JURISDICTION	:	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	:	CORONERS ACT 1996
CORONER	:	PHILIP JOHN URQUHART, CORONER
HEARD	:	16 - 18 JANUARY 2023
DELIVERED	:	13 FEBRUARY 2023
FILE NO/S	:	CORC 750 of 2020
DECEASED	:	SULLEY, PHILIP

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:

W.J. STOPS assisted the coroner
P.A. FEMIA, assisted by C. ARNOLD (State Solicitors Office) appearing on behalf of the East Metropolitan Health Service (EMHS) and Doctors Meintjes, Briggs, Zhang, Choy and Gupta, and Nurse Attwood
G.J.L. LEE (Australian Nursing Federation) appearing on behalf of Nurses Lavis, McGovern, Shadforth, Daniels, London and Kong

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

Nil

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Philip John Urquhart, Coroner, having investigated the death of ***Philip SULLEY*** *with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, PERTH, on 16-18 January 2023, find that the identity of the deceased person was* ***Philip SULLEY*** *and that death occurred on 27 April 2020 at Bentley Health Services, 18-56 Mills Street, Bentley, from coronary artery arteriosclerosis in the following circumstances:*

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LIST OF ABBREVIATIONS

Abbreviation	Meaning
ADHD	Attention Deficit Hyperactivity Disorder
BMHU	Bentley Mental Health Unit at Bentley Health Services
BWC	Body Worn Camera
CBD	Central Business District
CPR	Cardiopulmonary Resuscitation
ECG	Electrocardiogram
Form 1A	A referral made by a medical practitioner or an authorised mental health practitioner if it is reasonably suspected that a person is in need of an involuntary treatment order and requires an examination by a psychiatrist
Form 1B	To be completed if a variation is required to the terms of a Form 1A
Form 6A	An involuntary treatment order made by a psychiatrist that requires the person the subject of the order to be an involuntary patient at an authorised hospital
the Hotel	Pan Pacific Hotel
HHC	Homeless Healthcare
mg	milligrams
MHCRU	Mental Health Co-Response Unit
MHERL	Mental Health Emergency Response Line
PLN	Psychiatric Liaison Nurse
PSOLIS	Department of Health's Psychiatric Services Online Information System
PWH	Perth Watch House
RPH	Royal Perth Hospital

INTRODUCTION

1 The deceased (**Mr Sulley**) died on 27 April 2020, at the Bentley Mental Health Unit (**BMHU**), Bentley Health Services, from coronary artery arteriosclerosis. He was 58 years old.

2 At the time of his death, Mr Sulley was subject to a '*Form 6A - Inpatient Treatment Order in Authorised Hospital*', pursuant to section 55(1)(a) of the *Mental Health Act 2014* (WA). He was therefore an involuntary patient as defined in that Act.[1]

3 Accordingly, Mr Sulley was a *"person held in care"* within the meaning of the *Coroners Act 1996* (WA) and his death was a *"reportable death"*.[2]

4 In such circumstances, a coronial inquest is mandatory as Mr Sulley *"was immediately before death a person held in care"*.[3] Where the death is of the person held in care, I am required to comment on the quality of the supervision, treatment and care that person received while in that care.[4]

5 I held an inquest into Mr Sulley's death at Perth on 16 - 18 January 2023. Thirteen witnesses gave oral evidence at the inquest, comprising of doctors and nurses who treated Mr Sulley at Royal Perth Hospital (**RPH**) and BMHU, and an independent consultant forensic psychiatrist who provided his opinion as to the psychiatric care Mr Sulley received in the days before his death. The 13 witnesses were:[5]

(i.) Sara-Jayne Lavis, (Registered Nurse at RPH);
(ii.) Dr Wesley Meintjes, (Psychiatry Registrar at RPH);
(iii.) Suzanne McGovern, (Psychiatric Liaison Nurse at RPH);
(iv.) Dr Edward Briggs, (Emergency Department Registrar at RPH);
(v.) Amy Shadforth, (Enrolled Nurse at RPH);
(vi.) Sandra Daniels, (Registered Nurse at RPH);
(vii.) Dr Cathey Zhang, (Intern Doctor at BMHU);
(viii.) Jamie London, (Registered Nurse at BMHU);
(ix.) Brian Attwood, (Registered Nurse at BMHU);
(x.) Matthew Kong, (Registered Nurse at BMHU);
(xi.) Dr Winston Choy, (Consultant Psychiatrist at BMHU);
(xii.) Dr Mark Hall, (Consultant Forensic Psychiatrist); and
(xiii.) Dr Vinesh Gupta, (Medial Co-Director, Mental Health Division, Royal Perth Bentley Group).

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[1] *Mental Health Act 2014* (WA) s 4 and s 21(1)
[2] *Coroners Act 1996* (WA) s 3
[3] *Coroners Act 1996* (WA) s 22(1)(c)
[4] *Coroners Act 1996* (WA) s 25(3)
[5] The positions attributed to those witnesses who treated Mr Sulley are the positions they held at the relevant time

6 The documentary evidence comprised of two volumes of material which were tendered by Counsel Assisting as exhibit 1. Four minutes of Body Worn Camera (**BWC**) footage from a police officer involved in the apprehension of Mr Sulley on 22 April 2020 was played during the inquest. This BWC footage was marked for identification (MFI 2).

7 My primary function at the inquest was to investigate the quality of Mr Sulley's medical supervision, treatment and care that was provided to him when he attended the emergency department at RPH on 19 and 22 April 2020 and when he was admitted to BMHU from 23 April 2020 until his death four days later.

8 In making my findings, I have applied the standard of proof as set out in ***Briginshaw v Briginshaw*** (1938) 60 CLR 336, 361-362 (Dixon J) which requires a consideration of the nature and gravity of the conduct when deciding whether a matter has been proven on the balance of probabilities.

9 I am also mindful not to assert hindsight bias into my assessment of the actions taken by Mr Sulley's health service providers in their treatment of him at RPH and BMHU. Hindsight bias is the tendency, after an event, to assume the event was more predictable or foreseeable than it actually was at the time.[6]

MR SULLEY

Background [7]

10 Mr Sulley was born in Victoria on 25 December 1961. He was an only child. He had a happy childhood and was a very healthy child. Mr Sulley completed his secondary education in Perth. He then undertook an apprenticeship to become an electrician.

11 Mr Sulley moved out of his parents' home when he was about 22 years old. He experienced some periods of unemployment and did not have a long-term relationship with any person. He did not have any children. Mr Sulley ceased work when he was about 43 years old and received a disabilities support pension.

Psychiatric history [8]

12 When he was aged about 40 years, Mr Sulley attended a private psychiatrist, who attributed his mental health issues at the time to attention deficit

[6] Dillon H and Hadley M, *The Australasian Coroner's Manual* (2015) 10
[7] Exhibit 1, Volume 1, Tab 15, File Note by Senior Constable Nigel Foote dated 27 April 2020; Exhibit 1, Volume 1, Tab 19.1, Report of Dr Mark Hall dated 4 August 2022
[8] Exhibit 1, Volume 1, Tab 19.1, Report of Dr Mark Hall dated 4 August 2022

hyperactivity disorder (**ADHD**). He was prescribed stimulant medications to treat the ADHD.

13 Due to his mental health, Mr Sulley struggled to maintain stable accommodation. In mid-2004, when he was 42 years old, he lost his accommodation and he moved in with his parents who were residing in a retirement village. However, given his behaviour, his parents contacted mental health services. They reported that Mr Sulley had been unwell on and off for the past three years and would talk about police or John Kizon being out to get him. He also believed that police were bugging his car and his mobile phone.

14 On 8 September 2004, staff from Osborne Clinic visited Mr Sulley who said he had been exposed to radiation with nuclear dust, that he was in communication with then U.S. President George W. Bush, and that a nuclear war was going to start.

15 On 9 September 2004, Mr Sulley was admitted to Graylands Hospital. He was diagnosed with amphetamine-induced[9] psychosis and cluster B (emotionally unstable) personality traits. Following his discharge on 22 September 2004, Mr Sulley resided in Scarborough. He continued to take stimulants prescribed by his psychiatrist.

16 Between August 2007 and April 2013, Mr Sulley had seven hospital admissions relating to his mental health; five to Graylands Hospital, one to RPH and one to Swan District Hospital. The principal diagnoses were drug-induced psychosis and paranoid schizophrenia. He was treated with oral and depot antipsychotic medications. During this period, Mr Sulley's psychiatrist was advised of his psychosis and recent cannabis use, and an agreement was reached that Mr Sulley would not be prescribed any further stimulants to treat his ADHD.

17 On 5 November 2016, Mr Sulley saw a private psychiatrist, having been referred by his general practitioner for management of his ADHD. At this time, it had been over three years since Mr Sulley's last known psychotic episode. Mr Sulley reported that he had experienced considerable difficulties in doing his day-to-day activities and had difficulty functioning, which the psychiatrist considered to be consistent with ADHD. The psychiatrist sought and was granted permission from the Department of Health to prescribe stimulants for Mr Sulley.

18 From November 2016 to November 2018, this psychiatrist had regular consultations with Mr Sulley. The psychiatrist reported there was no evidence

[9] The source of this amphetamine would have been Mr Sulley's prescribed medication for his ADHD

of any emerging psychosis and that at no time had Mr Sulley reported any psychotic symptoms.

Recent medical history regarding heart issues [10]

19 On 20 May 2019, Mr Sulley was in the care of police at Perth Watch House (**PWH**) when he was found to have asymptomatic tachycardia (elevated heart rate). This had been detected by a nurse stationed at PWH during a routine assessment. Mr Sulley was taken to the emergency department at RPH. His history of previous presentations when he was tachycardic was noted at the time. Investigations, including an electrocardiogram (**ECG**), were performed, which did not reveal any conduction abnormalities. This included the "QT/QTc" interval (that part of the cardiac conduction cycle most commonly affected by psychotropic medication), which was found to be within normal limits. Mr Sulley was given intravenous hydration and he gradually improved. The cause for the tachycardia was considered to be dehydration.

20 An assessment by a psychiatry registrar during this admission at RPH determined there was no evidence of acute psychosis, and Mr Sulley was deemed suitable for discharge from a psychiatric point of view. He was subsequently discharged on 21 May 2019.

Referral to Start Court

21 On 5 November 2019, Mr Sulley was at Perth train station in Wellington Street, Perth when he began urinating in view of the public. A transit officer with the Public Transport Authority arrested Mr Sulley for disorderly behaviour. As he was being placed under arrest, Mr Sulley allegedly grabbed hold of the transit officer's arm and bit him on the forearm. Police attended and arrested Mr Sulley for assaulting a public officer. He was taken to PWH and was refused bail.[11]

22 Mr Sulley was remanded in custody to Hakea Prison, where he remained before he was granted bail and released on 18 February 2020.[12]

23 On 23 March 2020, Mr Sulley was assessed for participation in the Start Court. Start Court is a Magistrates Court that specialises in dealing with offenders who have mental health issues. The assessment took place over the telephone due to COVID related restrictions at the time. During the assessment, Mr Sulley reported symptoms of low mood and anxiety in the context of social stress, in particular his homelessness. He denied any

[10] Exhibit 1, Volume 1, Tab 19.1, Report of Dr Mark Hall dated 4 August 2022
[11] Police Statement of Material Facts for the alleged assault on the transit officer
[12] Exhibit 1, Volume 1, Tab 19.1, Report of Dr Mark Hall dated 4 August 2022, p. 6

psychotic symptoms. The clinician conducting the assessment noted Mr Sulley was pleasant and polite, despite having little insight into the benefits of antipsychotic medication. The clinician also recorded that, "*at the time of the assessment, Mr Sulley did not present with symptoms of deteriorated mental health*".[13]

24 On 1 April 2020, a clinical review meeting assessed Mr Sulley as being suitable to participate in the Start Court with respect to two charges of assaulting a public officer and a charge of breaching a bail undertaking. He was scheduled to appear in the Start Court on 22 April 2020.

MR SULLEY'S PRESENTATION AT RPH ON 19 APRIL 2020

25 Due to his homeless state and the outbreak of the COVID-19 pandemic, Mr Sulley was deemed to be at high risk following an assessment by Ruah Community Services[14] on 2 April 2020. On that day, he began residing in a room at the Pan Pacific Hotel (**the Hotel**) situated on Adelaide Terrace in the Perth CBD.[15]

26 For the first 16 days at the Hotel, Mr Sulley did not have any issues and was well-behaved. He ate all his meals and was compliant with the twice-daily health checks conducted by nurses from Homeless Healthcare (HHC).[16]

27 On 18 April 2020, Mr Sulley was agitated, requesting his old scripts from the pharmacy. He explained that he wanted the physical copies of the scripts, not the medications. A HHC nurse organised for the scripts to be dropped off to Mr Sulley and this was done on the afternoon of 19 April 2020.[17]

28 At about 3.00 pm on 19 April 2020, Mr Sulley was heard screaming and yelling inside his room. When attempts were made to check on him, he said he was fine and for staff to close the door. However, Mr Sulley could still be heard talking to himself and repeatedly saying "*I will kill them all*". Another visit by staff failed to settle Mr Sulley and he began saying, "*John Kizon is going to get you, that will make the nurse come quicker, he will be here, she better hurry up*". Complying with a previous request made by Mr Sulley, a HHC nurse handed him three containers of his medication.[18] Mr Sulley took

[13] Exhibit 1, Volume 1, Tab 19.1, Report of Dr Mark Hall dated 4 August 2022, p. 6
[14] Ruah Community Services is an integrated community service provider which offers support in the areas of housing and homelessness
[15] Exhibit 1, Volume 1, Tab 17, Letter from Ruah Community Services dated 22 May 2020 and attachment of Client Incident Form dated 19 April 2020
[16] Exhibit 1, Volume 1, Tab 17, Letter from Ruah Community Services dated 22 May 2020 and attachment of Client Incident Form dated 19 April 2020
[17] Exhibit 1, Volume 1, Tab 17, Letter from Ruah Community Services dated 22 May 2020 with attachment of Client Incident Form dated 19 April 2020
[18] This consisted of slow-release tramadol (35 tablets), medium-release tramadol (20 tablets) and diazepam (50 tablets).

the medication and immediately slammed the door. He could be heard speaking loudly and swearing to himself inside his room.[19]

29 Given Mr Sulley's behaviour, a HHC nurse telephoned the Mental Health Emergency Response Line (**MHERL**). The operator at MHERL advised the HHC nurse of Mr Sulley's psychiatric history and his current criminal charges and said that arrangements would be made by MHERL for Mr Sulley to have a mental health assessment.

30 MHERL then contacted Mr Lachlan Voight, a mental health nurse at City East Community Mental Health Service and requested that an assessment of Mr Sulley be undertaken, because of his increased aggression and possible deterioration in his mental state.

31 Due to Mr Sulley's alerts on the Psychiatric Services Online Information System (**PSOLIS**)[20] and recent alleged assaults, Mr Voight advised the HHC nurse at the Hotel that police presence will be required for him to complete an assessment of Mr Sulley.[21] The other option that Mr Voight suggested was for the HHC nurse to arrange for an ambulance (with police in attendance) to take Mr Sulley to the emergency department at RPH. A decision was made to take this course of action.[22]

32 At about 5.30 pm, five police officers attended the Hotel. Two ambulance officers arrived about 15 minutes later. Mr Sulley was asleep in his room and when he was woken, he initially expressed a reluctance to go to RPH. Although he was very abusive towards the police officers, Mr Sulley eventually agreed, and he was taken by ambulance to the emergency department at RPH.[23]

33 At 6.16 pm, the triage nurse at the emergency department assessed Mr Sulley. He was given a triage code score of 3, which meant he was to be seen by medical staff within 30 minutes.[24] He was allocated to the assessment corridor which is the area set aside for patients who are not critically unwell or who are experiencing mental health issues.[25]

34 An emergency department intern doctor saw Mr Sulley at 6.47 pm, at which time he was abrupt in response to questions, giving only "yes" or "no"

[19] Exhibit1, Volume 1, Tab 17, Client Incident Form dated 19 April 2020
[20] PSOLIS is the database operated by the Department of Health which has relevant information regarding members of the community with mental health issues
[21] Exhibit 1, Volume 1, Tab 24, Statement of Lachlan Voight dated 21 December 2022 at attachment LV1, p. 3
[22] Exhibit 1, Volume 1, Tab 24, Statement of Lachlan Voight dated 21 December 2022 at attachment LV1, p. 3
[23] Exhibit1, Volume 1, Tab 17, Client Incident Form dated 19 April 2020
[24] ts 16.1.23 (Ms Lavis), p. 12
[25] ts 16.1.23 (Ms Lavis), p. 15

answers. At the time, Mr Sulley was hypertensive with a blood pressure of 150/100 mmHg and an elevated heart rate of 105 beats per minute.[26]

Psychiatric assessment by Dr Wesley Meintjes and PLN Suzanne McGovern [27]

35 Later that evening, Mr Sulley had a psychiatric review at RPH conducted by a psychiatry registrar at the emergency department, Dr Wesley Meintjes, and a Psychiatric Liaison Nurse (**PLN**), Suzanne McGovern.

36 At 9.10 pm on 19 April 2020, Dr Meintjes documented that Mr Sulley had reported he often mumbled to himself and that he did not recall saying anything about hurting others at the Hotel. He told Dr Meintjes that he was annoyed the Hotel had not yet placed him into longer term accommodation. Dr Meintjes noted that Mr Sulley was, at times, angry and agitated during the interview; however, he was easily re-directed. Mr Sulley did not report any perceptual disturbances and he was not observed responding to any unseen stimuli during the review. Mr Sulley's thought process was that he was inconvenienced by the events of the evening and that he wanted to have his wishes respected, which were to organise his own accommodation. Dr Meintjes noted that Mr Sulley had chronically impaired insight and judgement which was secondary to schizophrenia. Nevertheless, Dr Meintjes considered there was no present evidence of an acute impairment of Mr Sulley's judgement. Dr Meintjes also noted there was no evidence of a relapse of Mr Sulley's schizophrenia or psychosis, and he determined there were no acute risks to Mr Sulley or third parties. PLN McGovern agreed with this assessment. Accordingly, Mr Sulley was discharged, and he left the emergency department at 9.52 pm. To avoid a return to the Hotel, he was provided with three nights' accommodation at the Charles Hotel in North Perth.

MR SULLEY'S PRESENTATION AT RPH ON 22 APRIL 2020 [28]

37 At 3.12 pm on 22 April 2020, the Police Operations Centre received a call from a member of the public stating that Mr Sulley was at a bus stop on Clarkson Road, Maylands. He was reported as displaying signs of psychotic behaviour, responding to unseen stimuli, and abusing and shouting at members of the public who were waiting for the bus. He tried to get on an arriving bus; however, he was refused by the bus driver.

[26] Exhibit 1, Volume 2, Tab 1, RPH Medical Records
[27] Exhibit 1, Volume 1, Tab 26, Statement of Dr Wesley Meintjes dated 9 January 2023 at attachment WM6
[28] Exhibit 1, Volume 1, Tab 8, Coronial Investigation Squad Report by Senior Constable Ross Nullaniff dated 1 May 2021; Exhibit 1, Volume 1, Tab 19.1, Report of Dr Mark Hall dated 4 August 2022; Exhibit 1, Volume 2, Tab 1, RPH Medical Records

38 At 3.33 pm, police officers from the Mental Health Co-Response Unit (**MHCRU**)[29] attended and spoke to Mr Sulley who was now sitting in a stationary bus. The MHCRU officers noted that Mr Sulley was acting very erratically, displaying psychotic behaviour, and was continuously talking to himself or to someone who was not present. At times, he escalated and became verbally loud and aggressive. He repeated that he was "*Alpha and Omega*" and "*I am a Nazi*". He advised the MHCRU nurse in attendance that he would get John Kizon to hurt him, that he was king of the world, and that he had powerful people helping him.

39 The MHCRU nurse placed Mr Sulley on a '*Form 1A - Referral for Examination by Psychiatrist*', pursuant to section 26 of the *Mental Health Act 2014* (WA). A Form 1A can be completed by a medical practitioner or an authorised mental health practitioner and permits the person named on it to be taken to an appropriate location (usually a hospital) to be examined by a psychiatrist.

40 The MHCRU nurse noted on the Form 1A that Mr Sulley was emotionally dysregulated, that he was shouting and abusing people in the street, that he was delusional about John Kizon coming to help him, that he was verbally hostile, that he lacked a capacity to make decisions about his own mental health and was a risk to others.[30] As it was recorded on the Form 1A that the examination by the psychiatrist was to take place at the emergency department at RPH, an ambulance took Mr Sulley there.[31]

41 At 4.36 pm, the triage nurse at the emergency department assessed Mr Sulley. He was given a triage code score of 3 and he was allocated to the assessment corridor. Mr Sulley was still rambling, agitated and verbally aggressive.

42 At 5.30 pm, a resident medical officer from the emergency department saw Mr Sulley. The doctor recorded, "*unable to take any observations*"; however, it was also recorded that a thorough examination "*from head to toe*" found no significant injury. The doctor prescribed a single dose of 20 mg olanzapine (an antipsychotic medication).

43 Mr Sulley was kept in the emergency department overnight and a one-to-one nurse companion was assigned to him. This meant a nurse continuously

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[29] The MHCRU is a mobile team comprising of police officers with specific training in mental health and an authorised mental health practitioner. These mobile teams provide the first response to police-initiated incidents where a person is suspected of experiencing a mental health crisis.

[30] Exhibit 1, Volume 2, Tab 2, BMHU Medical Records, Form 1A – Referral for Examination by Psychiatrist dated 22 April 2020 at 3.51 pm

[31] A person who is taken or admitted to a hospital under a Form 1A is not considered to be an involuntary patient, rather the person is on a referral to be examined by a psychiatrist. If, after the examination, the psychiatrist completes a '*Form 6A – Inpatient Treatment Order in Authorised Hospital*' then the person becomes an involuntary patient: Exhibit 1, Volume 1, Tab 27, Statement of Dr Winston Choy dated 10 January 2023, p.6

remained with Mr Sulley to ensure he was clinically safe. He continued to remain in an agitated state and sedatives had to be administered intravenously, including on one occasion when he ran away after going to the toilet.[32]

44 At 10.21 am on 23 April 2020, a mental health nurse at RPH completed a '*Form 1B - Variation of Referral*', pursuant to section 46 of the *Mental Health Act 2014* (WA). A Form 1B changes the place where the examination by a psychiatrist is to be conducted. In this instance, Mr Sulley was redirected to BMHU for his examination.

45 There is nothing in the RPH medical records to indicate that Mr Sulley was examined by a psychiatrist when he was at RPH. In light of that and the existence of the Form 1B, it is obvious no such examination was undertaken at RPH.

MR SULLEY'S PRESENTATION AT BMHU ON 23 APRIL 2020 [33]

46 At 11.50 am on 23 April 2020, Mr Sulley arrived at BMHU via an ambulance. Upon his arrival Mr Sulley was observed to be sedated, sleepy and tired. Although he was not aggressive, he refused to comply with admission paperwork. He also refused to have a physical assessment performed by an intern doctor, Dr Cathey Zhang. Mr Sulley was admitted to ward 6 at BMHU, which was an authorised and secure ward for patients.

47 At 2.15 pm, Dr Anthony Vu, a psychiatry registrar at BMHU, attempted to conduct a review of Mr Sulley. Mr Sulley, however, was aggressive and threatening, causing the review to be terminated in the interests of safety. Dr Vu prescribed Mr Sulley with low doses of olanzapine to be taken on an "*as needed*" basis.

Psychiatric assessment by Dr Winston Choy and Dr Anthony Vu [34]

48 At 9.30 am on 24 April 2020, Dr Winston Choy, the consultant psychiatrist at BMHU, and Dr Vu made another attempt to review Mr Sulley.

49 As he had done the previous day with Dr Vu, Mr Sulley refused to engage with the doctors. He shouted abuse and threatened to punch Dr Choy. Attempts to settle him down were unsuccessful and the doctors decided to terminate the review. Mr Sulley continued to shout out abuse even after the doctors had left his room.

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[32] These sedatives were midazolam and droperidol
[33] Exhibit 1, Volume 2, Tab 2, BMHU Medical Records
[34] Exhibit 1, Volume 1, Tab 27, Statement of Dr Winston Choy dated 10 January 2023; BMHU Medical Records

50 Notwithstanding the shortness of the review, Dr Choy made the decision to involuntarily commit Mr Sulley to BMHU as an inpatient. Given his behaviour before and after arriving at BMHU, Dr Choy considered that Mr Sulley was psychotic, posed a risk to himself and others, and did not have meaningful insight into his condition which meant that less restrictive modes of treatment could not be used.

51 At 9.36 am on 24 April 2020, Dr Choy completed a '*Form 6A – Inpatient Treatment Order in Authorised Hospital*', pursuant to section 55(1)(a) of the *Mental Health Act 2014* (WA). Dr Choy wrote on the Form 6A that the order was to expire on 15 May 2020 at 9.00 pm, the maximum time for an adult to be subject of an inpatient treatment order.[35]

52 Dr Choy prescribed 10 mg of olanzapine daily. He also prescribed low doses of chlorpromazine (another antipsychotic medication) for Mr Sulley to take on an "*as needed*" basis.

53 Despite regular requests from medical staff at BMHU, Mr Sulley continued to refuse to have a physical assessment.

EVENTS LEADING TO MR SULLEY'S DEATH [36]

54 Nursing entries over the weekend days of 25 and 26 April 2020 indicated that Mr Sulley continued to behave in an agitated and hostile manner. Although he was regularly given his prescribed medications to treat his behaviour, they were noted to have little effect.

55 At 5.30 am on 27 April 2020, the nursing entry noted Mr Sulley was not agitated and he had slept between 11.00 pm and 4.00 am. He then required a 100 mg dose of chlorpromazine at 5.20 am. Mr Sulley was given one mg of lorazepam (a benzodiazepine) at 10.35 am. As he was complaining of generalised pain, he was given paracetamol at 10.40 am. At 12.45 pm, Mr Sulley remained irritable and demanding. He was given 400 mg of ibuprofen (an anti-inflammatory medication) for generalised pain to his legs and back.

56 At about 1.20 pm, Mr Sulley had finished his lunch and was in the communal dining room in ward 6. As he was making a drink, he staggered backwards, lost his balance and fell onto another patient who was seated nearby. He then fell to the floor.

57 Nearby nurses immediately went to assist Mr Sulley. His face and hands appeared cyanotic,[37] and although his airway appeared to be clear, there was

[35] Exhibit 1, Volume 1, Tab 27, Statement of Dr Winston Choy dated 10 January 2023 at attachment WC9
[36] Exhibit 1, Volume 2, Tab 2, BMHU Medical Records

no respiratory rate, and he was not breathing. Cardiopulmonary resuscitation (**CPR**) was commenced, and a Code Blue medical emergency was made at 1.24 pm.

58 CPR was continued with appropriate compressions and a bag mask ventilation was applied. Although CPR was maintained and four doses of one mg of adrenaline was given, Mr Sulley remained unresponsive. He was certified life extinct at 1.47 pm on 24 April 2020.[38]

CAUSE AND MANNER OF DEATH [39]

59 Forensic pathologists, Dr Clive Cooke and Dr Reimar Junckerstorff, conducted a post mortem examination on Mr Sulley's body on 1 May 2020. The examination found the presence of an abdominal hernia and signs of attempted resuscitation. There was a narrowing of the arteries on the surface of the heart (coronary arteriosclerosis) and a thickening of the heart muscle (left ventricular hypertrophy).

60 Microscopic examination of Mr Sulley's heart showed focal areas of scarring (fibrosis). Severe narrowing of the coronary arteries (arteriosclerosis) was confirmed. Mr Sulley's lungs showed changes of terminal aspiration and there was a mild fatty change in his liver. The other internal organs showed no significant abnormalities.

61 A neuropathology examination of Mr Sulley's brain detected no significant abnormalities.

62 Toxicological analysis of blood and urine samples from Mr Sulley detected the presence of chlorpromazine at a therapeutic level and olanzapine at a non-toxic level. Also detected were diazepam (a benzodiazepine to treat anxiety) and paracetamol at therapeutic levels. The levels of these drugs were consistent with the dosages of medications Mr Sulley had been prescribed when in hospital.

63 Alcohol and common illicit drugs were not detected in Mr Sulley's system.

64 The forensic pathologists noted:[40]

> Severe narrowing of the coronary arteries (arteriosclerosis) is strongly associated with the development of an abnormal beating rhythm of the heart (cardiac

[37] A bluish-purple colour indicating decreasing oxygen levels in the blood
[38] Exhibit 1, Volume 1, Tab 4, Bentley Health Service Death in Hospital by Dr Hitesh Prajapati
[39] Exhibit 1, Volume 1, Tabs 5.1-5.4, Supplementary Post Mortem Report, Amended Post Mortem Report, Full Post Mortem Report, Interim Post Mortem Report; Exhibit 1, Volume 1, Tab 6.1, Neuropathology Report dated 7 May 2020; Exhibit 1, Volume 1, Tab 7, ChemCentre, Toxicological Report dated 11 January 2021
[40] Exhibit 1, Volume 1, Tab 5.1, Supplementary Post Mortem Report, p.2

> arrhythmia) and subsequent sudden death. Antipsychotic medications, including chlorpromazine and olanzapine, can be associated with abnormal beating rhythms of the heart (cardiac arrhythmias), with a possible increased risk of arrhythmia occurring with combinations of drugs in the presence of pre-existing cardiac disease; however a definite effect of these medications cannot be identified at post mortem medical examination. It is likely that Mr Sulley has died as a result of an abnormal beating rhythm of the heart (cardiac arrhythmia) on a background of severe coronary artery arteriosclerosis.

65 At the conclusion of their investigations, the forensic pathologists expressed the opinion that the cause of death was coronary artery arteriosclerosis.

66 I accept and adopt the opinion expressed by the forensic pathologists as to the cause of Mr Sulley's death.

67 Accordingly, I find that death occurred by way of natural causes.

ISSUES RAISED BY THE EVIDENCE

Mr Sulley's discharge from RPH on 19 April 2020

68 A matter that was considered at the inquest was whether Dr Meintjes and/or PLN McGovern ought to have reasonably suspected that Mr Sulley needed an involuntary treatment order and completed a Form 1A so that he could be examined by a psychiatrist. After a careful consideration of all relevant evidence, I have found that no error had been made in discharging Mr Sulley from RPH on 19 April 2020.

69 Although Dr Meintjes and PLN McGovern were authorised to complete a Form 1A, only a psychiatrist may make an involuntary treatment order.[41] As it was evident that Mr Sulley would not agree to be admitted to hospital voluntarily, Dr Meintjes and PLN McGovern had to determine whether he required an involuntary patient admission with a referral to a consultant psychiatrist. In making that determination a medical practitioner (or an authorised mental health practitioner) must consider the criteria for an involuntary treatment order. Section 25(1) of the *Mental Health Act 2014* (WA) sets that criteria out as follows:

> A person who is in need of an inpatient treatment order only if all of these criteria are satisfied –
>
> (a) the person has a mental illness for which the person is in need of treatment;
>
> (b) that, because of the mental illness, there is –
>
> (i) a significant risk to the health and safety of the person or to the safety of another person; or

[41] *Mental Health Act 2014* (WA) s 24(1)

> (ii) a significant risk of serious harm to the person or to another person;
>
> (c) the person does not demonstrate the capacity required by section 18 to make a treatment decision about the provision of the treatment to himself or herself;
>
> (d) that treatment in the community cannot reasonably be provided to the person;
>
> (e) that the 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 an inpatient treatment order.

70 As a psychiatry registrar at the RPH emergency department, Dr Meintjes' common practice was to access PSOLIS to research a patient's history before he reviewed them.[42] Dr Meintjes' evidence was: *"We would look at the PSOLIS entries and notes to gain an understanding of the patient's background and recent events. Patients were always reviewed with that context in mind"*.[43]

71 Through PSOLIS, Dr Meintjes was able to access material relevant to Mr Sulley's mental health history, including the five-page mental health triage relating to his assessment and inclusion in the Start Court programme.[44] Dr Meintjes also accessed the mental health triage document completed by Mr Voight regarding the incident at the Hotel on 19 April 2020.[45]

72 Dr Meintjes telephoned Mr Voight to further discuss the particular circumstances of Mr Sulley's presentation to the emergency department.[46] That conversation took place at 8.30 pm on 19 April 2020, indicating it occurred just before the review of Mr Sulley by Dr Meintjes and PLN McGovern.[47]

73 As to the threats that Mr Sulley was heard to say at the Hotel, Dr Meintjes testified at the inquest:[48]

> I don't recall any evidence of him being directly threatening to anyone or directly violent to anyone, and I don't recall any need for police to engage in any sort of physical restraint, him directing any specific, you know, violent or threatening statements towards police other than him being rude to police. I don't think he actually directly threatened any of them, and certainly there was no evidence of him threatening anyone directly in the emergency department. And in general, this

[42] ts 16.1.23 (Dr Meintjes), p.21
[43] Exhibit 1, Volume 1, Tab 26, Statement of Dr Wesley Meintjes dated 9 January 2023, p.3
[44] Exhibit 1, Volume 1, Tab 26, Statement of Dr Wesley Meintjes dated 9 January 2023 at attachment WM2
[45] Exhibit 1, Volume 1, Tab 26, Statement of Dr Wesley Meintjes dated 9 January 2023 at attachment WM3
[46] ts 16.1.23 (Dr Meintjes), p.25
[47] Exhibit 1, Volume 1, Tab 26, Statement of Dr Wesley Meintjes dated 9 January 2023 at attachments WM3, p.3 and WM6, p.1
[48] ts 16.1.23 (Dr Meintjes), pp.33-34

> is not uncommon for someone with schizophrenia, particularly someone that has had a lot of stress, living homeless, possibly not feeling like they had much social support.
>
> ...
>
> However, this is completely in keeping with the possibilities of someone who could be a bit unwell, could be a little bit of an angry person, but by no means that they are very mentally unwell, and we should keep them in the emergency department.

74 Dr Meintjes continued:[49]

> [T]he reports of what he was doing and his behaviour at Pan Pacific and his dealings with other people, that could have been compatible with a man that was becoming psychologically unwell. However, our impression – once we saw him and gathered evidence and wrote notes, our impression was that he wasn't becoming psychotic – or at least there wasn't sufficient enough evidence for it at the time, based on the fact that we thought this could be in keeping with how he was previously seen before when he wasn't psychologically unwell.
>
> ...
>
> And so we thought that given Mr Sulley typically, you know, didn't quite like authority and was very annoyed by the Pan Pacific referring him to the emergency department and him being brought in by police, we thought that that would have sufficiently agitated him enough so that if he was psychologically unwell or becoming psychotic, he would have lacked the inhibition at some point to show hostile behaviour which was characteristic of what he had done before.

75 Dr Meintjes explained that with respect to the threats made at the Hotel, his review factored in what Mr Sulley's baseline was, rather than the baseline of the general population. He testified:[50]

> A lot of patients with mental health issues have an increase in risk to themselves or increase in risk to others above the general population. So, for instance, if they have a mental health disorder which makes them impulsive or makes them hostile or angry or perhaps misinterpret the intentions of others, it may be more likely for them to be violent towards other people ... compared to the population at large. Your role in the emergency department is to see if their risk is acutely or majorly increased or increased at all above their baseline, right, not above sort of – not in general.
>
> ...
>
> He has apologised, "I'm sorry; I didn't mean to" – that would've made us conclude that he's showing enough behavioural restraint to not be at massively increased risk, compared to what he normally is, keeping in mind that he's chronically probably slightly more increased – his risk of violence is slightly more increased compared to the general population.

[49] ts 16.1.23 (Dr Meintjes), p.35
[50] ts 16.1.23 (Dr Meintjes), pp.39-40

76 At the inquest Dr Meintjes accepted that with the benefit of hindsight, "*it was a possibility that he had early signs of emerging psychosis when we saw him on the 19th*".[51]

77 Dr Meintjes then said that at the time he reviewed Mr Sulley he did consider that his behaviour may have been an emerging psychosis.[52] However, he determined that: "*On the balance of probabilities at the time on the 19th, that there wasn't enough evidence that he was definitely having emerging psychosis for us to institute the Mental Health Act*".[53]

78 Dr Meintjes also considered it to be a relevant factor in his decision to discharge Mr Sulley that he was attending the Start Court on 22 April 2020. As he explained:[54]

> On the 22nd, there would be another point at which he would be assessed, and if he was looking even more unwell at this time, this would give longitudinal sort of context as to why he was becoming unwell, and then at that point, possibly, there would need to be the institution of the Mental Health Act for him to be treated or not.

79 For the reasons advanced by Dr Meintjes and PLN McGovern in their statements and their evidence at the inquest, I am satisfied that their joint decision to discharge Mr Sulley on 19 April 2020 was appropriate. To find otherwise would be inserting impermissible hindsight bias.

80 In conclusion, I should note that the Court undertook the following exercise during Dr Meintjes' evidence at the inquest. To compare Mr Sulley's presentation at the RPH emergency department on 19 April 2020 with his behaviour when he was apprehended by the MHCRU on 22 April 2020, Dr Meintjes was shown the first four minutes of the BWC footage from one of the MHCRU police officers.[55]

81 After viewing the BWC footage, Dr Meintjes testified that Mr Sulley's behaviour on 22 April 2020 was completely different to how he behaved on 19 April 2020. He said it was a lot more hostile, it contained direct threats to hurt people, he was making statements consistent with a person who was psychotic, and he appeared to be having a lot of tangential thoughts.[56] Dr Meintjes further stated that had there been evidence of Mr Sulley behaving

[51] ts 16.1.23 (Dr Meintjes), p.55
[52] ts 16.1.23 (Dr Meintjes), p.56
[53] ts 16.1.23 (Dr Meintjes), p.57
[54] ts 16.1.23 (Dr Meintjes), pp.57-58
[55] MFI 2
[56] ts 16.1.23 (Dr Meintjes), p.59

like that on 19 April 2020, it would have been a "*clear-cut decision*" to have him referred to a psychiatrist under a Form 1A.[57]

Dr Mark Hall's opinion

82 At the request of the Court, Dr Mark Hall, a consultant forensic psychiatrist, prepared a report which included his opinion as to Mr Sulley's presentation at the emergency department at RPH on 19 April 2020. Dr Hall stated:[58]

> Mr Sulley's attendance at the emergency department on 19 April 2020 was a missed opportunity to treat an emerging acute relapse of his psychotic illness. In my opinion, it is likely that Mr Sulley was sufficiently unwell at the time of his attendance at the emergency department, that the right questions would be [sic - have] elicited his psychotic symptoms and further informed management decisions.

83 In his evidence at the inquest, Dr Hall clarified the above passage:[59]

> And when I say, "missed opportunity", there are missed opportunities all the time. And I want to stress that I don't consider a missed opportunity to equate [to] an error of judgment. It was simply a missed opportunity. And that's a – the mental health services are fraught with this kind of issue. Because, you're dealing with people that don't have any insight, and the question of risk and detention and – and so forth. And so it's not an easy call to make.

84 Dr Hall was subsequently asked the following questions by Counsel Assisting:[60]

> So do you have a view as to whether or not Mr Sulley should have been kept at RPH on 19 April? --- I don't think it was possible to keep him. I don't think there were grounds to keep him.
>
> Right. So you don't think that Dr Meintjes should have placed Mr Sulley under – for example – a Form 1A or something like that? --- No. I don't. On the information that was available at the time and what I understand the discussions to have been, I don't think that there were sufficient grounds for that.

85 Ms Femia, counsel appearing for Dr Meintjes, also asked this question:[61]

> And you said in your evidence that you think Dr Meintjes made the right decision? --- Yes. Based on the information that he elicited, yes. It is entirely possible that had a more senior mental health clinician explored some issues with Mr Sulley, that more florid psychosis may have expressed itself or been elicited, but that wasn't

[57] ts 16.1.23 (Dr Meintjes), p.66
[58] Exhibit 1, Volume 1, Tab 19.1, Report of Dr Mark Hall dated 4 August 2022, p.12
[59] ts 18.1.23 (Dr Hall), p.171
[60] ts 18.1.23 (Dr Hall), p.172
[61] ts 18.1.23 (Dr Hall), p.178

> the case. Dr Meintjes went in there with a certain amount of experience and did what would be expected of someone with that amount of experience.

86 Dr Hall also gave evidence that although Dr Meintjes discussed his plans to discharge Mr Sulley with the emergency department team, a written record of that should have been made by Dr Meintjes.[62]

87 At the completion of the oral evidence at the inquest, I asked Ms Femia if she could obtain some instructions from Dr Meintjes regarding that evidence from Dr Hall. After taking those instructions, Ms Femia advised that Dr Meintjes' "*short response is yes*".[63] Through Ms Femia, Dr Meintjes added that working in the emergency department is "*dynamic*", nevertheless he accepted, "*a third-party would recommend adherence to policy and it would have been ideal*".[64]

88 Dr Hall also expressed the opinion that Dr Meintjes ought to have contacted the on-call consultant psychiatrist to discuss Mr Sulley's case.[65] As Dr Hall explained at the inquest:[66]

> [Mr Sulley's] mental state appears to be fluctuating. So he is clearly on a decline from baseline. The question is then: What do you do with that? So he was very clearly not minded to engage voluntarily in treatment. To be prescribed anything; to be referred to a mental health clinic. Let alone a voluntary inpatient admission. So then the question is, well, now what do you do? Would he have, at that stage, risen to the threshold of being able to make a referral for an examination by a psychiatrist under a Form 1A and all that would go with that? Including detention in the emergency department and his response to that. That's where I think – the role of the senior clinician or on-call psychiatrist comes in to a decision like that. And the decision may ultimately be, "Look, no, I don't think we are at that stage". But then the clinicians who are at the coalface dealing with him are able to – there's a rationale. You know. There's a sound rationale that has been considered by senior clinicians. So for me that was a – that would have been a dilemma about what do we do with him. And it would be – and with dilemmas it would have been important to discuss it with the psychiatrist on-call. That's what they are there for.

89 Dr Hall later clarified that it was not his evidence that had Dr Meintjes contacted the on-call consultant psychiatrist then Mr Sulley would have been the subject of a Form 1A.[67]

90 Dr Meintjes' explanation as to why he did not discuss Mr Sulley with the on-call consultant psychiatrist was because he and PLN McGovern, "*considered*

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[62] ts 18.1.23 (Dr Hall), p.169
[63] ts 18.1.23 (Ms Femia), p.186
[64] ts 18.1.23 (Ms Femia), p.186
[65] ts 18.1.23 (Dr Hall), p.166
[66] ts 18.1.23 (Dr Hall), p.166
[67] ts 18.1.23 (Dr Hall), p.172

Mr Sully's risk to himself and others at the time to be relatively low".[68] He said he would contact the on-call consultant psychiatrist if a case was "*a bit complex, a bit difficult, a bit borderline*".[69] He did not think Mr Sulley's case fitted that category.

91 At the end of the oral evidence at the inquest, I provided Ms Femia the opportunity to obtain further instructions from Dr Meintjes as to whether it would have been appropriate to have contacted the on-call consultant psychiatrist. Ms Femia's instructions were as follows:[70]

> Dr Meintjes accepts yes, it may have been appropriate, but wishes to qualify his answer as follows: He does not think the situation indicated – given [the] specifics of this case – it wasn't common practice to discuss discharge with the consultant psych during the day or night unless a very complex or borderline case presented itself where there was a difference of opinion between Dr Meintjes and the Psychiatric Liaison Nurse. And in this instance, he felt confident – given that substantial two decades experience of the Psychiatric Liaison Nurse that he was working with – that he did not need to make that phone call. He felt reassured.

92 After careful consideration of the evidence regarding this matter, I accept the explanations from Dr Meintjes as to why he did not contact the on-call consultant psychiatrist.

Mr Sulley's medical treatment at RPH on 22-23 April 2020

93 As referred to above, Mr Sulley was taken to the emergency department at RPH on the afternoon of 22 April 2020. For the 18 hours he was at the emergency department, no ECG[71] or blood tests were performed. Monitoring of Mr Sulley found he had low blood pressure and low oxygen saturation levels at some stages.

94 Dr Edward Briggs was an emergency registrar at RPH in April 2020. As to the absence of an ECG or blood tests being performed for Mr Sulley, he stated:[72]

> We would not ordinarily screen all Emergency Department patients with an electrocardiogram (ECG) or blood tests unless there were particular reasons to suspect relevant abnormalities (for example, toxicology risk assessments, or presenting symptoms of chest pain and breathlessness).
>
> We would not typically conduct these tests on a person presenting in a usual manner with a background chronic history of psychosis.

[68] Exhibit 1, Volume 1, Tab 26, Statement of Dr Wesley Meintjes dated 9 January 2023, at p.8
[69] ts 16.1.23 (Dr Meintjes), p.65
[70] ts 18.1.23 (Ms Femia), p.187
[71] An ECG records the electrical signal from the heart and is performed to check for heart-related conditions
[72] Exhibit 1, Volume 1, Tab 23, Statement of Dr Edward Briggs dated 21 December 2022, p.4

The RPH records of Mr Sulley's presentation do not indicate that an ECG or blood tests were necessary in the Emergency Department assessment.

95 During his stay at the emergency department, Mr Sulley complained of back pain and of pain "*everywhere*".[73] He was provided with pain relief medication. As to these complaints of pain, Dr Briggs stated: "*Migratory pain in itself wouldn't lead me to think that there is anything going on that would warrant a cardiac investigation*".[74]

96 I am satisfied that in accordance with emergency department policy and the absence of any complaint by Mr Sulley of specific chest pain and/or breathlessness, the fact no ECG or blood tests were performed to investigate any heart-related condition was understandable.

97 On 23 April 2020, Sandra Daniels, a registered nurse, was Mr Sulley's one-to-one nurse companion. At 7.30 am, Ms Daniels recorded in Mr Sulley's observations chart that his vital signs were within the normal limits, but his blood pressure was low at 97/60.[75] Given this reading, Ms Daniels notified the emergency department registrar. The registrar attributed the low blood pressure to the sedative medication that Mr Sulley had been given an hour earlier.[76]

98 By 8.00 am, Mr Sulley's blood pressure had risen slightly to 108/64, which was still considered to be low.[77]

99 Dr Briggs stated that when someone is given intravenous sedation, a lower blood pressure would be a side effect. He also noted that as Mr Sulley was not symptomatic and not complaining of anything firmly organic, the low blood pressure readings did not warrant any action other than further monitoring.[78]

100 Mr Sulley also had a pulse oximeter on his finger which measured his oxygen saturation levels. An oxygen saturation level of 93% or below would be an area of concern, particularly if other symptoms were present.[79]

101 At 10.00 am, Ms Daniels made an entry into Mr Sulley's continuation notes that he had "*some sleep apnoea*" and that his oxygen saturation levels were "*down 88% for short periods but returns to 98%*".[80]

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[73] Exhibit 1, Volume 1, Tab 31, Statement of Sandra Daniels dated 10 January 2023, p.6
[74] ts 16.1.23 (Dr Briggs), p.79
[75] Exhibit 1, Volume 1, Tab 31, Statement of Sandra Daniels dated 10 January 2023, p.4
[76] ts 17.1.23 (Ms Daniels), p.91
[77] Exhibit 1, Volume 1, Tab 31, Statement of Sandra Daniels dated 10 January 2023, p.5
[78] ts 16.1.23 (Dr Briggs), p.78
[79] ts 17.1.23 (Ms Daniels), p.91
[80] Exhibit 1, Volume 1, Tab 31, Statement of Sandra Daniels dated 10 January 2023, p.8

102 Ms Daniels testified that this reading, although below 93%, did not cause her concern. This was because sleep apnoea can be one cause for a lower reading and that sometimes a reading can also be interfered with if the patient clenches their finger or rolls on to their arm or bends their arm up.[81] As noted by Ms Daniels at the inquest: "*When he repositioned his arm and his neck, then his oxygen levels would come back to within a normal limit, in fact, a good amount at 98%*".[82]

103 Dr Briggs gave the same explanations for the lower reading. He also added that the intravenous sedation Mr Sulley had earlier received can cause more significant obstructive sleep apnoea episodes and this would also cause a drop in oxygen saturation levels.[83]

Mr Sulley was not physically assessed at BMHU

104 As I have already noted, Mr Sulley refused all requests from medical staff that he be physically assessed and have his bloods taken when he was at BMHU.

105 He refused to have physical observations performed during his admission at 11.50 am on 23 April 2020.[84] At 3.00 pm, Dr Zhang offered Mr Sulley a physical assessment and routine blood tests, but he again declined. Dr Zhang was of the view that given Mr Sulley's aggressive behaviour, she could not safely perform these tasks without his consent.[85] Dr Zhang repeated her offer to Mr Sulley on 24 April 2020 at 3.00pm. He again refused and Dr Zhang made a note for the weekend medical staff at Bentley Hospital to follow up. Dr Zhang's note also recorded that the plan was to "*continue to offer daily physical exam and routine bloods*".[86]

106 Mr Sulley's integrated progress notes do not have a record of whether he was asked to have a physical assessment on 25 April 2020.[87] At 1.45 pm on 26 April 2020, Matthew Kong, a registered nurse, recorded in Mr Sulley's integrated progress notes that he had refused to have his observations taken.[88]

107 Dr Choy was of the view that he would not ordinarily expect staff to restrain a patient for the purposes of a physical assessment, stating: "*It would not usually be good practice to physically restrain someone for that purpose in a mental health unit*".[89] Despite Dr Choy's long career in mental health, he had

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[81] ts 17.1.23 (Ms Daniels), p.96
[82] ts 17.1.23 (Ms Daniels), p.96
[83] ts 16.1.23 (Br Briggs), pp.76-77
[84] Exhibit 1, Volume 2, Tab 2, BMHU Medical Records, Integrated Progress Notes
[85] Exhibit 1, Volume 1, Tab 21, Statement of Dr Cathey Zhang dated 19 December 2022, p.5
[86] Exhibit 1, Volume 1, Tab 21, Statement of Dr Cathey Zhang dated 19 December 2022, p.5
[87] Exhibit 1, Volume 2, Tab 2, BMHU Medical Records, Integrated Progress Notes
[88] Exhibit 1, Volume 1, Tab 32, Statement of Matthew Kong dated 10 January 2023, pp.11-12
[89] Exhibit 1, Volume 1, Tab 27, Statement of Dr Winston Choy dated 10 January 2023, p.11

never seen a patient physically restrained so that a physical assessment could be performed.[90]

108 I agree with Dr Choy's evidence with respect to this matter. The patient's safety and the safety of hospital staff must take precedent in circumstances where a patient refuses to be physically assessed. Mr Sulley was not only a man who had a large build,[91] but he was also behaving aggressively for most of the time he was at BMHU. In those circumstances, I find that a physical assessment could only be performed if he not only consented, but also continued to co-operate during the assessment.

109 I should also add that my reading of the provisions in the *Mental Health Act 2014* (WA) which permit treatment to be given without the informed consent of the patient would not extend to an examination for the purposes of routine physical assessments and taking blood samples. Section 22(1) of the *Mental Health Act 2014* (WA) states:

> An inpatient treatment order is an order enforced under this Act in which a person can be admitted by a hospital, and detained there, to enable the person to be provided with treatment without informed consent being given to the provision of the treatment.

110 "Treatment" is defined in section 4 of the *Mental Health Act 2014* (WA):

> ***treatment*** means the provision of a psychiatric, medical, psychological or psychosocial intervention intended (whether alone or in combination with one or more other therapeutic interventions) to alleviate or prevent the deterioration of a mental illness or a condition that is a consequence of a mental illness, and does not include bodily restraint, seclusion or sterilisation.

111 In my view, it would require an unjustifiably broad reading of this definition of treatment to include a routine physical assessment and the taking of a blood sample without the informed consent of the patient.

112 As to the potential of a physical assessment and/or blood tests detecting the coronary artery heart disease that Mr Sulley had, Dr Zhang explained that one part of the assessment relevant to the heart involved an auscultation to ascertain heart sounds and murmurs using a stethoscope. She added: "*In terms of a heart problem, auscultating the heart can provide information about the heart rate, potentially the rhythm, and if there are any murmurs. However, it*

[90] ts 18.1.23 (Dr Choy), p.140

[91] The forensic pathologists recorded that he was 177 cm in height and weighed 106 kg: Exhibit 1, Volume 1, Tab 5.1, Supplementary Post Mortem Report, p.2

is by no means a comprehensive assessment of someone's health of their heart".[92]

113 Although an ECG would also be routinely done, Dr Zhang noted: "*It gives you very specific information about the patient's heart health. Mainly the electrical conduction of the heart which by itself would not be a comprehensive assessment of someone's heart health*".[93]

114 As to the detection of any coronary artery disease, Dr Zhang said that from her understanding, the definitive investigation would be a coronary angiogram.[94] However, a coronary angiogram would not be part of a patient's routine physical assessment.

115 Dr Zhang also explained that there was no single blood test that can confirm if a patient has or does not have a heart problem; it is only part of a bigger picture which would include a history from the patient, examinations, and other investigations as required.[95]

Did the antipsychotic medication given to Mr Sulley contribute to his death?

116 As already referred to above, the two forensic pathologists who performed Mr Sulley's post mortem examination noted that antipsychotic medications (including those administered to Mr Sulley) can be associated with cardiac arrhythmias, with a possible increased risk occurring with combinations of drugs and in the presence of a pre-existing cardiac disease.[96]

117 Dr Hall was of the view that the amount of psychotropic medications[97] prescribed to Mr Sulley at BMHU from 23 - 27 April 2020, "*would be considered moderate even in someone who was not as aroused and agitated as Mr Sulley*".[98] Dr Hall went on to state: "*In my opinion, Mr Sulley did not receive excessive or unsafe amounts of psychotropic medications*".[99]

118 At the inquest, Counsel Assisting asked Dr Hall whether he was concerned that the medications given to Mr Sulley had contributed to his death. Dr Hall responded:[100]

> No, it doesn't. Because it's very common to give that amount of medication to someone that agitated. And even if it had been known that Mr Sulley had [a] heart

[92] ts 17.1.23 (Dr Zhang), p.104
[93] ts 17.1.23 (Dr Zhang), p.106
[94] ts 17.1.23 (Dr Zhang), p.107
[95] ts 17.1.23 (Dr Zhang), p.104
[96] Exhibit 1, Volume 1, Tab 5.1, Supplementary Post Mortem Report, p.2
[97] Antipsychotic drugs are a class of psychotropic medications
[98] Exhibit 1, Volume 1, Tab 19.1, Report of Dr Mark Hall dated 4 August 2022, pp.12-13
[99] Exhibit 1, Volume 1, Tab 19.1, Report of Dr Mark Hall dated 4 August 2022, p.13
[100] ts 18.1.23 (Dr Hall), pp.162-163

> condition, it's likely that he still would have required that amount of medication. Unfortunately ... his mental state was not such that the sorts of physical investigations – physical observations – could be conducted safely.
>
> CORONER: Was there any alternative antipsychotic medication he could've received, if the doctors were aware of these heart conditions? --- No. I think that the medications that were chosen were appropriate. Even in the event that they had known about an underlying ischaemic heart disease.

119 As to the hypothetical situation of Mr Sulley's treating doctors being aware of his heart disease, Dr Hall further explained:[101]

> ... in that scenario your staff would be cognisant that the medications are being given to someone with an underlying heart condition. Absolutely. But the problem still remained that he was acutely psychotic and needed treatment. We can't leave him untreated because that's also a risk factor for his heart – for a cardiac event in the state that he was in. Also, it's not necessarily going to be safe for him, or for staff, to be approached and restrained to take observations or an ECG. That's not necessarily a sensible thing to do. So it is regrettable that in that sort of scenario you are, to some extent, flying blind. And on doing what you think on balance is going to provide the best outcome and the fastest recovery and settling effect.

120 I agree with these observations made by Dr Hall. I also agree with his assessment in his report that Mr Sulley's acute psychotic state, by itself, would have placed his heart under a serious strain and that the fatal consequence of that strain could not have been foreseen on the information that was available to his mental health service providers at the time.[102]

121 I also note the findings of the forensic pathologists that the actual effect of the antipsychotic medications prescribed to Mr Sulley could not be definitively identified from the post mortem examination.[103]

122 Upon consideration of all the evidence, I am unable to find to the requisite standard that the antipsychotic medications administered to Mr Sulley in the days before he died contributed to his death. Even if I was to find that was the case, no criticism could be made of the decision to prescribe these medications as they were necessary to treat Mr Sulley's acute psychotic episode.

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[101] ts 18.1.23 (Dr Hall), p.163
[102] Exhibit 1, Volume 1, Tab 19.1, Report of Dr Mark Hall dated 4 August 2022, p.13
[103] Exhibit 1, Volume 1, Tab 5.1, Supplementary Post Mortem Report, p.2

QUALITY OF MR SULLEY'S SUPERVISION, TREATMENT AND CARE

At RPH

123 In the early evening of 19 April 2020, Mr Sulley was brought to RPH by police due to aggressive and paranoid behaviour he had displayed that afternoon. He remained in the emergency department at RPH before he was discharged later that evening.

124 Overall, I am satisfied with the supervision, treatment and care Mr Sulley received at RPH during this short stay. Dr Meintjes did not make a written record of his conversations with the emergency department medical team as to his proposed discharge of Mr Sulley and did not contact the on-call psychiatrist to discuss Mr Sulley's case. Best practice would suggest that these tasks ought to have been completed by Dr Meintjes. However, I do accept that an emergency department is always dynamic and usually very busy, and I am not critical of Dr Meintjes' oversight in not performing these tasks. Similarly, I make no criticism of the decision by Dr Meintjes and PLN McGovern not to complete a Form 1A referring Mr Sulley for an examination by a psychiatrist. Based on the information they had at the time, I find that it was appropriate for Mr Sulley to be discharged.

125 I am also satisfied that the supervision, treatment and care of Mr Sulley at his subsequent presentation to the emergency department at RPH on 22 April 2020 was appropriate. He was carefully monitored by nursing staff overnight and although he did not have a psychiatric review, he was transferred in a timely manner to BMHU on the morning of 23 April 2020 where that review was to take place.

At BMHU

126 I am also satisfied that the supervision, treatment and care Mr Sulley received at BMHU from 23 - 27 April 2020 was appropriate. Although no physical assessment or blood sample was taken from Mr Sulley during this period, his refusal to give consent and his agitated demeanour provided sound explanations as to why these procedures did not take place. It was recorded he was asked on four occasions if a physical assessment and/or blood testing could be performed. Although there is no record on Mr Sulley's integrated progress notes that he was asked by medical staff to have these procedures performed on 25 April 2020 or on the day he died, I have little doubt that had he been asked he would have declined.

127 The decision by Dr Choy to make Mr Sulley the subject of a '*Form 6A – Inpatient Treatment Order in Authorised Hospital*' on 24 April 2020 was appropriate. I find that Mr Sulley was in urgent need of an involuntary

admission to an authorised hospital so that his psychotic illness could be treated.

128 I agree with Dr Hall's opinion that, "*Mr Sulley's care whilst an involuntary patient at Bentley mental health unit was to a high standard. Furthermore, the mental health staff at Bentley mental health unit could not have done anything differently to prevent Mr Sulley's death*".[104]

IMPROVEMENTS SINCE MR SULLEY'S DEATH

129 Dr Vinesh Gupta, the Medical Co-Director, Mental Health Division, Royal Perth Bentley Group, prepared a statement and gave evidence at the inquest regarding the improvements in the treatment of mental health patients that have been made since Mr Sulley's death.

130 These improvements have included the following:

- A new 12 bed mental health unit has been opened at RPH. It is a locked authorised ward which has meant that patients presenting at the RPH emergency department need not be transferred to BMHU. Although this unit had been closed at the time of the inquest due to structural issues, Dr Gupta expected that it would be re-opened.[105]
- There is now a process where individuals who present to the emergency department at RPH with mental health issues are directly assessed by the PLN who does the triage of that person and can decide whether the person should be discharged or admitted. This has the advantage of facilitating a quicker assessment.[106]
- Due to the significant shortage of consultants in psychiatry, the Office of Chief Psychiatrist has had amendments made to the *Mental Health Act 2014* (WA) that will enable senior psychiatry registrars and other suitably qualified doctors to have authority to exercise powers under the Act that had previously been reserved for consultant psychiatrists. Applications for these new roles have now closed, and it is intended that the selected applicants will undertake the necessary training, following which they will be permitted to use the Act without the involvement of a consultant psychiatrist.[107]
- There is a review underway regarding the provision of physical health care for mental health patients in the community and in inpatient services. One model from Canada that is currently being

[104] Exhibit 1, Volume 1, Tab 19.1, Report of Dr Mark Hall dated 4 August 2022, p.13
[105] ts 18.1.23 (Dr Gupta), pp.181-182
[106] ts 18.1.23 (Dr Gupta), p.182
[107] ts 18.1.23 (Dr Gupta), pp.182-183

looked at is where general practitioners attend mental health inpatient units to monitor and manage the physical health issues of patients in consultation with the mental health treating team.

131 I commend these changes that have either been implemented or are being considered by the Department of Health.

CONCLUSION

132 Mr Sulley had suffered from late-onset schizophrenia in the context of treatment he had received with prescribed amphetamines. He had no insight into his mental illness and his need for psychiatric treatment. Consequently, his mental health service providers had great difficulty engaging with him. He had had previous admissions to hospital for mental health issues and had spent long periods being homeless. Two months before his death, he had been released from Hakea Prison after he had been imprisoned on remand for three months.

133 On 19 April 2020, an acute relapse of Mr Sulley's psychotic illness was beginning. At about 6.00 pm, he was taken to the emergency department at RPH. However, he was discharged later that evening. Given the information available to the psychiatry registrar and the nurse responsible for that discharge, I have found that it was appropriate.

134 By 22 April 2020, Mr Sulley's psychotic illness had considerably worsened. After a short encounter with him, a MHCRU nurse made Mr Sulley the subject of a Form 1A, which was appropriate given his psychotic behaviour. An order under a Form 6A making him an involuntary inpatient at BMHU two days later was also entirely appropriate. Mr Sulley would have clearly posed a danger to himself and to others had either of those orders not been made.

135 Regrettably, Mr Sulley did not provide his consent for a physical assessment and for his bloods to be taken when he was at BMHU. Nor did he complain to hospital staff at RPH or BMHU of chest pain, breathlessness or other symptoms that may have indicated a heart condition.

136 Unfortunately, Mr Sulley's coronary artery disease, which was the cause of his death, remained undetected during his life. His most recent ECG had been performed on 20 May 2019 and had not revealed any abnormalities.

137 On 27 April 2020, Mr Sulley unexpectedly collapsed in a communal area in ward 6 at BMHU. Despite the prompt assistance provided to him by medical staff, Mr Sulley could not be revived, and he died a short time later.

138 It would be remiss of me not to note that Mr Sulley was treated during the early stages of the COVID-19 pandemic. This was a very difficult and challenging time for hospitals and their staff as they navigated the balancing act of providing optimal care for patients and preventing a potentially deadly outbreak of a virus within a hospital setting. As Dr Choy testified at the inquest: "*Despite over three decades as a medical practitioner with the Health Department, I have not seen the health system in that state as it was with the emerging pandemic*".[108]

139 After careful consideration of the documentary and oral evidence presented at the inquest, I am satisfied that the supervision, treatment and care Mr Sulley received at RPH and/or BMHU on 19 April 2020 and 22-27 April 2020 was appropriate.

140 Sadly, the following passages from Dr Hall's report apply to the circumstances that Mr Sulley was facing in the period before his death:[109]

> The psychiatric literature is replete with high-level evidence that individuals with chronic mental illness are at greater risk than the general population of all-cause morbidity and premature mortality, but particularly cardiovascular disease, due to multiple inter-related factors including stress, diet, difficulties accessing health care and healthy lifestyle options, unstable social circumstances, substance use particularly tobacco, problems with adherence to prescribed treatments, and adverse metabolic effects of psychotropic medications.
>
> In acute psychosis, there is physiological arousal with increased cardiac output. This is amplified when there is overt agitation and anger. Mr Sulley's acute psychotic mental state placed his heart under strain. However, given all the information that was at hand at the time, a serious pathological consequence of that strain could not have been foreseen.

141 I extend my condolences to the family of Mr Sulley.

PJ Urquhart
Coroner
13 February 2023

[108] ts 18.1.23 (Dr Choy), p.138
[109] Exhibit 1, Volume 1, Tab 19.1, Report of Dr Mark Hall dated 4 August 2022, p.13