Coroners Act 1996
[Section 26(1)]

Western *Australia*

RECORD OF INVESTIGATION INTO DEATH

Ref No: 5/ 18

I, Barry Paul King, Coroner, having investigated the death of ***Brook Damian Cain*** *with an inquest held at* ***Perth Coroner's Court*** *on* ***23 January 2018****, find that the identity of the deceased person was* ***Brook Damian Cain*** *and that death occurred on or about* ***13 November 2014*** *at* ***Unit 1, 5 Little Street, Carey Park,*** *from* ***ligature compression of the neck (hanging)*** *in the following circumstances:*

Counsel Appearing:

Ms S J K Teoh assisted the Coroner
Mr B G Humphris (WA Police Service) appeared for the Commissioner of Police and the WA Police Force
Mr J F Bennett (State Solicitor's Office) appeared on behalf of the WA Country Health Service and the North Metropolitan Health Service
Ms B E Burke (Australian Nursing Federation) appeared for Nurse Pauline Lang

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INTRODUCTION

1. On 12 or 13 November 2014, Brook Damian Cain (the deceased) died from ligature compression of the neck after he had hanged himself at his home in Carey Park.

2. The deceased's death was a 'reportable death' under section 3 of the *Coroners Act 1996* (the Act) because it appeared 'to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from injury'.

3. Under section 19 of the Act, I had the jurisdiction to investigate the deceased's death because it appeared to me that the death was or may have been a reportable death.

4. The deceased was subject to a community treatment order (CTO) under the *Mental Health Act 1996* (the MHA) at the time of his death, so he was an 'involuntary patient' within the meaning of the MHA.[1] He was therefore a 'person held in care' under section 3 of the Act.

5. Section 22(1)(a) of the Act provides that a coroner who has jurisdiction to investigate a death must hold an inquest if the death appears to be a Western Australian death and the deceased was immediately before death a person held in care.

6. An inquest into the death of the deceased was, therefore, mandatory.

7. I held an inquest into the deceased's death on 23 January 2018 at the Perth Coroners Court. The documentary evidence adduced at the inquest consisted of:

    a) an investigation report and associated attachments prepared by Constable M Greenmount of the Western Australia Police (WAPOL) together with reports, records and statements of witnesses obtained by the Court;[2]

[1] s3 *Mental Health Act 1996* (repealed)
[2] Exhibit 1, Volumes 1, 2 and 3.

b) the statement of Philip O'Keefe, senior nurse at the Mental Health Emergency Response Line (MHERL);[3] and

c) a WAPOL timetable of probationary police officers' training.[4]

8. Oral testimony was provided by:

a) Sergeant David Groenenberg, a police officer who had arrested the deceased on 12 November 2014;

b) Dr Steve Patchett, a consultant forensic psychiatrist who reviewed the deceased's case and provided a report on the care provided to him by WA State Mental Health Services;[5]

c) Debbie Easther, the clinical coordinator at Bunbury Community Mental Health Service (Bunbury CMHS) in November 2014 and the regional manager for mental health at the WA Country Health Service – South West at the time of the inquest;

d) Mr O'Keefe;

e) Pauline Lang, a clinical nurse specialist and the deceased's case manager at Bunbury CMHS in November 2014; and

f) Acting Inspector David White, the officer in charge of the WAPOL Mental Health Co-response Unit.

9. Under section 25(3) of the Act, where a death investigated by a coroner is of a person who was held in care, the coroner must comment on the quality of the supervision, treatment and care of the person while in that care.

10. I have found that all persons involved in the clinical supervision, treatment and care provided to the deceased acted appropriately and with the deceased's best interests

[3] Exhibit 2
[4] Exhibit 3
[5] ts 24-39

in mind, within the applicable legal framework. To the extent that shortcomings have been identified, those shortcomings have since been addressed and were unlikely to have changed the outcome in any event.

11. I have found that the training provided to police officers with respect to dealing with people with mental health issues should be regularly reinforced, and I have made a recommendation accordingly.

THE DECEASED

12. The deceased was born in Subiaco on 6 May 1975, making him 39 years old at the time of his death.

13. The deceased's parents separated after he was born. He moved to Queensland with his mother and his elder brother, David Cain, then returned to Perth with them when he was 13 years old.

14. The deceased was described as hyperactive with difficulty concentrating at school, and he moved around a lot as an adolescent. There is evidence to indicate that he was sexually abused by an older boy when he was six years of age.[6]

15. When he was young, the deceased was a talented vocalist and won several competitions. However, when he was about 16 years old he left school and moved from the country town where his family lived to Perth, where he shared a flat with a cousin. He began to abuse cannabis and alcohol, and he dabbled in other drugs. From then on, the deceased's life followed the now-familiar cycle of drug addiction, criminal activity and mental illness, although for some time he also did casual labouring jobs, bar work and part-time painting for his step-father.

16. In a letter apparently written by the deceased to warn young people of the dangers of drug use, he described how he spent years after leaving home struggling with a cannabis

[6] Exhibit 1, Volume 2, Tab 2, progress notes 12/11/12

and alcohol addiction before moving to Mt Magnet and Yalgoo in an unsuccessful attempt to get away from the unhealthy lifestyle. He worked in both those places but also picked up convictions for disorderly conduct and possession of cannabis.[7]

17. While he was away from Perth, the deceased met a woman with whom he went on to have three children, but apart from that, things did not go well. He re-located back to Perth and moved into a house in the city where he started using intravenous amphetamine. He quickly became addicted and, though he managed to work, spent all his money on amphetamine.[8]

18. The deceased's life got progressively worse. When he was about 23 years old he began to experience severe mental health problems that would continue to his death.

THE ONSET OF SEVERE MENTAL ILLNESS

19. In January 2005 the deceased attended the emergency department at Bunbury Hospital with paranoid ideation. In 2006 he was treated at Bentley Hospital and then Graylands Hospital, where he was diagnosed with drug-induced psychosis.[9] That diagnosis was later revised to schizophrenia and then schizoaffective disorder when an associated mood component was evident. He was also diagnosed with anti-social personality traits, and he had a history of self-harm and suicide attempts when he was acutely unwell.[10]

20. The deceased continued to be involved with mental health facilities, both as a voluntary patient, an involuntary in-patient and as an out-patient on a CTO. He was also convicted of traffic and assault offences, leading to Drug Court supervision.

[7] Exhibit 1, Volume 1, Tab 30
[8] Exhibit 1, Volume 1, Tab 30
[9] Exhibit 1, Volume 2, Tab 2, file note 12/4/11
[10] Exhibit 1, Volume 3, Tab 1, letter 1/05/14 Dr M Costello to Mental Health Review Board

21. Difficulties in treating the deceased for his mental illness were compounded by his lack of insight into his condition, with associated non-compliance with oral medication as well as on-going drug abuse, which exacerbated his symptoms. His psychoses were characterised by religious and paranoid delusions, including the belief that his parents and family were imposters, which meant that he was psychologically unable to use their willing support.

22. The deceased was mostly treated with depot antipsychotic medication while on a CTO in order to overcome his non-compliance with oral medication.

23. The deceased also made his treatment more difficult than usual by moving regularly, generally between his mother's home in Bunbury and his father's home in Perth. Each time he moved, his care would have to be transferred between mental health service providers. He was treated by North Metro Stirling from March 2007 to October 2014, Bunbury Mental Health from May 2005 to June 2014, Armadale Health Service from July 2007 to January 2008, and South West Mental Health from February 2011 to October 2014.

24. In May 2013 the deceased was convicted of stealing a motor vehicle and was incarcerated in Bunbury Prison, during which time he self-harmed by slashing his wrists badly enough to require stitches. He was transferred to the Frankland Unit at Graylands Hospital and was put back on depot medication.

DECEASED LIVES IN BUNBURY

25. The deceased was released from prison on a CTO on 25 March 2014. He went to live in Myalup with his mother, Kaaren Dobson, and her husband, and the CTO was managed by Dr Morgan Costello at the Bunbury CMHS. He was prescribed 900 mg of quetiapine nightly and fortnightly depot injections of zuclopenthixol 200 mg.

26. On 27 March 2014 the deceased was reviewed by Dr Morgan and a case manager. Dr Morgan considered that

he lacked insight and was possibly heading towards hypomania but that he was not psychotic.[11] After the review, Ms Dobson contacted Bunbury CMHS and expressed concerns that the deceased was on a massive high, was drinking beer every night and was not taking oral quetiapine.[12]

27. Ms Dobson initially had trouble coping with the deceased living with her, but he seemed to settle somewhat for about a month. However, on 13 May 2014 she called Bunbury CMHS to say that the deceased went to Hamersley to stay with his father, Jonathon Cain, and had stolen $1200 from his father's wallet and had spent it on drugs. His mother told him that he could not return to live with her.[13]

28. The deceased nonetheless returned to the Bunbury area and stayed with a friend in Eaton. He repaired his relationship with his parents, and his mother let him stay with her again after he was kicked out of his friend's home.[14]

29. Dr Morgan reviewed the deceased on 29 May 2014 and suspected that he was using drugs again, but noted that he was presenting well and was compliant with the depot injections and a proportion of the oral medication. He denied taking drugs and stealing from his father. The CTO was extended for another three months. The next day, Ms Dobson called Bunbury CMHS and said that the deceased admitted to using drugs and was acting strangely.[15]

30. On 2 and 3 June 2014 respectively, Ms Dobson called MERHL and Bunbury CMHS to say that she no longer felt safe having the deceased stay with her. He was staying with his father in Hamersley again at that time. Arrangements were made to have him receive his depot injection at the Osborne Community Mental Health Service (Osborne CMHS) in Osborne Park. He returned to Bunbury in mid-June and received his depot injection there.

[11] Exhibit 1, Volume 3, Tab 1, Second Admission
[12] Exhibit 1, Volume 3, Tab 1, Second Admission
[13] Exhibit 1, Volume 3, Tab 1, Second Admission
[14] Exhibit 1, Volume 3, Tab 1, Second Admission
[15] Exhibit 1, Volume 3, Tab 1, Second Admission

It seems that he was not taking his quetiapine. Ms Dobson called Community Mental Health Nurse Jannette Riddell at Bunbury CMHS and said that he appeared better than he had been, but that he was still not right.[16]

31. On 18 and 19 June 2014 Ms Dobson called MHERL and Bunbury CMHS and reported that the deceased's mental state had declined markedly, with paranoia and persecutory delusions. She felt that he needed to be in hospital as he was not safe and might harm himself or someone else.

32. On 19 June 2014 Ms Riddell completed a brief risk assessment of the deceased which indicated that he had moderate levels of risk for both suicide and violence.[17]

33. Dr Costello interviewed the deceased and arranged for him to be admitted to the psychiatric unit at Bunbury Hospital for about five days. He was admitted voluntarily but was not happy about it.[18] He showed no signs of depression or active psychosis, but had chronic paranoid ideations and delusions. He denied drug use, but was tested positive for amphetamines. He was assessed as not being a risk to himself or family members but was in the initial stages of decompensation. He was discharged on 24 June 2014 on 300 mg of depot zuclopenthixol fortnightly with follow up with the Bunbury CMHS, but it was understood that he was going to head back to Perth to stay with his father in Hamersley.[19]

DECEASED MOVES TO HAMERSLEY

34. By the end of July 2014 the deceased was living full-time with his father, and management of his care under the CTO was transferred to Dr Nicola Simmons at Osborne CMHS.[20]

35. On 13 August 2014 the deceased was reviewed by Consultant Psychiatrist Dr Helen Ward at Osborne CMHS after spending two weeks at Richmond Fellowship Respite.

[16] Exhibit 1, Volume 3, Tab 1, Second Admission
[17] Exhibit 1, Volume 3, Tab 1, Third Admission
[18] Exhibit 1, Volume 3, Tab 1, Second Admission
[19] Exhibit 1, Volume 2, Tab 2, Second Admission
[20] Exhibit 1, Volume 2, Tab 1, ED/OPD

He looked well and was not displaying any psychotic or affective symptoms. He said that he was not using amphetamines and denied delusional beliefs. He had no insight into the need for ongoing medication and wanted to stop the depot injections. Dr Ward agreed to reduce the depot by extending the interval between injections to four weeks, with a review at his next appointment. The CTO was not reviewed, but Dr Ward noted that a new CTO would be warranted if he refused voluntary depot injections.[21]

36. On 2 September 2014 the deceased's father called Osborne CMHS to inquire about accommodation support because the provision of housing for the deceased was taking so long and he, the deceased's father, required respite.[22]

37. On 10 September 2014 Ms Dobson called to say that the deceased's behaviour had improved after the change to the depot dose. She also inquired about the accommodation issue.[23]

38. Also on 10 September 2014 the deceased failed to attend his appointment with the psychiatrist despite his assurances that he would attend for the depot injection. Following a home visit and a phone call by a community mental health nurse, he said that he would attend the Osborne CMHS on 17 September 2014 for a reduced depot dose of 200 mg, but he failed to attend and failed to respond to subsequent messages. Dr Simmons completed a new CTO and an order to attend by 23 September 2014, and on the morning of that day the community mental health nurse spoke to him by phone. The deceased became oppositional on the phone and did not attend as required.[24]

39. On 24 September 2014 Dr Simmons issued a new order to attend, plus a transport order under the MHA for the deceased to be taken to Graylands Hospital for the depot injection with the dose increased to 300 mg.[25]

[21] Exhibit 1, Volume 2, Tab 1, ED/OPD
[22] Exhibit 1, Volume 2, Tab 1, ED/OPD
[23] Exhibit 1, Volume 2, Tab 1, ED/OPD
[24] Exhibit 1, Volume 2, Tab 1, ED/OPD
[25] Exhibit 1, Volume 2, Tab 1, ED/OPD

40. On 25 September 2014, Ms Dobson called Osborne CMHS and spoke to a community mental health nurse. She expressed concerns about the time that the deceased had gone without his depot injection, and she informed the nurse that the deceased had been offered a Department of Housing unit in Bunbury, which he had to accept by 26 September 2014. [26]

41. Later on 25 September 2014, two mental health nurses attended the deceased's home accompanied by police officers. The deceased eventually agreed to have the depot at home but was belligerent and hostile. An appointment was arranged for 8 October 2014 with Dr Ward.[27]

DECEASED RETURNS TO BUNBURY

42. On 1 October 2014 Ms Dobson called Osborne CMHS to advise that the deceased had moved back to Bunbury, and Bunbury CMHS called to request the relevant paperwork. The deceased was formally discharged from Osborne CMHS on 7 October 2014 and a brief risk assessment was completed, which indicated that he was at a low/moderate level of suicide risk and at a moderate level of violence risk.[28]

43. The deceased was given an appointment at Bunbury CMHS on 23 October 2014 for his next depot injection and a review with Dr Costello.[29]

44. On the morning of 13 October 2014 Ms Dobson contacted Bunbury CMHS with concerns that the deceased's mental state was deteriorating. Ms Riddell called the deceased, who said that he was fine and declined an earlier appointment. That afternoon the deceased called Ms Riddell and requested that he be admitted to hospital as he felt a little paranoid. An appointment was arranged with Dr Costello for the next day and the deceased was advised to attend the emergency department that evening.[30]

[26] Exhibit 1, Volume 2, Tab 1, ED/OPD
[27] Exhibit 1, Volume 2, Tab 1, ED/OPD
[28] Exhibit 1, Volume 3, Tab 1, Third Admission
[29] Exhibit 1, Volume 3, Tab 1, Third Admission
[30] Exhibit 1, Volume 3, Tab 1, Third Admission

45. Ms Riddell called the deceased the next morning. He said that he had attended the emergency department but there were a lot of people there and he did not want to wait. He said that he felt better and did not need to see Dr Costello.[31]

46. In a root cause analysis undertaken by WA Country Health Service following the deceased's death, the deceased's presentation to the emergency department on 13 October 2014 was identified as a missed opportunity to engage him when he was actively seeking help. It was noted that there was not a concrete plan in place to ensure that the psychiatric liaison officer at the hospital was aware that he might attend. The root cause analysis resulted in a recommendation that plans be put in place to rectify that situation.[32]

47. On 16 October 2014 Ms Dobson sent the manager of the Family Carer Program a letter in which she detailed her concerns about the deceased and requested that they be passed along to Dr Costello.[33]

48. On 17 October 2014 Ms Riddell and a colleague visited the deceased at home. He seemed reluctant to engage in conversation but did say that he did not want to be on a CTO or to have to take medication which he did not need. He denied symptoms of paranoia or suicidal ideation.[34]

49. On 22 October 2014, the deceased's case manager, Ms Lang, returned a call from Ms Dobson and discussed the deceased at length. Ms Lang had not received the letter written by Ms Dobson on 16 October 2014, but she was able to obtain it from a colleague who had received it by mistake. The deceased called Ms Lang and asked if he could get his depot injection that morning, and she reminded him of his appointment the next day. He also said that he would attend the Mental Health Review Board Hearing on 6 November 2014 and that he wanted to get off the CTO.[35]

[31] Exhibit 1, Volume 3, Tab 1, Third Admission
[32] Exhibit 1, Volume 1, Tab 41.1
[33] Exhibit 1, Volume 3, Tab 1, Correspondence
[34] Exhibit 1, Volume 3, Tab 1, Third Admission
[35] Exhibit 1, Volume 3, Tab 1, Third Admission

50. The deceased attended the appointment with Dr Costello on 23 October 2014. He was angry and irritated about being on the CTO and wanted to stop the depot medications. Dr Costello had considered that the dose should be increased to 300 mg fortnightly given reports from Osborne CMHS and the deceased's family, but for safety reasons did not consider that it was possible to discuss this with the deceased because of his level of irritation. Instead, Dr Costello made a plan to monitor the situation until the Mental Health Review Board hearing and, if problems arose before then, to increase the dosage at that point.[36]

51. On 31 October 2014 the deceased called Ms Lang and asked for a prescription for quetiapine. Dr Costello decided that he could not provide the deceased with one, but that he and the deceased could discuss it further on 6 November 2014. The deceased seemed agreeable to that plan.[37]

52. On the evening of 3 November 2014 Ms Dobson called MHERL to report that the deceased had again stolen $1200 from his father and had 'put it in his arm'. He had been ringing her intensely and had walked and hitchhiked to her house in Myalup. She refused to allow him to stay the night and drove him back to his unit in Bunbury. She said that he was paranoid and had abused her on the way back to Bunbury.[38]

53. On the morning of 4 November 2014 MHERL called Bunbury CMHS to relay Ms Dobson's concerns, and Ms Riddell called the deceased to arrange a home visit with him. She went to his home later that morning but he did not answer the door.[39]

54. On 6 November 2014 Ms Lang called Ms Dobson and spoke to her about the deceased's trip to her home on 3 November 2014. Ms Dobson said that the deceased had sold a new washing machine and a fridge that Partners in Recovery had given him as well as a TV that she had lent him. She said that she felt concerned for her safety.[40]

[36] Exhibit 1, Volume 3, Tab 1, Third Admission
[37] Exhibit 1, Volume 3, Tab 1, Third Admission
[38] Exhibit 1, Volume 3, Tab 1, Correspondence
[39] Exhibit 1, Volume 3, Tab 1, Third Admission
[40] Exhibit 1, Volume 3, Tab 1, Third Admission

55. The deceased attended the Bunbury CMHS reception at 10.15 am on 6 November 2014 for the Mental Health Review Board hearing, but it was listed for 3.15 pm. He was given a taxi home and another taxi was arranged to pick him up for the hearing, but he did not return. That afternoon, Ms Lang returned a call from the deceased's father, who expressed his concerns about the deceased and did not think that Bunbury CMHS were doing enough to help him. Ms Lang explained that the deceased's substance abuse was the problem.[41]

56. On 8 November 2014 Ms Dobson called MHERL to discuss her ongoing problems with the deceased: he was very unwell and was blaming her as part of a plot to destroy him. She was frightened. The MHERL call-taker advised contacting the police, who could take the deceased to the emergency department and could also call MHERL for additional information.[42]

57. On 10 November 2014 Ms Lang returned a call from Ms Dobson, who wanted to discuss the deceased being unwell and the fact that she was scared of him on occasions. Ms Lang reiterated previous advice to contact the police and to obtain a restraining order. That afternoon, Ms Lang and Ms Riddell went to the deceased's home and had a brief conversation with him. He was unkempt and dressed inappropriately warmly for the weather conditions, but he was friendly and denied any problems. He said that Ms Dobson was a drama queen. Upon return to the Bunbury CMHS, Ms Lang contacted Bunbury police to voice Ms Dobson's concerns and to let them know of her advice to her to obtain a restraining order.[43]

EVENTS LEADING UP TO DEATH

58. At about 2.00 pm on 12 November 2014 the deceased dropped in on Rowan Teakle, an acquaintance who lived in Withers. Mr Teakle also had schizophrenia. They sat on Mr Teakle's veranda and chatted for a while. The deceased

[41] Exhibit 1, Volume 3, Tab 1, Third Admission
[42] Exhibit 1, Volume 3, Tab 1, Third Admission
[43] Exhibit 1, Volume 3, Tab 1, Third Admission

smoked some cannabis, after which his attitude appeared to change. Mr Teakle felt uncomfortable so he went inside the house to get away from the deceased, but the deceased followed him with a bag of groceries and asked if Mr Teakle wanted to cook. Mr Teakle declined and indicated that he wanted to do some bible studies, so the deceased went out of the front of the house and Mr Teakle locked the door.[44]

59. Half an hour later, the deceased knocked on Mr Teakle's front door and asked Mr Teakle through the screen door to make him a cup of tea. Mr Teakle told him to leave, and after words were exchanged, the deceased picked up a vase from a window ledge and threw it into the lounge room window, smashing the glass.[45]

60. Mr Teakle went to a neighbour's house and called the police. Another neighbour tried to mediate, but the deceased claimed that Mr Teakle had assaulted him and called the police himself. The deceased then went to his shopping bag on the veranda and took out a kitchen knife with which he threatened Mr Teakle. Mr Teakle went to the neighbour's house while the deceased sat on Mr Teakle's veranda to wait for the police.[46]

61. At about that time, the deceased's brother David called him and learned that the deceased had an argument with Mr Teakle, had thrown a vase through a window, and was waiting for the police. David called Ms Dobson to advise her about what had happened.[47]

62. Ms Dobson then contacted MHERL and asked them to direct police to take the deceased to the emergency department for assessment. The MHERL call-taker told her that he could not direct police as to what action to take but would be willing to speak to them if contacted. Ms Dobson said that she would liaise with police and Bunbury CMHS.[48]

63. Senior Constable Groenenberg and Constable Ken Waters arrived at Mr Teakle's house at about 7.00 pm.

[44] Exhibit 1, Volume 1, Tab 15
[45] Exhibit 1, Volume 1, Tab 15
[46] Exhibit 1, Volume 1, Tab 15
[47] Exhibit 1, Volume 1, Tab 27
[48] Exhibit 1, Volume 1, Tab 31

The deceased was waiting in the front yard. He was calm and not displaying any abnormal behaviour. He claimed that Mr Teakle had punched him in the eye, but Senior Constable Groenenberg could not see any injury.[49]

64. One of the neighbours informed Senior Constable Groenenberg that the deceased had waved a knife around, and the deceased admitted that he had done so because he was pissed off.[50]

65. Senior Constable Groenenberg spoke to Mr Teakle, who told him of the preceding events. Constable Waters searched the deceased and found a syringe and an empty clip seal bag. The police officers told the deceased that he would have to go back to the Bunbury Police Station with them, and he walked to the police vehicle willingly. They informed him that he was under arrest for criminal damage.[51]

66. On the way to the police station, Senior Constable Groenenberg asked the deceased several conversational questions and the deceased responded appropriately.[52]

67. At the police station, Senior Constable Groenenberg was told that Ms Dobson had called to ask what had happened to the deceased and to inform police that he had schizophrenia so they should take him to the hospital as an involuntary patient. Senior Constable Groenenberg noted that the deceased had more than 80 charges in his criminal history.[53]

68. Senior Constable Groenenberg conducted a video interview during which the deceased made some admissions about damaging the window, but said 'No comment' to most of the questions. He was quiet, attentive and quite reasonable for the entire time he was in police custody, though he did make a comment at the beginning of the interview that his family owned Toyota Australia and that there was a conspiracy against him.[54]

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[49] Exhibit 1, Volume 1, Tab 9
[50] Exhibit 1, Volume 1, Tab 9
[51] Exhibit 1, Volume 1, Tabs 9 and 12
[52] ts 9 per Groenenberg, D
[53] Exhibit 1, Volume 1, Tab 9
[54] ts 10-11 per Groenenberg, D; Exhibit 1, Volume 1, Tabs 9 and 14

69. Senior Constable Groenenberg understood that the power under the MHA for a police officer to take a person to hospital required the officer to reasonably suspect that the person had a mental illness and that the person was a danger to himself, to another person or to property. He did not see anything to suspect that the deceased was capable of self-harm or that he needed assessment at a hospital.[55]

70. Senior Constable Groenenberg did not consider calling MHERL about the deceased because he was not familiar with the service and because he did not consider that the deceased was in need of medical intervention. He said that, if he thought that MHERL needed to be contacted, he probably would have taken the deceased to hospital himself.[56]

71. Senior Constable Groenenberg spoke to the station's operations manager, Sergeant Leishman, and told him about the call from Ms Dobson suggesting that the deceased be taken to hospital involuntarily. Sergeant Leishman asked him if he had any concerns, and he said that the deceased had given him no indication at all that he required a mental health assessment.[57] Sergeant Leishman told Senior Constable Groenenberg that he concurred with his assessment, but recommended that he call Ms Dobson to explain.[58]

72. Senior Constable Groenenberg then went to the change room and saw the deceased, who asked him for a cigarette. They went to the exercise yard and Senior Constable Groenenberg gave the deceased one of his cigarettes and they had a general conversation about the price of cigarettes and about future court dates. The deceased gave no suggestion that he was capable of self-harm.[59]

73. After the deceased had been processed for the charge against him, Senior Constable Groenenberg offered him a

[55] ts 11
[56] ts 14-15 and 18 per Groenenberg, D
[57] ts 12
[58] Exhibit 1, Volume 1, Tab 14
[59] Exhibit 1, Volume 1, Tab 9

lift home. The deceased accepted and was calm, quiet and attentive on the drive to his unit. After dropping him off, Senior Constable Groenenberg stayed in his driveway until a light went on in the unit to ensure that he was able to get in.[60]

74. When Senior Constable Groenenberg got back to the police station, he called Ms Dobson to explain what had happened. She gave him a lot of background information about the deceased and he gave her a brief insight into the way in which police officers deal with people who have mental health problems. After speaking with her, he did not change his opinion about whether he had the power to take the deceased to hospital involuntarily.[61]

75. At about 9.15 pm the deceased called his brother, David, and they had a brief conversation which ended civilly. The deceased appeared withdrawn, but made no mention of feeling down or hurting himself. There was nothing different about the conversation compared to hundreds of other conversations David had had with the deceased.[62]

76. Also around 9.00 pm that night, the deceased went to a neighbour's unit where he asked for a cigarette and for money. He mentioned that he had no food in his fridge. He appeared agitated and a bit disturbed. He stayed for only a short time.[63]

77. On the morning of 13 November 2014 Ms Dobson tried to call the deceased, but her call went straight to message bank, which was unusual. She called Ms Lang and asked that she conduct a welfare check.[64]

78. Shortly after 10.00 am on 13 November 2014, Ms Lang and Ms Riddell went to the deceased's unit, where they found the deceased hanging by the neck with washing line cord tied to a wooden beam of a pergola in the rear

[60] Exhibit 1, Volume 1, Tab 9
[61] ts 13
[62] Exhibit 1, Volume 1, Tab 27
[63] Exhibit 1, Volume 1, Tab 16
[64] Exhibit 1, Volume 3, Tab 1, Third Admission

yard. Lividity was present, indicating that he was dead. On the ground nearby was an upturned dining chair, and a utility knife was next to that.

79. Ms Lang called the Bunbury police. Moments later, ambulance officers attended and confirmed the deceased's death. The deceased had small, superficial cuts on his neck and arms with very little blood loss. [65]

80. Police detectives and forensic investigators then arrived. The deceased's bags of shopping that he had taken home when dropped off by Senior Constable Groenenberg were on the kitchen floor. In the bathroom two razor blades from a broken razor blade head were found in the basin with a small amount of blood on them, presumably related to the cuts on the deceased's arms.[66] There was no evidence to indicate that another person had been involved in the death.[67]

CAUSE OF DEATH

81. On 19 November 2014, forensic pathologist Dr D M Moss conducted a post-mortem examination of the deceased and found a ligature in place and a ligature mark to the neck with underlying injury to the greater horn of the hyoid bone. There was no evidence of significant natural disease. There were small incised wounds to the front of the left wrist and the right elbow crease.[68]

82. Toxicological analysis showed the presence of a low level of zuclopenthixol and a low level of methylamphetamine. Alcohol and other common drugs were not detected.[69]

83. Dr Moss formed the opinion, which I adopt as my finding, that the cause of death was ligature compression of the neck (hanging).

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[65] Exhibit 1, Volume 1, Tab 8
[66] Exhibit 1, Volume 1, Tab 8
[67] Exhibit 1, Volume 1, Tab 8
[68] Exhibit 1, Volume 1, Tab 5
[69] Exhibit 1, Volume 1, Tabs 5 and 6

HOW DEATH OCCURRED

84. On the basis of the evidence available, I am satisfied that, with an intention to end his life, the deceased hanged himself with a ligature and compressed his neck, which caused his death.

85. I find that death occurred by way of suicide.

COMMENTS ON THE SUPERVISION, TREATMENT AND CARE OF THE DECEASED

86. Ms Dobson and David Cain both wrote to the Court to express their dissatisfaction with the deceased's treating clinicians and with police officers. They believed that more should have been done to ensure that the deceased was hospitalised and his medication re-assessed, particularly in the last few weeks of his life when his mental condition was becoming worse.[70]

87. They felt that the clinicians should have listened and considered their concerns and should have met with them regularly and included them in discussions and treatment plans. They believed that there was a sense of indifference.[71] Ms Dobson noted that there was no help for mental health patients in Bunbury after 4.00 pm or on weekends. Mr Cain noted that a person who has a mental illness can find significant challenges in waiting in an emergency department.[72]

88. Ms Dobson and Mr Cain were also very disappointed in the way the Bunbury Police liaised with them after the deceased's death, but that issue is possibly outside my jurisdiction to investigate the circumstances surrounding the death.

89. In relation to WAPOL, the appropriateness of Senior Constable Groenenberg's decision, with Sergeant Leishman's concurrence, not to take the deceased to

[70] Exhibit 1, Volume 1, Tabs 28 and 29
[71] Exhibit 1, Volume 1, Tabs 28 and 29
[72] Exhibit 1, Volume 1, Tab 29

hospital is clearly relevant in my view. In particular, though I make no criticism of Senior Constable Groenenberg, his stated understanding of the requirements of the MHA to justify taking the deceased to hospital for assessment after he had been arrested was incomplete, as I shall discuss below.

90. Dr Patchett provided a report of the deceased's case, in which he noted the difficult problems in treating the deceased's mental illness due to the fact that treating teams were unable to form a solid therapeutic alliance with him because of his lack of insight into his illness and the exacerbating and complicating effects of substance abuse. That was so despite the fact that he had a supportive family who were willing to mediate and participate in his care.[73]

91. Dr Patchett said that the combination of pathologies and factors made management of the deceased's problems very difficult, and meant that the use of the MHA was the only way to secure treatment, and that the MHA was used appropriately. He also noted that the deceased's delusional belief that his family were imposters created an enormous barrier to the involvement of family members in his care.[74]

92. Dr Patchett considered that there were some elements in the care provided to the deceased which were less than ideal, but he did not feel that there were serious failures that impacted significantly on the final outcome.[75]

93. The first element which Dr Patchett identified as being less than ideal was the fact that the deceased was living between his parents, requiring the transferring of the deceased's care from Bunbury CMHS to Osborne CMHS and back. The team at Osborne CMHS did not have a therapeutic relationship with him, and Dr Ward had little alternative but to attempt to negotiate a reduction in his medication to start an alliance. That reduction probably caused a slippage in his mental state.[76]

[73] Exhibit 1, Volume 1, Tab 21
[74] Exhibit 1, Volume 1, Tab 21
[75] Exhibit 1, Volume 1, Tab 21
[76] Exhibit 1, Volume 1, Tab 21

94. The second element identified by Dr Patchett involved the communications between agencies; specifically Prison Health Services, other health services and the police. He felt that better communication and sharing of information between Prison Health Services and general mental health services might have resulted in the deceased being identified as unwell earlier in his incarceration.[77]

95. Dr Patchett also thought that better communication between police and Bunbury CMHS and Ms Dobson might have resulted in the deceased being assessed and admitted to Bunbury Hospital, which may have prevented his death. In oral evidence Dr Patchett explained that, if there had been a co-ordinated care plan involving the deceased, his family and Bunbury CMHS, then Ms Dobson could have advised the police to speak to Bunbury CMHS to understand the deceased's early signs of deterioration and to understand the need to take the deceased to the emergency department.[78]

96. I note that Senior Nurse O'Keefe said that, if police had called MHERL and said that they have the deceased in custody and he has schizophrenia, he would have looked up the deceased's information on the database PSOLIS and would have disclosed any information which could have helped the police.[79] On the basis of Dr Patchett's evidence, if there had been a co-ordinated care plan for the deceased, it would have been on PSOLIS, so MHEHL could have alerted police of the need to for the deceased to be assessed.

97. Dr Patchett did not think that there was anything which the police could have identified on the night of 12 November 2014 which would have indicated that the deceased was deteriorating.[80]

98. Dr Patchett thought that some of the deceased's family's frustration with their perception that they were not listened to and not enlisted into the deceased's care came from the peculiarities of the deceased's psychopathology.

[77] Exhibit 1, Volume 1, Tab 21
[78] ts 37-38 per Patchett, S
[79] ts 51-52 per O'Keefe, P
[80] ts 38-39 per Patchett, S

The deceased's delusional beliefs about his family would have led the clinicians to be very wary of forming alliances or sharing information without his clear permission.[81]

99. Ms Easther's view was that the deceased's team at Bunbury CMHS was taking the deceased's family's concerns very seriously, but were restricted in what they could tell the family because the deceased did not agree to the release of information.[82]

100. Dr Patchett did not think that there were strong indications that the deceased needed to be admitted into a hospital at the end of October 2014. He was stabilised on zuclopenthixol and the reduced dose was being built back up. He was not completely off medication and suicidal as he was in prison. The problem was really his comorbid drug use and he specifically continued to deny suicidal ideation or intent. Dr Patchett believed that it was reasonable to persist treating him at home with the close support he was provided.[83]

101. To return to Senior Constable Groenenberg's understanding of the MHA, he was correct that the power under the MHA to apprehend a person to be examined required a suspicion on reasonable grounds that the person had a mental illness and needed to be apprehended to protect the safety of the person or another person or to prevent serious damage to property.[84]

102. However, in the deceased's case, he had already been arrested for a suspected offence when Senior Constable Groenenberg considered whether he needed mental health assessment. The precondition for Senior Constable Groenenberg to arrange for the deceased to be examined by a medical practitioner or an authorised mental health practitioner was simply that he suspected on reasonable grounds that the deceased had a mental illness which needed immediate medical treatment.[85]

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[81] Exhibit 1, Volume 1, Tab 21
[82] ts 45 per Easther, D
[83] Exhibit 1, Volume 1, Tab 21
[84] s195(1) *Mental Health Act 1996* s195(1) *Mental Health Act 1996*
[85] s196(1) *Mental Health Act 1996*; ts 80 per White, D

103. On the basis of the deceased's presentation at the relevant time, Senior Constable Groenenberg was justified in concluding that the deceased did not need immediate medical treatment. However, had Senior Constable Groenenberg been more aware of the operation of the MHA where a person with a suspected mental illness is under arrest, he may have taken a different approach. For example, he may have put more importance on the information supplied by Ms Dobson about the deceased's recent deterioration or, had he been more familiar with the service provided by MHERL, he may have called MHERL in order to get up to date information about the deceased's mental illness. In either case, it is possible that he would have then decided to take the deceased to hospital for assessment.

104. I must emphasise that I am not suggesting that Senior Constable Groenenberg was likely to have taken the deceased to hospital had he been more aware of the operation of the MHA at the relevant time. As he said, the deceased gave him no indication that he required assessment at all, and 'A lot of people have mental illnesses, but of course we don't just take them to hospital involuntarily for that reason'.[86]

105. In addition, it would be speculative to suggest that the outcome would have been different, or even to suggest that the deceased would have been kept in hospital for treatment, had Senior Constable Groenenberg taken him there. Despite the deceased's lack of insight into his condition, he appeared to have been able to modify his behaviour when necessary to control his presentation. Moreover, he had given no indication of a suicidal intent. For example, he had never spoken to Ms Lang about any sort of self-harm, and she had no concerns that he was a suicide risk at that time.[87] Risk assessments done at Bunbury CMHS on 19 June 2014 and Osborne CMHS on 7 October 2014 rated his risk of suicide as moderate.[88]

[86] ts 12 per Groenenberg, D
[87] ts 65 and 70 per Lang, P
[88] Exhibit 1, Volume 2, Tab 1. Risk

106. Finally, a call to MHERL by Senior Constable Groenenberg would not have changed his decision not to take the deceased to hospital unless MHERL had been able to provide him with information indicating a need to do so. In the absence of a co-ordinated treatment plan for the deceased, such information may not have been available.

107. On the basis of the foregoing, it appears to me that the particular circumstances of the deceased's illness, including the difficulties in treating it combined with a care plan that was less than ideal for those circumstances and with insufficient communication between agencies, led to a missed opportunity for the deceased to be assessed when that assessment may have led to a different outcome at the time.

108. However, it also appears to me that, unless the deceased were able to stop using drugs, especially methylamphetamine, from that time, any reduction to the risk of his suicide was likely to have been temporary.

109. I am satisfied that everyone involved in the deceased's supervision, treatment and care while he was on a CTO acted in what they considered to be the deceased's best interests and that the standard of care was generally acceptable at the time. However, that is not to say that improvements could not have been made.

CHANGES TO RESOURCES AND TRAINING

110. Ms Easther, who at the time of the inquest was the manager of operations of South West Mental Health Service (SWMHS) noted that in 2014 clients were managed on a case management model involving the provision of services one-on-one, but that a new model was being implemented at that time. The new model, which is a multidisciplinary team approach whereby medical staff oversee the treatment of all patients, is now in place.[89]

[89] Exhibit 1, Volume 1, Tab 41

111. Ms Easther said that the new model focusses on the patient's recovery and is person-centred. This requires the development of therapeutic relationships, working in partnership collaboratively with all stakeholders, social inclusion, and a co-ordinated evidence-based service delivery where the service is accountable to the patient, carer and clinical governance structures.[90]

112. In other words, the care co-ordinator puts the patient at the centre of his or her own care and the role of co-ordinator is to work with the patient and all those involved in the care, including family, support agencies and general practitioners.[91]

113. In 2015 SWMHS implemented a new review process in which there were three-monthly reviews with the patient, the identified family or carers, and any other service involved in the care.[92]

114. A number of other improvements were initiated by SWMHS after the deceased's death, including: reduced caseloads and monthly management supervision for staff to review caseloads; stronger links with the emergency department and monthly meetings with the psychiatric liaison nurse; capacity for the community team to see people on the day of presentation and for people to be assessed at home or at their GP; and, crisis plans for all patients who are high risk.[93]

115. Ms Easther said in oral evidence that SWMHS had just received funding to provide after-hours services, which were expect to be extended hours during the week and an ability to follow up people in the community on weekends.[94]

116. Ms Easther also noted that there are now regular meetings between her and local police and between clinical co-ordinators and sergeants to discuss any issues. Clinicians

[90] Exhibit 1, Volume 1, Tab 41
[91] Exhibit 1, Volume 1, Tab 41
[92] Exhibit 1, Volume 1, Tab 41
[93] Exhibit 1, Volume 1, Tab 41
[94] ts 41 per Easther, D

will also now talk with police on roster on any particular day about individual cases.[95]

117. At the time of the inquest, Acting-Inspector David White was responsible for co-ordination of the Mental Health Co-response Project, which involved the creation of two mobile teams of two police officers and an authorised mental health practitioner in two police districts in the Perth metropolitan region which attend incidents where mental illness appears to be an issue, plus the placing of a mental health practitioner at the Perth Watch House.[96]

118. Acting-Inspector White was also responsible for the review and update of WAPOL policy regarding mental health as well as some mental health training of police officers. He said that police recruits undertake training from MHERL. He said that they have about nine hours of training in mental health and would address relevant issues in brief, not fine, detail.[97]

119. Acting-Inspector White said that there is a clear policy for officers to contact MHERL if they suspect they are dealing with a person with a mental illness. The officers can contact MHERL directly. He considered that, while not being critical of Senior Constable Groenenberg's decision not to contact MHERL, in hindsight it would have been prudent to have done so.[98]

120. In relation to a potential need to provide police officers with ongoing training in relation to mental health, Acting-Inspector White said that he had done some research and was surprised to learn that there was no ongoing training. He said that in 2007 there were 5000 jobs involving mental health and in 2016 there were 22,000 mental health jobs. While part of that increase may be improved recording procedures, there was scope for the current discussion about an additional day of mental health training for police officers.[99]

[95] ts 42 per Easther, D
[96] ts 74 per White, D
[97] ts 78 per White, D
[98] ts 77 per White, D
[99] ts 83 per White, D

121. When it was suggested that the apparent growth of mental health problems in the community, especially coinciding with the growth of methylamphetamine use, indicated the need for annual training in mental health, Acting-Inspector White said that 'reinforcing it (mental health training) on an annual basis would be a massive boost because it is a really large part of what we do on a daily basis and … in my own experience, 20 years down the track I've really received little other training since I left the academy'.[100]

COMMENTS ON CHANGES

122. The evidence in relation to the changes at SWMHS following the deceased's death appear, on Dr Patchett's evidence in particular, to have been well-considered and adopted.

123. In addition, the changes would address the concerns raised by the deceased's family in relation to the apparent failure by Bunbury CMHS to listen to them and to ensure that that deceased was assessed.

124. The changes at WAPOL have been much less dramatic but have been significant nonetheless. All police officers now have received training on mental health issues[101] and the co-response project had been trialled in the Perth Metro area for two years. An evaluation of the project being undertaken by Edith Cowan University will also gather information from front-line police officers and others involved in the project about their knowledge and experience in dealing with mental health matters.[102]

125. The steps taken by WAPOL to equip police officers with the tools necessary to deal with persons with mental illness are important, but in my view the evidence revealed a likely need for ongoing training of front-line officers of their powers and responsibilities in this area.

126. Because of the high expectations placed on them by the community, police officers undergo rigorous training in

[100] ts 84 per White, D
[101] ts 78 per White, D
[102] ts 82 per White, D

relation to a bewildering number of legal and practical issues. It may be too much to expect that recruits will recall much of the training in relation to all of those issues unless they go on to deal with them regularly as part of their operational duties.

127. I note, for example, that Sergeant Groenenberg, who impressed me as a competent police officer, was not familiar with even the existence of MHERL, let alone its role or the services it provides.

128. In these circumstances, it appears to me that, with mental health-related issues becoming increasingly fundamental to front-line police officers, regular in-service training of police officers in this area is likely warranted. The following recommendation is intended to address that notion:

RECOMMENDATION

The Commissioner of Police consider and, if appropriate, implement regular in-service training of operational police officers in relation to mental health related issues.

CONCLUSION

129. The evidence at the inquest established that, in an apparently impulsive act after an adult life of drug abuse and mental illness, the deceased took his own life.

130. The inquest focused on the cause and circumstances surrounding the deceased's death, but severe mental illness can be an ongoing tragedy in itself. Where it leads to a person ending his or her own life, family members and carers can feel guilt or can look to blame others for not having taken steps which, in the clarity of hindsight, could have been taken.

131. In the deceased's case, attempts to care for the deceased and to treat his mental illness were restricted by the resources and legal powers available to those with those

responsibilities. In particular, the first object of the *Mental Health Act 1996* was to ensure that persons having a mental illness receive the best care and treatment with the least restriction of their freedom and the least interference with their rights and dignity.[103]

132. The deceased could not be detained involuntarily for treatment unless he had a mental illness requiring treatment which was required in order to protect him or another person or property, and he could not have been treated adequately in a way that would involve less restriction of choice and movement.[104]

133. The deceased was able to mask his more severe symptoms. As Dr Patchett stated, there were no strong indications that the deceased needed to be admitted to hospital on his return to Bunbury. He was stabilised on zuclopenthixol and he specifically continued to deny suicidal ideation or intent. The problem, said Dr Patchett, was the deceased's comorbid drug use.[105]

134. Since the deceased's death, improvements have been implemented to the way in which mental health patients are managed by the SWCMHS. I can only hope that the fact that the deceased's death has led to improved care for others can offer some solace to the deceased's family.

B P King
Acting Deputy State Coroner
27 June 2018

[103] s5(a) *Mental Health Act 1996*
[104] s26(1) *Mental Health Act 1996*
[105] Exhibit 1, Volume 1, Tab 21