JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	MICHAEL ANDREW GLIDDON JENKIN, CORONER
HEARD	**:**	7 JUNE 2023
DELIVERED	**:**	28 JUNE 2023
FILE NO/S	**:**	CORC 1384 of 2021
DECEASED	**:**	CRIPPS, NICHOLAS ARTHUR

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:

Mr W. Stops appeared to assist the coroner.

Mr E. Heywood (State Solicitor's Office) appeared for the North Metropolitan Health Service.

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Michael Andrew Gliddon Jenkin, Coroner, having investigated the death of ***Nicholas Arthur CRIPPS*** *with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, PERTH, on 7 June 2023, find that the identity of the deceased person was* ***Nicholas Arthur CRIPPS*** *and that death occurred on or about 24 May 2021 at 203A Newborough Street, Doubleview, from combined acute effects of multiple drugs in obese man with enlarged heart and arterial hypertension in the following circumstances:*

Table of Contents

INTRODUCTION

1. Nicholas Arthur Cripps (Mr Cripps) died on or about 24 May 2021 at his home in Doubleview from combined acute effects of multiple drugs in obese man with enlarged heart and arterial hypertension. He was 47-years of age.[1,2,3,4,5,6]

2. At the time of his death, Mr Cripps was the subject of a community treatment order (CTO)[7] made under the *Mental Health Act 2014* (WA) (the MHA)[8] and was managed by the Osborne Adult Community Mental Health Service (Osborne Clinic). Because he was the subject of a CTO, Mr Cripps was an "*involuntary patient*" and thereby a "*person held in care*", so that his death was a "*reportable death*".[9]

3. In such circumstances, a coronial inquest is mandatory and where, as here, the death is of a person held in care, I am required to comment on the quality of the supervision, treatment and care that the person received whilst in that care.[10]

4. On 7 June 2023, I held an inquest into Mr Cripps' death at Perth. The inquest focused on the circumstances of Mr Cripps' death and the supervision, treatment and care he received while he was the subject of a CTO. The Brief of evidence tendered at the inquest consisted of one volume and included a police investigation report, expert psychiatric reports, and Mr Cripps' medical records. The following witnesses gave evidence during the inquest:

a. Dr Chris Hodgson (Consultant Psychiatrist, Graylands Hospital);
b. Dr Kasia Frydrych (Consultant Psychiatrist, Osborne Clinic); and
c. Mr Craig Jermy (Case Manager, Osborne Clinic).

---

[1] Exhibit 1, Vol. 1, Tab 1, Life Extinct Form (31.05.21)
[2] Exhibit 1, Vol. 1, Tabs 2.1 & 2.2, P98 Mortuary Admission Forms (31.05.21)
[3] Exhibit 1, Vol. 1, Tab 3.1, P92 Identification of Deceased Person Form (04.06.21)
[4] Exhibit 1, Vol. 1, Tabs 3.2 & 3.3, Affidavits - Sen. Const. C. Asher & Sen. Const. C. Chandler(04.06.21)
[5] Exhibit 1, Vol. 1, Tab 3.4, PathWest Coronial Identification Report (04.06.21)
[6] Exhibit 1, Vol. 1, Tab 4.1, Supplementary Post Mortem Report (08.08.22)
[7] An order made under the MHA that a person receive treatment on an involuntary basis in the community.
[8] Exhibit 1, Vol. 1, Tab 12, Form 5C Variation of Terms of Community Treatment Order (17.05.21)
[9] Section 3, *Coroners Act 1996* (WA)
[10] Sections 22(1)(a) & 25(3), *Coroners Act 1996* (WA)

MR CRIPPS

Background and medical conditions[11,12,13,14,15,16,17]

5. Mr Cripps was born in New Zealand on 6 March 1974, and he had one brother. After his parents separated, Mr Cripps came to Perth with his mother and brother in about 1983. Mr Cripps attended Scarborough High School where he completed Year 12, and he had reportedly worked as a kitchenhand and in a plant nursery.

6. Mr Cripps lived alone in Doubleview, and was not working at the time of his death. He had received ongoing support from his mother until about October 2020, when his aggressive and violent behaviour towards her had obliged her to obtain a restraining order against him.

7. Mr Cripps was a large man and was about 192 cm tall and weighed about 160 kg. It was thought that he may have sleep apnoea and been pre-diabetic, and it appears he did have a regular GP. His medical history also included high blood pressure and metabolic syndrome, and he also had a history of persistent and regular polysubstance use, including cannabis, alcohol, and methylamphetamine.

Mental health diagnoses[18,19,20,21]

8. Mr Cripps first reported contact with mental health services appears to have been in 1994, when he was admitted to Graylands Hospital (GH). He was diagnosed with schizophrenia.[22] Subsequently Mr Cripps was also diagnosed with substance abuse disorder, and antisocial personality disorder, and his schizophrenia was regarded as "*treatment resistant*".

[11] Exhibit 1, Vol. 1, Tab 5, P100 - Report of Death (31.05.21)
[12] Exhibit 1, Vol. 1, Tab 6.1, Report to the Coroner - Coronial Investigator P Chiles (04.11.22), p4
[13] Exhibit 1, Vol. 1, Tab 8, Background Information Report
[14] Exhibit 1, Vol. 1, Tab 13, Statement - Mr C Jermy (25.05.23), paras 9-16
[15] Exhibit 1, Vol. 1, Tab 14, Report - Dr K Frydrych (29.05.23), pp1-2
[16] Exhibit 1, Vol. 1, Tab 15, Report - Dr A Van Hattem (05.10.18), pp2-4
[17] Exhibit 1, Vol. 1, Tab 16, Report - Dr C Hodgson (31.05.23), p7 and ts 07.06.23, (Hodgson), pp13-14
[18] Exhibit 1, Vol. 1, Tab 13, Statement - Mr C Jermy (25.05.23), paras 11-12
[19] Exhibit 1, Vol. 1, Tab 14, Report - Dr K Frydrych (29.05.23), pp1-2
[20] Exhibit 1, Vol. 1, Tab 15, Report - Dr A Van Hattem (05.10.18), pp4-6
[21] Exhibit 1, Vol. 1, Tab 16, Report - Dr C Hodgson (31.05.23), p2
[22] Schizophrenia is a serious mental illness in which people interpret reality abnormally

9. Between 1994 and 2003, Mr Cripps had various admissions to GH, and other hospitals which were usually in the context of psychotic symptoms and aggressive behaviour associated with non-compliance with his medication regime. When he was unwell Mr Cripps often exhibited aggressive and/or violent behaviour and he had assaulted numerous people including police, clinical staff, patients in hospital and members of the community.

10. Mr Cripps was described as "*scary*" when he was angry,[23] and as a result of his aggressive behaviour, he had sometimes required seclusion during admissions to hospital and on some occasions, constant supervision from multiple nurses.

11. Nevertheless, records establish that Mr Cripps enjoyed a 10-year period of stability whilst taking clozapine, an antipsychotic medication regarded as "*the gold standard*" for treatment resistant schizophrenia.[24] Clozapine is available in tablet form or as an oral suspension, and must be taken regularly. When patients are started on clozapine, they must have weekly blood tests for a period of time, and monthly blood tests thereafter. These blood tests are necessary to monitor clozapine levels, because the medication can cause serious side-effects including heart issues, seizures and a decrease in white blood cell count.[25,26]

12. In Mr Cripps' case, despite the fact that clozapine appeared to be successful, he stopped using the medication in March 2003 because he refused to continue with the mandatory monthly blood tests that clozapine users were required to undergo.

13. During an admission to GH in 2018, Mr Cripps underwent a forensic assessment of his risk of violence to others. Mr Cripps' history of assaulting numerous people was noted and a "*clear relationship*" between his psychotic symptoms, including auditory hallucinations, and his "*violence risk*" was established.[27]

---

[23] Exhibit 1, Vol. 1, Tab 13, Statement - Mr C Jermy (25.05.23), para 13
[24] ts 07.06.23 (Hodgson), p9
[25] ts 07.06.23 (Hodgson), p9
[26] See: https://www.nps.org.au/australian-prescriber/articles/clozapine-in-primary-care
[27] Exhibit 1, Vol. 1, Tab 15, Report - Dr A Van Hattem (05.10.18), p15

14. The forensic assessment noted Mr Cripps' lack of insight into his mental health issues and need for treatment, as well as his tendency to minimise or excuse his aggressive and violent behaviour. These factors were said to further heighten his level of risk. The forensic assessment recommended Mr Cripps be managed on a CTO in order to maintain him on antipsychotic medication, with "*rapid referral to hospital*" in the event of relapse. Although it was considered that Mr Cripps' symptoms would be best managed on clozapine, it was accepted that Mr Cripps' lack of insight meant the viability of this option "*may be limited*".[28,29]

Community treatment order[30,31,32]

15. The MHA provides that a person is not to be placed on a CTO unless: "*[T]he person cannot be adequately provided with treatment in a way that would involve less restriction on the person's freedom of choice and movement than making a community treatment order*".[33] Mr Cripps was managed on a succession of CTOs from about 1997 onwards, on the basis that he lacked insight into his mental conditions, did not have the capacity to make treatment decisions about his mental health, and was routinely non-compliant with his medication regime.[34]

16. From 2002, whilst he was the subject of CTOs, Mr Cripps' care was managed by Osborne Clinic. In the period prior to his death, his treating team consisted of his supervising psychiatrist, Dr Kasia Frydrych, and his case manager, Mr Craig Jermy, who was a very experienced mental health nurse, and who saw him more frequently.

17. One of the benefits of managing Mr Cripps on a CTO was that he could be regularly monitored by Osborne Clinic, where he was required to attend for fortnightly injections of the antipsychotic medication, zuclopenthixol (depot injection). When Mr Cripps failed to attend for his depot injection (which was a regular occurrence despite reminders and warnings), breach action could be taken under the MHA.[35]

---

[28] Exhibit 1, Vol. 1, Tab 15, Report - Dr A Van Hattem (05.10.18), pp12-15
[29] See also: ts 07.06.23, (Frydrych), p22
[30] Exhibit 1, Vol. 1, Tab 13, Statement - Mr C Jermy (25.05.23), paras17-19
[31] Exhibit 1, Vol. 1, Tab 14, Report - Dr K Frydrych (29.05.23), pp3 & 9 and ts 07.06.23 (Frydrych), p23
[32] Exhibit 1, Vol. 1, Tab 16, Report - Dr C Hodgson (31.05.23), p1 and ts 07.06.23 (Hodgson), p15
[33] s25(2)(e), *Mental Health Act 2014* (WA)
[34] ts 07.06.23, (Frydrych), p23
[35] Exhibit 1, Vol. 1, Tab 14, Report - Dr K Frydrych (29.05.23), pp3 & 9 and ts 07.06.23 (Frydrych), p19-20

18. When he failed to attend his scheduled appointments at Osborne Clinic, Mr Cripps would be served with a breach notice and an order under the MHA, requiring him to attend to receive his depot injection. When he ignored these orders (as he sometimes did) Mr Cripps' CTO was revoked and he was taken to GH by police. Mr Cripps would be given his depot injection, and once his condition had been stabilised, he would be discharged home on a further CTO.[36]

19. Having carefully reviewed the available evidence, I am satisfied that the decision to place Mr Cripps on successive CTOs was justified on the basis that this was the least restrictive way to ensure that he was provided with appropriate treatment for his mental health conditions.

Management in the community[37,38,39]

20. The evidence before me clearly establishes that Mr Cripps' mental health was extremely difficult to manage, and that he presented a number of significant challenges to his treating team. As noted, Mr Cripps had been diagnosed with schizophrenia (which was considered "treatment resistant") and his symptoms included delusions, hallucinations and paranoia.

21. Mr Cripps' paranoia often extended to his treating team at Osborne Clinic, meaning that "*he often thought we were acting in a way that would harm rather than help him*".[40] Mr Cripps had also been diagnosed with antisocial personality disorder, the features of which include impulsivity, aggression, irresponsibility, failure to comply with laws and social norms, deceptive conduct and an inability to feel remorse. As Dr Frydrych noted in her report:

> These characteristics in themselves make it difficult to develop a therapeutic relationship. These characteristics, when combined with active psychotic symptoms and stimulant abuse made his treatment even more challenging.[41]

[36] For example, see: Exhibit 1, Vol. 1, Tab 13, Statement - Mr C Jermy (25.05.23), paras 42-126
[37] Exhibit 1, Vol. 1, Tab 13, Statement - Mr C Jermy (25.05.23), paras 26-126 and ts 07.06.23 (Jermy), p27-35
[38] Exhibit 1, Vol. 1, Tab 14, Report - Dr K Frydrych (29.05.23) and ts 07.06.23 (Frydrych), p17-27
[39] Exhibit 1, Vol. 1, Tab 12, Osborne Clinic Records (Vol 7)
[40] Exhibit 1, Vol. 1, Tab 14, Report - Dr K Frydrych (29.05.23), p8
[41] Exhibit 1, Vol. 1, Tab 14, Report - Dr K Frydrych (29.05.23), p9

22. Mr Cripps was also a frequent user of cannabis, alcohol and methylamphetamine and this exacerbated his mental health conditions and complicated his management. He also experienced long-standing social withdrawal, and he regularly complained of feeling bored, lonely and isolated.

23. However, Mr Cripps' treating team at Osborne Clinic had determined that it was impossible to link him up with available social supports (e.g.: peer support workers or services offered by non-government organisations) because of the unacceptable risks posed by his propensity to unpredictable aggression and violence when he was unwell.[42]

24. In any event, Mr Cripps persistently refused to take up any offer of services because, as Dr Hodgson put it at the inquest:

> [I]n a sense he felt he was better than the people in those services. He didn't really want to associate with them. He wanted to live a normal life. So he wanted a job. He wanted normal relationships. He didn't want to be treated as someone who had a mental illness.[43]

25. During admissions to GH, Mr Cripps had also refused referrals to National Disability Insurance Scheme providers, the Lorikeet Centre, the Creative Expression Unit at GH, and offers to be found supported accommodation. Further, despite the fact that boredom was a major factor in his life, he declined to consider voluntary work despite "*stating on multiple occasions that he would like to get a job*".[44,45]

26. Mr Cripps' reluctance to engage with staff at Osborne Clinic meant that developing any sort of rapport with him was extremely difficult. On those occasions he did attend Osborne Clinic, Mr Cripps usually declined to discuss his mental or physical health in any meaningful way, and he repeatedly declined to engage with drug rehabilitation services, despite the ongoing and persistent efforts of his treating team.[46]

---

[42] ts 07.06.23, (Frydrych), pp21-22
[43] ts 07.06.23, (Hodgson), p13
[44] Exhibit 1, Vol. 1, Tab 16, Report - Dr C Hodgson (31.05.23), p3 and ts 07.06.23, (Hodgson), pp9-10
[45] See also: ts 07.06.23, (Jermy), p34
[46] ts 07.06.23, (Frydrych), pp20-21 and ts 07.06.23, (Jermy), p29

27. There are two reported exceptions to Mr Cripps' usual approach to the offer of rehabilitation services. First, during his last admission to GH between April and May 2021, Mr Cripps said he was agreeable to a referral to the Harry Hunter Rehabilitation Centre and/or Palmerston Farm. Second, Mr Cripps agreed to meet with a rehabilitation counsellor at Osborne Clinic to pursue the referrals. However, despite these apparent changes of heart, Mr Cripps did not attend his appointment at Osborne Clinic, and he died before the referrals could be actioned.[47,48]

28. Mr Cripps generally declined to be formally reviewed by Dr Frydrych when he attended Osborne Clinic, meaning that the medical reviews which occurred were typically brief and opportunistic. Dr Frydrych said she was sometimes able to see Mr Cripps in the depot room where he received his injection or in a corridor, but that any attempts on her part to assess Mr Cripps' symptoms were met with increasing aggression. As Dr Frydrych noted in her report: "*Conducting reviews in this manner is far from my standard practice, but it was the only chance I had to see Mr Cripps at all*".[49]

29. During the reviews she was able to conduct, Dr Frydrych made assessments of Mr Cripps' mental state, and attempted to discuss his physical health issues. Mr Cripps was significantly overweight and he had high blood pressure. His regular methylamphetamine use was also a major risk to his mental and physical health, and for all these reasons, Dr Frydrych and Mr Cripps' case manager, Mr Jermy, routinely attempted to encourage Mr Cripps to engage with rehabilitation services.

30. Mr Cripps had numerous alerts on his record relating to acts of verbal and physical aggression and intimidating behaviour towards staff and others, assaulting a member of the public, and aggression requiring restraint. As I have noted, the fact that Mr Cripps was tall and had a large frame, meant that his propensity to display aggressive behaviour was potentially very dangerous and for that reason, home visits without the attendance of police were not possible.[50,51]

---

[47] Exhibit 1, Vol. 1, Tab 13, Statement - Mr C Jermy (25.05.23), paras 127-132 and ts 07.06.23, (Jermy), p29
[48] Exhibit 1, Vol. 1, Tab 16, Report - Dr C Hodgson (31.05.23), p3
[49] Exhibit 1, Vol. 1, Tab 14, Report - Dr K Frydrych (29.05.23), p8 and ts 07.06.23, (Frydrych), pp26-27
[50] Exhibit 1, Vol. 1, Tab 16, Report - Dr C Hodgson (31.05.23), p2
[51] ts 07.06.23, (Frydrych), pp18-19 and ts 07.06.23, (Jermy), p30

Management at Graylands Hospital[52,53,54,55]

31. As I have noted, Mr Cripps had regular admissions to GH and his treating psychiatrist at GH since 2020, Dr Chris Hodgson, noted that Mr Cripps' presentations were usually precipitated by his refusal to comply with his depot injection regime and/or his substance abuse. Between 2003 and his death, Mr Cripps was admitted to GH on 12 occasions, with his last admission there occurring on 18 April 2021.

32. During his last three admissions to GH, Mr Cripps had been given education and counselling about the benefits of engaging with drug rehabilitation, but he refused to accept that his use of drugs (including methylamphetamine), was a problem.[56] As noted, once Mr Cripps' mental state had settled, GH would liaise with Osborne Clinic and Mr Cripps would be discharged into their care on a CTO.

33. As noted, Mr Cripps' last admission to GH occurred on 18 April 2021, after he called the Mental Health Emergency Response Line (MHERL) and Osborne Clinic to say he was feeling suicidal and that if staff did not come to collect him "*they would be sorry*". Mr Cripps' depot injection was also one week overdue, and it appears he was "*labelled as an acute risk of suicide in the community with a chronic longitudinal risk of aggression*" and he was admitted to GH as an involuntary patient.[57,58,59]

34. During his admission, Mr Cripps expressed his loneliness and boredom and said that he "*couldn't keep living like this*". He said he felt safe at GH and would like GH staff to solve his issues with loneliness. Mr Cripps also said he could guarantee his own safety and that of others and he expressed no self-harm, suicidal or homicidal ideation, and did not exhibit any psychotic symptoms.

[52] Exhibit 1, Vol. 1, Tab 16, Report - Dr C Hodgson (31.05.23) and ts 07.06.23, (Hodgson), pp5-15
[53] Exhibit 1, Vol. 1, Tab 9.1, Graylands Hospital Discharge Summary (10.05.21)
[54] Exhibit 1, Vol. 1, Tab 9.2, Graylands Hospital Discharge Summary (19.03.21)
[55] Exhibit 1, Vol. 1, Tab 11, Graylands Hospital Medical Records (Vol. 9)
[56] ts 07.06.23, (Hodgson), pp7-8
[57] Exhibit 1, Vol. 1, Tab 13, Statement - Mr C Jermy (25.05.23), para 126
[58] Exhibit 1, Vol. 1, Tab 16, Report - Dr C Hodgson (31.05.23), p5 and ts 07.06.23, (Hodgson), pp6-7 & 12-13
[59] ts 07.06.23, (Frydrych), pp22-23

35. At the inquest, Dr Hodgson said he assessed Mr Cripps' mental state as better than his previous admissions, and thought that Mr Cripps' comments to MHERL and Osborne Clinic may have been misconstrued. Dr Hodgson did not consider Mr Cripps was suicidal and felt that his last admission to GH was related more to Mr Cripps' chronic social isolation and was consistent with his usual pattern of becoming symptomatic after not complying with his medication regime.[60]

36. During his admission, Mr Cripps appeared to be future focussed and he expressed the desire to visit a family member in New Zealand, although he also "*reported not having hope for his future in Australia as he felt he had not had family, friends or a relationship for many years*".[61]

37. Mr Cripps abstained from "*recreational drugs*" during his admission and his mental state settled. He asked to be discharged home and claimed he was still keen to attend Harry Hunter Rehabilitation Centre or Palmerston Farm. At the inquest, Dr Hodgson said he felt that Mr Cripps seemed mainly interested in the rural settings of these services, rather than having any genuine desire to undergo drug rehabilitation.[62]

38. In any case, Mr Cripps was given his depot injection before being discharged home on a CTO on 10 May 2021.

[60] ts 07.06.23, (Hodgson), pp6-7 & 14
[61] Exhibit 1, Vol. 1, Tab 16, Report - Dr C Hodgson (31.05.23), pp5-6 and ts 07.06.23, (Hodgson), p8
[62] ts 07.06.23, (Hodgson), pp7 & 14-15

EVENTS LEADING TO MR CRIPPS' DEATH[63,64,65,66,67]

39. On 24 May 2021, Mr Cripps failed to attend Osborne Clinic for his scheduled depot injection, and he could not be contacted by phone or text message. On 25 May 2021, a clinician from Osborne Clinic placed a breach notice and an order under the MHA in Mr Cripps' letterbox. The order required Mr Cripps to attend Osborne Clinic for his depot injection, but there was no response from Mr Cripps to the order or to follow-up calls made by staff at Osborne Clinic.

40. At the inquest, Mr Jermy explained that staff serving documents on Mr Cripps had to exercise caution because of his propensity to react aggressively if staff attempted personal service. Mr Jermy said after checking Mr Cripps was not in his front garden, he would place the documents being served on Mr Cripps in his letterbox, and then call or text Mr Cripps to let him know that an order had been served.[68]

41. In this case, when Mr Cripps made no response to the first order, a second order requiring him to attend GH for his depot injection was prepared.[69] It appears the intention was to transport Mr Cripps to GH on 28 May 2021 with assistance from police. However, a memo from Scarborough Police Station states: "*On 28/05/21 there was a conveyance job on for the deceased to convey him to Graylands Hospital but there wasn't enough resources and the job didn't get picked up*".[70]

42. In any event, at about 12.00 pm on 31 May 2021, a clinician from Osborne Clinic went to Mr Cripps' home with two police officers and an ambulance, in order to transport Mr Cripps to GH for his overdue depot injection. By coincidence, police had been contacted by a worker from the WA Housing Authority, who had attended Mr Cripps' home earlier and noticed "*a bad smell coming from the house and a lot of flies hanging around the door*".[71]

---

[63] Exhibit 1, Vol. 1, Tab 6.1, Report to the Coroner - Coronial Investigator P Chiles (04.11.22), p4
[64] Exhibit 1, Vol. 1, Tab 6.2, Memorandum - Const. J Moran, Coronial Investigation Unit (31.05.21)
[65] Exhibit 1, Vol. 1, Tab 13, Statement - Mr C Jermy (25.05.23), paras 134-141
[66] Exhibit 1, Vol. 1, Tabs 6.3, Email - Det. Sgt. J Binder, Coronial Investigation Unit (20.12.22)
[67] ts 07.06.23 (Frydrych), pp20 & 24-25
[68] ts 07.06.23 (Jermy), pp31-32
[69] Exhibit 1, Vol. 1, Tab 12, Osborne Clinic Records - Form 5F Order to Attend (28.05.21)
[70] Exhibit 1, Vol. 1, Tab 6.2, Memorandum - Const. J Moran, Scarborough Police Station (31.05.21), p2
[71] Exhibit 1, Vol. 1, Tab 6.1, Report to the Coroner - Coronial Investigator P Chiles (04.11.22), pp1-2

43. Police had to force entry into the home, and found Mr Cripps, clearly deceased, sitting on a couch in front of his TV (which was on). He was dressed only in shorts, and there were two bottles of propranolol (his blood pressure medication) on a side table next to him. There is no record that police located any note written by Mr Cripps in his home.

44. Notwithstanding post mortem changes, police found no visible signs of injury to Mr Cripps' body, and noted that when they had arrived at his home, the premises were "*secure*". Following an investigation, police concluded there was no evidence of criminality, third party involvement or suspicious circumstances in regard to Mr Cripps' death. Ambulance officers subsequently arrived and confirmed that Mr Cripps had died.[72,73]

CAUSE AND MANNER OF DEATH[74,75]

45. Dr Nermina Vagaja (a forensic pathologist) conducted a post mortem examination of Mr Cripps' body at the State Mortuary on 8 June 2021. Dr Vagaja noted widespread post mortem changes, and that Mr Cripps' heart was enlarged.

46. Microscopic examination of tissues identified scarring of Mr Cripps' heart muscle, moderate coronary artery atherosclerosis and some pigment in his lungs, as can occur with smoking. Mild scarring in the kidneys was also noted, but there was no significant inflammation in the brain.

47. Toxicological analysis detected methylamphetamine and its metabolite amphetamine in Mr Cripps' system, along with clopenthixol, quetiapine, amlodipine, and propranolol. The levels of quetiapine and propranolol detected were within the reported lethal range in non-decomposed tissue, and the amount of propranolol in Mr Cripps' gastric contents was "*supratherapeutic*".[76,77]

---

[72] Exhibit 1, Vol. 1, Tab 7.1, SJA Patient Care Record (Crew WNG47DD), (31.05.21)
[73] Exhibit 1, Vol. 1, Tab 1, Life Extinct Form (31.05.21)
[74] Exhibit 1, Vol. 1, Tab 4.1, Supplementary Post Mortem Report (08.08.22)
[75] Exhibit 1, Vol. 1, Tab 4.3, Post Mortem Report (08.06.21)
[76] Exhibit 1, Vol. 1, Tab 4.2, ChemCentre Toxicology Report (20.06.22), p5
[77] Exhibit 1, Vol. 1, Tab 4.1, Supplementary Post Mortem Report (08.08.22), p2

48. Dr Vagaja said that an overdose with propranolol can cause profoundly diminished blood glucose levels, slow heart rate, low blood pressure, breathing issues, seizures and coma. Dr Vagaja noted that Mr Cripps had been given a 14 day supply of medication when he was discharged from GH on 10 May 2021, and from the "tablet count" although it was possible Mr Cripps had used his medication as prescribed, it was also possible he had saved up some tablets in order to deliberately overdose.

49. Dr Vagaja stated that the level of propranolol in Mr Cripps' stomach contents, and the fact that he was found seated next to two bottles of propranolol, made the possibility of a deliberate overdose (or over treatment) possible.

50. Dr Vagaja said that an overdose of quetiapine can cause sedation, low blood pressure and cardiac arrhythmias, whilst the methylamphetamine in Mr Cripps' system may have caused anxiety, and increases in his blood pressure and heart rates, which propranolol would "*antagonise*".[78]

51. Dr Vagaja also noted that in addition to Mr Cripps' various psychiatric conditions, he had "*significant physical comorbidities*", namely obesity, arterial hypertension, and an enlarged heart, which predisposed him to a premature death.

52. At the conclusion of her post mortem examination, Dr Vagaja expressed the opinion that the cause of Mr Cripps' death was from combined acute effects of multiple drugs in obese man with enlarged heart and arterial hypertension.

53. I accept and respectfully adopt Dr Vagaja's conclusion as my finding as to the cause of Mr Cripps' death.

54. As to the manner of Mr Cripps' death, I accept there is a possibility that he may have deliberately taken his life. However, Mr Cripps had been known to mental health services since 1994, and had no documented history of self-harm or suicidal ideation.

[78] See also: ts 07.06.23, (Hodgson), pp10-11

55. Further, there is no evidence that any note expressing any self-harm or suicidal intention was ever located.[79,80] In my view, it is also significant that none of Mr Cripps' inpatient or outpatient treating clinicians (i.e.: Dr Hodgson, Dr Frydrych, or Mr Jermy) were of the opinion that Mr Cripps had taken his life or was suicidal in the period before his death. Further I note that although Mr Cripps was socially isolated and often expressed feelings of boredom and loneliness, during his last admission to GH in May 2021, he had said he wanted to travel to New Zealand to visit a family member, and he appeared to be future focussed.[81,82,83]

56. Therefore, having carefully considered all of the available evidence, I am not satisfied that Mr Cripps took an overdose of his medication with the intention of taking his life. In light of the available evidence about his mental state, I find instead that Mr Cripps' death occurred by way of accident.

TREATMENT OPTIONS SINCE MR CRIPPS' DEATH

Review by Office of Chief Psychiatrist[84]

57. At an inquest I conducted into the death of Mr Boris Drleski (the Drleski Inquest), the Chief Psychiatrist, Dr Nathan Gibson, said that in 2020 his office had conducted a review of the services available to mental health consumers with complex needs (the Review), including those with "*co-occurring severe mental illness and substance abuse issues*".

58. Amongst other issues, the Review had examined the availability of long-term complex care or extended care units, and available substance use treatment options for patients (like Mr Cripps) with substance use issues and complex mental health conditions.

---

79 Exhibit 1, Vol. 1, Tab 6.1, Report to the Coroner - Coronial Investigator P Chiles (04.11.22), p4
80 Exhibit 1, Vol. 1, Tab 6.3, Email - Det. Sgt. J Binder, Coronial Investigation Unit (20.12.22)
81 ts 07.06.23, (Frydrych), p24
82 Exhibit 1, Vol. 1, Tab 16, Report - Dr C Hodgson (31.05.23), p3 and ts 07.06.23, (Hodgson), pp6-8, 12 & 14
83 ts 07.06.23, (Jermy), p33
84 [2022] WACOR 24, Record of Investigation into Death, Mr B Drleski (13.04.22), paras 77-79

59. At the Drleski Inquest, Dr Gibson also noted that the Review had identified that mental health consumers with co-occurring severe mental illness and substance abuse issues (like Mr Cripps) were commonly rejected by available services "*as a potential consequence of being too difficult or not meeting the entry criteria*".[85]

Response by the Mental Health Commission[86]

60. At the Drleski inquest, the Mental Health Commissioner, Ms Jennifer McGrath explained that the Mental Health Commission had been established in March 2010, and worked closely with the Department of Health and service providers to lead mental health reform throughout the State and work towards a modern effective mental health system that places the individual and their recovery at the centre of its focus.

61. During her evidence at the Drleski Inquest, Ms McGrath referred to two initiatives that may have been relevant to Mr Cripps' treatment and management, namely Secure Extended Care Units, and Community Care Units. In summary her evidence about these facilities was as follows:[87]

a. *Secure Extended Care Units* (SECU):
SECU are intensive inpatient rehabilitation units. They are designed for individuals admitted on an involuntary basis, who have severe and chronic mental health illnesses with co-occurring conditions and challenging behaviours, who pose a significant risk. The goal of treatment at a SECU is for the patient to be transitioned to community rehabilitation and eventually to either supported, or independent living.

b. *Community Care Units* (CCU):
CCU provide long-term treatment, rehabilitation and recovery care for individuals transitioning out of inpatient facilities, including SECUs. CCUs provide "*open, home like environments*" and are staffed by a multi-disciplinary team that offers recovery-based psychosocial and clinical care in a residential setting.

[85] [2022] WACOR 24, Record of Investigation into Death, Mr B Drleski (13.04.22), paras 77 & 79
[86] [2022] WACOR 24, Record of Investigation into Death, Mr B Drleski (13.04.22), paras 80-85
[87] [2022] WACOR 24, Record of Investigation into Death, Mr B Drleski (13.04.22), para 83

62. In his report, and at the inquest, Dr Hodgson (with whom Dr Frydrych Mr Jermy agreed) said that Mr Cripps might have benefitted from placement in a SECU, had such a facility been available. As Dr Hodgson noted: "*A SECU placement would have better suited Mr Cripps' complex psychiatric illness, risk issues, and his need to be treated in a facility that could rehabilitate him from drug use*".[88,89,90]

63. In Mr Cripps' case, one option might have been to have admitted him to the SECU as an involuntary patient. There he would be offered treatment for his polysubstance use, and he could have been encouraged to resume taking clozapine. After an extended period of treatment at a SECU, Mr Cripps could then have been transitioned to a CCU, with the ultimate aim of returning to the general community, perhaps in some form of supported accommodation, or even independently.[91]

64. In his report, Dr Hodgson noted that Mr Cripps was considered unsuitable for admission to the Hospital Extended Care Service because of his "*level of aggression in the inpatient setting and his poor prospects of rehabilitation*".[92] Dr Hodgson also noted that in the past, it had been possible to refer patients like Mr Cripps to Whitby Falls Hospital (Whitby Falls).

65. Whitby Falls had a farm-like setting and had been successful in keeping patients drug free, thereby stabilising their mental health. However, Whitby Falls was closed in 2006, following a review which had found that the facility:

> [D]id not meet modern mental health treatment standards and the residents were isolated from the community and could not mix with other people".[93]

[88] Exhibit 1, Vol. 1, Tab 16, Report - Dr C Hodgson (31.05.23), pp7-8 and ts 07.06.23, (Hodgson), pp11-12 & 15-16
[89] ts 07.06.23, (Frydrych), pp25-26
[90] ts 07.06.23, (Jermy), pp34-35
[91] Exhibit 1, Vol. 1, Tab 16, Report - Dr C Hodgson (31.05.23), p6 and ts 07.06.23, (Hodgson), pp14-15
[92] Exhibit 1, Vol. 1, Tab 16, Report - Dr C Hodgson (31.05.23), p6 and ts 07.06.23, (Hodgson), p9
[93] Exhibit 1, Vol. 1, Tab 16, Report - Dr C Hodgson (31.05.23), p6

66. However, as Dr Hodgson pointed out, Mr Cripps was "*isolated and couldn't mix with other people*" and whilst in the community, Mr Cripps was vulnerable to exploitation and drug use. Although it was true that de-institutionalisation worked well for some patients, Dr Hodgson said it "*didn't work well for Mr Cripps*" and although admission to a facility like Whitby Falls may have suited Mr Cripps, there were no such facilities in Western Australia.[94]

QUALITY OF SUPERVISION, TREATMENT AND CARE

67. At the inquest, Dr Hodgson said that in hindsight, he did not think Mr Cripps' care could have been any different, and in his report, Dr Hodgson made the following assessment of Mr Cripps' care:

> In my personal professional opinion, Mr Cripps received a high standard of multi-disciplinary team care during all of his Graylands admissions. Community management was made difficult due to Mr Cripps' ongoing drug use and his propensity to violence when unwell…It is my opinion that both the inpatient teams and the community mental health teams provided the best care they could given the resource constraints under which they work.[95]

68. I also note that following Mr Cripps' death, an investigation panel was convened and conducted a clinical review into his care (SAC1). The SAC1 concluded that "*there were no healthcare factors contributing to this incident*", and no recommendations were made.[96]

69. In my view, the evidence in this case clearly establishes that Mr Cripps had complex psychiatric issues, and his lack of insight and his substance use exacerbated the management of his mental health. Although he had enjoyed a decade long period of relative stability while using clozapine, in about March 2003, he declined to continue to do so and was subsequently managed with depot injections of antipsychotic medication.

[94] Exhibit 1, Vol. 1, Tab 16, Report - Dr C Hodgson (31.05.23), p6
[95] Exhibit 1, Vol. 1, Tab 16, Report - Dr C Hodgson (31.05.23), pp7-8 and ts 07.06.23, (Hodgson), p13
[96] Exhibit 1, Vol. 1, Tab 14, Report - Dr K Frydrych (29.05.23), p9

70. In addition to the challenges presented by Mr Cripps' complex mental health issues and his lack of insight into his need for ongoing treatment, Mr Cripps' management was complicated by his propensity for violence when unwell and his refusal to engage with his treating clinicians in any meaningful way.

71. Given all of those circumstances, it is my view that clinical staff interacting with Mr Cripps did their best to manage his complex needs by a combination of community care, (which largely consisted of brief fortnightly assessments and depot injections), and by inpatient admissions to GH when required. Whilst this management approach enabled Mr Cripps to remain in his home, it was not "*recovery focussed*" and was essentially aimed at maintaining the status quo.

72. Had these facilities been available, it is at least possible Mr Cripps may have benefitted from a long-term admission to a SECU, with a view to transitioning him to a CCU after a period of treatment, and then eventually to supported or independent accommodation.

73. As noted, Mr Cripps' longstanding polysubstance use was a major impediment to the management of his mental health and despite the repeated efforts of his treating inpatient and outpatient treating teams, it was never successfully addressed.

74. The integrated model planned for SECUs, where polysubstance use and mental health issues are addressed in a coordinated fashion, was simply unavailable. Had Mr Cripps been able to be admitted to a SECU, it may also have been possible to have restarted him on clozapine, a medication he used successfully for many years, although I accept that Mr Cripps may have continued to decline the required blood tests.

75. Having carefully considered all of the available evidence, it is my view that Mr Cripps' management whilst he was an involuntary patient at GH, and whilst the subject of a CTO under the care of Osborne Clinic, was reasonable when considered in the context of the resources available to his treating team. Although Mr Cripps wasn't getting any better while he was on a CTO, at least he was able to stay in his own home.

76. However, given that Mr Cripps' supervision, treatment and care during the time he was the subject of a CTO was not recovery focussed, it cannot be said to have been optimal. In essence, Mr Cripps' management plan essentially aimed at maintaining the status quo and there did not appear to be any expectation that Mr Cripps would (or could) get better.

77. The possibility that Mr Cripps' supervision, treatment and care may have benefitted from an admission to a SECU if this option had been available to his treatment teams remains a tantalising prospect. That is because no SECUs are currently available, although a 12-bed facility to be located at the Bentley Hospital campus is in the planning stages.[97,98]

CONCLUSION

78. Mr Cripps' case demonstrates the difficulties faced by clinicians attempting to care for individuals who have complex needs, and whose chronic polysubstance use adversely impacts on the management of their mental health illnesses. It can only be hoped that the innovative facilities I have referred to (i.e.: SECU) will be made available to mental health consumers as quickly as possible.

79. In conclusion, as I did at the inquest, I wish to again convey to Mr Cripps' family, on behalf of the Court, my very sincere condolences for their loss.

MAG Jenkin
Coroner
28 June 2023

[97] [2022] WACOR 24, Record of Investigation into Death, Mr B Drleski (13.04.22), para 83
[98] ts 07.06.23 (Hodgson), p11