to the patient and community;
- administrative complexity and delays in renewing MHA forms; and
- the need for more intensive interventions at a later stage to manage heightened risk and clinical deterioration.

93 Dr McAndrew advised the NMHS understands the delays may be associated with WA Police's threshold for confirming attendance, with WA Police prioritising attendance where there is evidence of current violence, threats, or possession of weapons, and evidence of historical risk factors or recent risk history alone may not be sufficient to support deployment.[85]

94 Dr McAndrew advised the recent experience of NMHS Community Health Service Providers since the introduction of the new WA Police process has been a continuation of previous delays in police attendance. An audit for the period 1 January to 15 July 2026 of requests for assistance related to MHA Forms 1A and 4A (so excluding general welfare check requests) indicated there had been more than 70 delays in WA Police attendance, with the duration of the delays commonly between one to three days, but up to 14 days. In seven instances the delay persisted beyond the 72-hour validity of the relevant Form 1A.[86]

95 NMHS acknowledged the need to balance consumer rights, clinical risk, staff safety and operational capacity, but it is clear health services are dependent upon the police in many cases to facilitate safe transport of psychiatrically unwell patients.[87]

96 WA Police provided a response to the concerns raised by the NMHS in a letter provided by Acting Assistant Commissioner Quentin Flatman APM, who is responsible for the Operations Support Portfolio. WA Police confirmed that under the centralised assessment process, assessment of transport requests is now undertaken by PAC and then dispatch of police resources is managed by SOCC. WA Police advised the centralised process was "developed following work undertaken collaboratively with the WA Country Health Service, the Department of Health and the Mental Health Commission."[88] The purpose of the

[85] Exhibit 2.
[86] Exhibit 2.
[87] Exhibit 2.
[88] Exhibit 3, p. 1.

process was said to be numerous, including to provide a consistent assessment process, establish a single point of contact for Health Service Providers and "support a reduction in unnecessary police involvement in mental health transport matters."[89]

97 As foreshadowed by Dr McAndrew, there is a focus on the health service providing information that WA Police accepts supports "the necessary "significant risk" pursuant to section 149(2)(a) or (b) of the *Mental Health Act* justifying police involvement is present; and to promote the use of health-led transport options wherever appropriate."[90] The 'significant risk' is a reference to a significant risk of serious harm to the person being transported or to another person. In the WA Police response, it is suggested that "a finding of significant risk does not automatically require police attendance, nor does it prevent a suitably trained transport officer from undertaking the transport."[91] Rather, it is suggested a health-led response should still be prioritised and "police involvement in mental health incidents should occur only where there is an identified policing capability requirement supported by reasonable, relevant and current information indicating violence, aggression, access to weapons, criminality or an imminent risk to life."[92]

98 Where police involvement is approved by PAC, a CAD task is created and managed through the SOCC. It is allocated a priority based on risk and urgency, then balanced against other priority tasks, with available police resources directed towards the highest priority incidents first. Where delays occur, health service providers are notified and there is an escalation pathway via the Custodial Services and Mental Health Division.[93]

99 What is clear from the information provided by NMHS and WA Police is that there is a disconnect between the health service's position that police involvement is regularly required for the safety of the individual and the health staff, including community mental health staff and ambulance officers, and the key objective of WA Police "to reduce excessive involvement in mental health responses, increase utilisation of dedicated health transport capabilities, and ensure police resources

[89] Exhibit 3, p. 1.
[90] Exhibit 3, p. 2.
[91] Exhibit 3, p. 2.
[92] Exhibit 3, p. 2.
[93] Exhibit 3, p. 2.

remain available for core policing functions and community safety matters."[94]

100 As far as I am aware, there are no other security providers who might be able to assist where police are unavailable. Therefore, health service providers must simply wait until police are available, or risk the safety of their staff and ambulance staff, as well as potentially the unwell person and other potential bystanders.

101 In this particular case, the issues with arranging transport for David to hospital are not directly connected to the circumstances of David's death. Therefore, the evidence did not address this issue extensively and what solutions might be available. I do not consider it appropriate to make a recommendation in such circumstances. At this stage, I simply raise it as an important issue that requires further discussion between WA Police and NMHS, as well as other health providers, to see whether there is a compromise or better solution available that will ensure there are less delays in transporting patients for assessment under the *Mental Health Act*, while ensuring everyone is kept safe. WA Police are correct that a 'health led' response is to be preferred in such cases, where possible, but I am concerned from a death prevention perspective that the safety risks are potentially being underestimated.

CONCLUSION

102 Sadly, David was injured while serving in our defence forces and this impacted the rest of his life. At the time of his death, David was a 54 year old man with an established diagnosis of schizophrenia and a history of recurring unprovoked deep vein thrombosis with pulmonary embolism. He had recently been treated in hospital due to a relapse of his schizophrenia in the setting of ceasing his medication. He was being managed under a CTO to ensure his compliance with his antipsychotic medication, which was given by depot injection at a community mental health clinic. David was also required to engage in other treatment, such as attending psychiatric review, while on the CTO, but he died before this could occur.

103 It was known by his treating practitioners that David had stopped taking his anticoagulant medication, along with his antipsychotic medication, and attempts had been made to convince David to take it voluntarily. He had refused and it had been decided that the appropriate plan was to discharge David from hospital and allow him more time for his mental

[94] Exhibit 3, p. 2.

state to stabilise on the depot medication, then hopefully he could be convinced to start taking his anticoagulant medication again.

104 It is speculative whether David would eventually have been agreeable to re-starting his anticoagulation, given his long term non-compliance and ongoing refusal in the hospital setting, but in any event there wasn't an opportunity for his allocated psychiatrist at the Osborne Clinic, nor his long-term GP, to try to talk him around, as he died suddenly only a couple of weeks after discharge from hospital.

105 David's parents, who were actively involved in his life and had a good understanding of his health care, have not raised any concerns about the treatment he received, either in hospital or while on the CTO. They believe David was fortunate to have a good therapeutic relationship with Dr Woodall and Dr Veling. He enjoyed a period of stability for many years under their care until he made a choice to stop his depot medication, which led to a relapse.

106 As David's treating team changed, first to SCGH and then the Osborne Clinic staff, his parents were kept informed of events and they appear to have understood that David was making some choices about his treatment that were for certain health reasons, but put his overall health at risk. However, they could see that his mental health had been improving again, once he was back on his depot medication, and his sudden death no doubt came as a shock to them both.

107 I am satisfied the overall treatment, care and supervision provided to David, both in hospital and then on the CTO, was reasonable and appropriate, acknowledging the need to provide David with the least restrictive method of care. The primary focus was on re-establishing David on his anti-psychotic medication, with the hope that once his mental state stabilised there would be an opportunity to engage him in meaningful discussion about his physical health care choices. Sadly, David died before this could occur after his known risk of sudden death due to pulmonary thromboembolism was realised.

S H Linton
Acting State Coroner
17 September 2026

CORONERS COURT OF WESTERN AUSTRALIA