Coroners Act 1996
[Section 26(1)]

Western ***Australia***

RECORD OF INVESTIGATION INTO DEATH

Ref: 23 /17

I, Sarah Helen Linton, Coroner, having investigated the death of ***James Michael Chee Ming YUNG*** *with an inquest held at the* ***Perth Coroner's Court, Court 51, CLC Building, 501 Hay Street, Perth*** *on* ***15 June 2017*** *find that the identity of the deceased person was* ***James Michael Chee Ming YUNG*** *and that death occurred on* ***20 June 2015 on Jarrahdale Road near Balmoral Road, Jarrahdale*** *as a result of* ***multiple injuries*** *in the following circumstances:*

Counsel Appearing:

Ms A Sukoski assisting the Coroner.
Ms N Eagling (State Solicitor's Office) appearing on behalf of the North Metropolitan Health Service.

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INTRODUCTION

1. James Yung (the deceased) died in a traffic crash in Jarrahdale on 20 June 2015. At the time of his death he was subject to a Community Treatment Order made under sections 76 and 79 of the *Mental Health Act 1996* (WA). Accordingly, the deceased came within the definition of an involuntary patient pursuant to section 3 of that Act.

2. As the deceased was an involuntary patient at the time of his death, he was a 'person held in care' for the purposes of the *Coroners Act 1996* (WA). In such circumstances, a coronial inquest is mandatory.[1] I held an inquest at the Perth Coroner's Court on 15 June 2017. The inquest was held jointly with the inquest into the death of another person, Mr Mamadou Diallo, who also died in a traffic collision in 2015 while subject to a Community Treatment Order. Both deaths raised the issue of the system in place for assessing fitness to drive in patients with chronic psychiatric conditions.

3. The documentary evidence included a comprehensive report of the investigation into the death by the Western Australia Police.[2] The author of the report was called as a witness at the inquest. In addition, evidence was heard from the deceased's supervising psychiatrist, Dr John Fletcher, and Dr Murray Chapman, who reviewed the deceased's records and provided an expert report on the quality of the deceased's supervision, treatment and care while he was subject to a Community Treatment Order.

4. The inquest focused primarily on the psychiatric care provided to the deceased while on the final Community Treatment Order prior to his death, as well as the circumstances of his death and the question of his fitness to drive given his psychiatric disorder.

THE DECEASED

5. The deceased was born on 11 May 1973 in Hong Kong. He later lived in the United Kingdom before moving to Australia with his parents in 1998. He held dual UK and Australian nationality and later spent some years living again in the United Kingdom before returning to live in Western Australia. He never married and had no children.

6. The deceased was highly intelligent and completed a university degree in mathematics and physics. He later tutored and taught mathematics and physics at the University of Western Australia. He enjoyed building electronics as a hobby.[3]

7. The deceased was also known to enjoy driving into the countryside alone to look into the sky and see the sun and the moon.[4]

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[1] Section 22(1) (a) *Coroners Act*.
[2] Exhibit 1.
[3] Exhibit 1, Tab 9 and Exhibit 2, Tab 1, London 2013 report, p. 4.
[4] Exhibit 2, Tab 1, Correspondence, Email 22.6.2015.

8. At the time of his death the deceased lived independently in a unit in Shenton Park. He was unemployed and received a disability pension as well as considerable financial and emotional support from his parents.[5]

BACKGROUND MEDICAL HISTORY

9. The deceased was first diagnosed with a mental illness in 1993, when he began to hear auditory hallucinations and developed delusional beliefs. His diagnosis varied and had at different times been labelled delusional disorder, paranoid schizophrenia and schizoaffective disorder. It was agreed he had a significant longstanding psychiatric illness with disturbances of mood, thought and perception and very disturbed behaviour. When untreated the deceased had a tendency to act on his delusional and mostly paranoid beliefs, causing significant distress to himself and potential harm to himself and to others.[6]

10. The deceased was not known to abuse substances or alcohol regularly, although he was known to infrequently binge on alcohol.[7]

11. The deceased had a number of physical medical illnesses, including type 2 diabetes, severe obesity and hypertension, but he did not regularly take any medications for these.[8]

12. The deceased was noted to have poor insight into his mental illness and poor judgment. He had a very strong history of poor compliance with medication, due to his poor insight and concerns about the side effects of his antipsychotic medication. This had led him to generally be treated by way of depot antipsychotic injection and he had been subject to a number of Community Treatment Orders under the *Mental Health Act.*[9]

13. The deceased had had a number of in-patient admissions in hospitals in both Australia and the United Kingdom.[10]

14. In 2013 the deceased travelled to the United Kingdom without consulting his parents. He initially stayed with his aunt but his disruptive and aggressive behaviour, including an obsession with "cleaning and purifying" things, caused his aunt to feel threatened and he was eventually admitted to a psychiatric hospital on 19 August 2013 with a diagnosis of schizoaffective disorder, manic type. He was admitted to a secure ward and treated with paliperidone depot injection and oral medication but he continued to be very disruptive, grandiose and delusional. He pursued a member of staff, threatened to kill medical staff and threw hot water at nursing staff. He also threatened to kill himself if he was administered depot medication. Over time his mental state improved sufficiently that he was able to be discharged on

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[5] Exhibit 1, Tab 13B.
[6] Exhibit 2, Tab 1, NOCC/PSOLIS, letter to Registrar Mental Health Review Board 22.5.2015 from Dr Fletcher.
[7] Exhibit 1, Tab 13B; Exhibit 2, Tab 1, NOCC/PSOLIS, letter to Registrar Mental Health Review Board 22.5.2015 from Dr Fletcher.
[8] Exhibit 1, Tab 13B, p. 15.
[9] Exhibit 2, Tab 1, NOCC/PSOLIS, letter to Registrar Mental Health Review Board 22.5.2015 from Dr Fletcher.
[10] Exhibit 2, Tab 1, NOCC/PSOLIS, letter to Registrar Mental Health Review Board 22.5.2015 from Dr Fletcher.

23 December 2013 and he travelled on a direct flight back to Australia accompanied by his cousin.[11]

15. Approximately two weeks after his return to Perth, on 7 January 2014, the deceased saw a new psychiatrist, Consultant Psychiatrist Dr John Fletcher, at the Subiaco Community Mental Health Service Clinic/Avro House where the deceased had been receiving psychiatric treatment for some years. Despite being on depot antipsychotic medication and sodium valproate the deceased's mood had deteriorated since his return from the UK. Dr Fletcher had to terminate the interview after approximately 15 minutes as the deceased presented as highly aroused with evidence of psychotic and manic features. The deceased was extremely threatening towards Dr Fletcher, who was concerned for his own safety during the interview. After terminating the interview Dr Fletcher arranged an involuntary admission to Graylands Hospital under Form 1 and Form 3 of the *Mental Health Act*. The deceased remained at Graylands Hospital for a period of 80 days, with most of that time being spent in a locked ward. Over the course of the admission his mental state fluctuated, but with a definite trend of improvement. After successful day leave and extended leave, as part of a graded discharge plan, he was discharged on 27 March 2014 on a Community Treatment Order.[12]

16. The deceased was admitted again as an involuntary patient to Graylands Hospital on 15 May 2014 after being referred on forms by Sir Charles Gairdner Hospital, where he had presented as psychotic and delusional after making threats to his father secondary to those delusional beliefs. The relapse was precipitated by non-compliance with his medication. The deceased was admitted for 36 days and was discharged on 18 June 2014, again on a Community Treatment Order.[13]

17. The deceased was last admitted as an involuntary patient to Graylands Hospital on 18 December 2014 due to a severe relapse after he was non-compliant with his medication. He expressed delusions of a religiose nature. The deceased was initially hostile and aggressive and was admitted to a locked ward. He spent long periods staring directly at the sun as he believed this helped his mind. He was resistant to taking his medications so various alternatives were introduced and eventually he was happy and compliant with a new treatment regime. When he became settled he was transferred to an open ward and after an admission of 83 days he was discharged on 10 March 2015 on a Community Treatment Order. He presented with good insight at that time and indicated he was happy to comply with his medication regime.[14]

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[11] Exhibit 2, Tab 1, Discharge Summaries, Westminster Adult Mental Health Services, 31.12.2013, pp. 2 – 3.
[12] T 13; Exhibit 2, Tab 1, NOCC/PSOLIS, letter to Registrar Mental Health Review Board 22.5.2015 from Dr Fletcher and Discharge Summary, Graylands Hospital, 27.3.2014.
[13] Exhibit 2, Tab 1, NOCC/PSOLIS, letter to Registrar Mental Health Review Board 22.5.2015 from Dr Fletcher.
[14] Exhibit 2, Tab 1, NOCC/PSOLIS, letter to Registrar Mental Health Review Board 22.5.2015 from Dr Fletcher and Discharge Summary, Graylands Hospital, 10.3.2015.

LAST COMMUNITY TREATMENT ORDER

18. As noted above, the deceased's last Community Treatment Order was started on 10 March 2015 by Consultant Psychiatrist Dr Rajan Iyyatol at Graylands Hospital. Consultant Psychiatrist Dr Fletcher at the Avro clinic was the deceased's community Supervising Psychiatrist for the order. The deceased also had a very experienced Community Mental Health Nurse, Mr Ray McCrystal, as his Case Manager and Responsible Practitioner.[15]

19. The deceased had been referred to the clinic in 2010 and remained a patient thereafter. Initially he had been treated by a different psychiatrist but his medical management was transferred to Dr Fletcher on 6 January 2014 and Dr Fletcher had continued to supervise his treatment from that date. The deceased was always managed as an involuntary patient while subject to a Community Treatment Order, and never as a voluntary patient, during that period.[16]

20. After his discharge from hospital in early March 2015, the deceased was reviewed by Dr Fletcher in a face-to-face meeting on 18 March 2015 and again with his parents and Mr McCrystal on 26 March 2015. The deceased at this time was noted to be inappropriate with a lot of his behaviour and at times disinhibited, but compared to other times he was relatively friendly and cooperative on this occasion.

21. The deceased continued to be managed by Mr McCrystal with overall supervision by Dr Fletcher.

22. On 9 April 2015 the deceased attended the clinic independently and received his depot injection. Following the injection he was interviewed by Dr Fletcher and Mr McCrystal. The deceased was normal in mood during the interview but did show features of schizophrenia and some symptoms of hypomania. The deceased complained of tiredness, but not specifically sedation, and expressed a strong belief that his tiredness was a side effect of the depot medication. Dr Fletcher acknowledged this was very possible. The deceased said he hated the injection as he wanted to exercise but felt too tired to do so and, as a result, he was getting more obese. The deceased stated categorically he would not take any medications, depot or oral, if he was not on a Community Treatment Order.[17]

23. Following the interview it was decided the deceased's Community Treatment Order would need to continue and Dr Fletcher altered the deceased's depot injections to three weekly (rather than four weekly), which was the highest recommended dose. He was rebooked for a further appointment, with an agreement that he would always have two clinicians present when dealing with him at the clinic due to his unpredictability, which posed a risk to the clinicians.[18]

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[15] T 12; Exhibit 2, Tab 1, NOCC/PSOLIS, letter to Registrar Mental Health Review Board 22.5.2015 from Dr Fletcher.
[16] Exhibit 1, Tab 13B.
[17] Exhibit 1, Tab 13B.
[18] Exhibit 1, Tab 13B.

24. On 8 May 2015 the deceased's father reported to the clinic staff some concerns about the deceased's behaviour. Mr McCrystal visited the deceased's unit but the deceased did not answer the door. The deceased's father sent emails to the clinic reiterating his concerns, which prompted Mr McCrystal to try telephoning the deceased on the morning of 12 May 2015 to arrange an appointment to assess his mental state. The deceased returned the call and was asked whether Mr McCrystal could visit his unit, but the deceased declined. During the afternoon of 12 May 2015 the deceased's father was spoken to and the deceased's father expressed the belief that the deceased was not taking his oral medications. Mr McCrystal visited the deceased's unit twice that afternoon but still could not make contact with him. Mr McCyrstal returned to the deceased's unit the following day but could not locate him. He also tried telephoning the deceased, without success.

25. Mr McCrystal eventually made contact with the deceased at his unit on 14 May 2015, at which time the deceased was relatively stable and said he "felt good."[19] He showed Mr McCrystal empty Webster packs to demonstrate that he was taking his oral medications, although he later admitted he had been throwing them in the rubbish bin as they were from a previous hospital discharge. Information also later came in from his pharmacy that he had not collected any new Webster packs since 20 April 2015. Nevertheless, at that time Mr McCrystal formed the view the deceased's mental state was stable with no detectable disorder displayed. The deceased was reminded that his depot would be due on 21 May 2015.[20]

26. The deceased did not attend his scheduled depot appointment on 21 May 2015. He was not able to be contacted by phone.[21]

27. The Community Treatment Order was due to expire on 9 June 2015 so Dr Fletcher provided a report to the Mental Health Review Board on 22 May 2015. Dr Fletcher set out the deceased's history, including reference to various incidents where the deceased had been threatening to medical and nursing staff, and concluded that the deceased had a severe psychiatric disorder that put him at some risk to himself but mostly to others. Dr Fletcher's view at that time was that the deceased had schizoaffective disorder, as he presented at times acutely psychotic in a schizophrenic way and at other times acutely manic in a bipolar looking syndrome, so he effectively had a dual diagnosis.[22] Dr Fletcher believed that the least restrictive option for the deceased was a Community Treatment Order due to his complete lack of insight, which meant he would not attend appointments or take medications voluntarily, especially if they were depot medications. Accordingly, Dr Fletcher recommended that the deceased's current Community Treatment Order be continued and the request for continuation was granted and the order extended until 9 September 2015.[23]

[19] Exhibit 1, Tab 13B.
[20] Exhibit 1, Tab 13B.
[21] Exhibit 1, Tab 13B.
[22] T 13; Exhibit 2, Tab 1, NOCC/PSOLIS, letter to Registrar Mental Health Review Board 22.5.2015 from Dr Fletcher.
[23] Exhibit 1, Tab 13B; Exhibit 2, Tab 1, NOCC/PSOLIS, letter to Registrar Mental Health Review Board 22.5.2015 from Dr Fletcher.

28. On the same day as the Mental Health Review Board hearing, the deceased was visited at his unit by Mr McCrystal and a colleague but no one answered the door.

29. The deceased eventually received his depot medication on 25 May 2015. His mental state was reviewed at that time and he was pleasant and showed no delusional beliefs. The deceased's father's belief that the deceased was relapsing was noted and there were some signs of breakthrough symptoms noted. However, the deceased was generally assessed as a low risk to himself or others at that time, although at moderate risk of impulsivity. At the end of the interview the deceased was reminded that his next depot medication would be due on 16 June 2015.[24]

30. Around this time a review of the deceased's case by the Multi-Disciplinary Team considered strategies to improve the deceased's compliance with his medication. It was agreed that if he was not compliant consideration would need to be given to revoking his order and placing him in a hospital.[25]

31. On 28 May 2015 the deceased did not attend a scheduled appointment with Dr Fletcher. However, the deceased's father attended and indicated he believed the deceased was "well and settled."[26] The deceased was rebooked to see Dr Fletcher on 3 June 2015.

32. The following day the deceased spontaneously attended the clinic. Although the deceased did not have an appointment Dr Fletcher agreed to see him so that he could assess the deceased's mental state and determine whether he was relapsing enough to require hospitalisation. Dr Fletcher saw the deceased with Mr McCrystal. The deceased commenced by indicating he wanted a long session with Dr Fletcher, which was unusual. Dr Fletcher noted the deceased was inappropriate in behaviour, suspicious and evasive and he admitted to being paranoid. He was also significantly thought disordered. The deceased admitted he had stopped his oral medication the day he came out of Graylands Hospital and stated he was sick of his medication and thought it was rubbish so he had thrown it in the rubbish bin. He also expressed a desire to reduce his depot injection. At the same time, the deceased expressed fear that he would be sent back to Graylands.[27]

33. During the interview the deceased stated he had booked a ticket to fly to London on 5 June 2015 so that he could relax and receive medical treatment there. He also expressed a delusional belief he was doing a task for the UK government. The deceased's parents joined the interview and indicated they were unaware that he had bought a ticket to London and they believed the deceased's passport had expired. The deceased was asked if he would give his passport to his parents, which he refused, but he indicated he would give it to Mr McCrystal (although this never eventuated). The deceased became progressively rude and aggressive towards his parents as the interview

[24] Exhibit 1, Tab 13B.
[25] Exhibit 1, Tab 13B.
[26] Exhibit 1, Tab 13B.
[27] T 15; Exhibit 1, Tab 13B.

continued and eventually his parents left the interview. After they left the deceased was observed to settle considerably.[28]

34. The deceased was assessed as being in the early stages of a relapse secondary to non-compliance with his oral medications and having his depot injection late. The possibility that he might need to be put into an inpatient ward was discussed with him and he strongly requested that they did not do so. Dr Fletcher described the deceased as being "absolutely terrified of being admitted to Graylands Hospital."[29] The deceased promised he would take an alternative oral medication tablet, such as Abilify, which he had taken in the past. It was agreed that he would be changed to Abilify at a dose of 15mg daily. He was also noted to be up to date with his depot medication. The deceased asked to be assessed again after the coming long weekend as he believed he would be much improved.[30]

35. It was noted that the deceased was very close to sufficiently relapsing to require readmission to hospital but Dr Fletcher did not think that hospitalisation was absolutely necessary at that time as the deceased's mental state traditionally fluctuated and it was thought he might settle down over the next few days. The clinic staff were also aware that there were five other people already on the waiting list for a locked inpatient bed in an authorised hospital over the long weekend. The decision was therefore made to reassess the deceased on the Tuesday following the long weekend. He was asked to come in at any time that day and see Mr McCrystal, and Dr Fletcher if required.[31]

36. The deceased was not thought to be at great suicidal risk or as presenting a significant risk to others, despite his deteriorating mental state. However, it was suggested that the deceased's parents avoid contact with him over the weekend if he seemed aggressive.[32]

37. The deceased attended his pharmacy on Monday, 1 June 2015 and collected his Webster pack with his new oral medication, Abilify.

38. On Tuesday, 2 June 2015 the deceased did not attend the clinic as requested. Mr McCrystal tried to visit him at his unit, but he was not at home. An appointment card was left for him for the next day.

39. The following day, being Wednesday 3 June 2015, the deceased telephoned Mr McCrystal but he was out of the office so Dr Fletcher took the call. The deceased appeared relatively calm and pleasant but announced he was in Melbourne and intended to stay there for the next two weeks "in order to have a holiday."[33] He refused to give the name of the hotel where he was staying. The deceased claimed to be compliant with the Abilify and said it had made him calmer and less anxious. He also stated he believed the depot injection was helping him but wanted to negotiate a reduced dose with the

[28] T 15 – 16.
[29] T 16.
[30] T 16; Exhibit 1, Tab 13B.
[31] Exhibit 1, Tab 13B.
[32] Exhibit 1, Tab 13B.
[33] Exhibit 1, Tab 13B.

next injection. The deceased sounded much more normal and appropriate during the call than he had at the last interview. He gave Dr Fletcher his telephone number and said he was happy for Mr McCrystal to telephone him in the afternoon.[34]

40. Dr Fletcher also notified the deceased's parents that the deceased had rung to say he was in Melbourne. They rang the deceased on his mobile telephone and he answered and spoke to them. He told them that he was there for a holiday and was intending to buy some clothes and to hire a car and drive to Sydney. They later tried to call him again but his phone was switched off.[35]

41. As the deceased had left Western Australia he was technically no longer under the jurisdiction of the *Mental Health Act*. Dr Fletcher had the option to revoke the Community Treatment Order in those circumstances, noting that it appeared the deceased had absconded to avoid the involuntary treatment. However, Dr Fletcher was concerned that the deceased may be lying about his whereabouts and could still be in Western Australia. Alternatively, if he had left the state he could return to the jurisdiction at any time. The advantage of continuing the current order in those circumstances was that if or when the deceased was found, the clinicians could more effectively reinstitute treatment and management without delay.[36]

42. Dr Fletcher therefore made the decision to continue the deceased on the Community Treatment Order, which he later extended for another six month period on 9 June 2015.[37] The order remained in effect at the time of the deceased's death, although he was not seen again by the clinic staff prior to his death.

43. Dr Fletcher explained at the inquest that they were aware that the deceased had absconded to Melbourne in the past but they had been more focussed on his threat to abscond to London at the time of the last interview, but had been reassured by the fact that he didn't have a valid passport.[38]

EVENTS IN MELBOURNE

44. On 9 June 2015 Dr Fletcher received a fax from Virgin Australia at 1.30 pm informing him that the deceased had boarded a flight in Melbourne and an incident had occurred on board during which the deceased was behaving erratically.[39] This caused the aircraft to return to the gate and the deceased was removed from the flight. The fax requested Dr Fletcher to complete a medical certificate certifying that the deceased was fit to fly. Dr Fletcher immediately telephoned Virgin Australia and informed them that the deceased was categorically not fit to fly and asked that the deceased be put on a 'watch list' or 'do not fly' list so that other airlines would also be alerted

[34] T 16; Exhibit 1, Tab 13B.
[35] Exhibit 1, Tab 16.
[36] Exhibit 1, Tab 13B.
[37] Dr Fletcher noted that under the new *Mental Health Act 2014* (WA)it appers this option would no longer be possible once the deceased had absconded – Exhibit 1, Tab 13B, p. 13.
[38] T 16.
[39] He was apparently smoking on the aircraft, which is not permitted. See Exhibit 1, Tab 15, Email from Federal Agent Bruce Segrave, dated 7 July 2015.

to the situation if the deceased attempted to board another flight. Dr Fletcher was conscious of the fact that he was breaching the deceased's confidentiality in doing so, but believed he owed a duty of care to the deceased and other passengers to ensure the deceased did not fly until he had been reviewed by a psychiatrist.[40]

45. Dr Fletcher was advised that Virgin Australia would inform the other airlines that fly to Perth that the deceased should not be allowed to board until he had a medical certificate from a consultant psychiatrist certifying that he was fit to fly.[41] Dr Fletcher was also told that airline staff would arrange for the deceased to be put in a taxi to take him to hospital for assessment. It is not clear if this occurred.

46. In the early hours of the following day, being 10 June 2015, the deceased came to the attention of the Australian Federal Police at the Melbourne Airport. Police officers located the deceased in a smoker's area at the airport at about 1.45 am, following a complaint. There is a suggestion the deceased had tried to gain admission to an exclusive airport lounge and attempted to set a person's hair on fire.[42] Police checks identified that the deceased suffered from schizophrenia and when questioned he advised that he had not taken his medication for nearly a month and was feeling extremely anxious. The deceased admitted to hearing voices in his head and exhibited unusual speech and behaviour. The police officers requested an ambulance attend. The ambulance officers assessed the deceased and determined he needed further medical examination in a hospital. He was taken by ambulance to the Royal Melbourne Hospital.[43]

47. On arrival at the hospital the deceased became agitated and was hostile to staff. He expressed paranoid ideas and refused treatment. He was placed on an assessment order under the Victorian equivalent of the *Mental Health Act* and given some sedatives. He was placed in a high observation cubicle after being medicated to await transfer to a mental health Intensive Care Area. At 4.21 am he was checked and appeared to be sleeping. At 5.18 am he refused to allow nurses to do his observations, stating that he was going to go. He was checked by nurses three more times at 7.15 am, 7.22 am and 9.39 am, and appeared to be sleeping on each occasion. Nursing notes recorded he was last seen going to the bathroom at about 11.30 am and was discovered missing at 12.14 pm. Security camera footage showed the deceased had left his room at 11.23 am and gone to the waiting room of the Emergency Department. He sat there for approximately 10 minutes and then absconded from the hospital via an exit. He was reported as missing person to police and an incident report was completed.[44]

48. On 14 June 2015 the deceased was approached by two Australian Federal Police officers on patrol at Melbourne Airport. He was seen staring into the flame of his cigarette lighter for a prolonged period (which the deceased's father confirmed is something that the deceased would do when he was

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[40] T 19.
[41] T 19.
[42] Exhibit 1, Tab 14.
[43] Exhibit 1, Tab 9 and Tab 15, Email from Federal Agent Bruce Segrave dated 7 July 2015.
[44] Exhibit 1, Tab 9, Tab 14 and Tab 15, Email from Federal Agent Bruce Segrave dated 7 July 2015.

'having an episode' or unwell).[45] His speech was also noted to be unusual. The deceased told the officers he had a room at the Park Royal Hotel, which was confirmed, and had come to the terminal to buy cigarettes. The police officers made enquiries and noted his earlier history of absconding from the Royal Melbourne Hospital. It was noted by police that no formal treatment order was in place and a new psychiatric assessment process would have to be initiated. The deceased admitted that he had been in hospital and confirmed he received a monthly medication injection. He told the officers he was not willing to return to the Royal Melbourne Hospital voluntarily and from their observations he did not appear sufficiently unwell to require being apprehended under s 351 of the *Mental Health Act 2014* (Vic). The deceased was allowed to return to his hotel room, which he had booked for several more days.[46]

THE DECEASED'S RETURN TO PERTH

49. The deceased returned to Perth on 18 June 2015. He reportedly managed to board a plane, despite the attempt by Dr Fletcher to have him on a watch list. It does not seem that the deceased drew any attention to himself or aroused any concerns while on the flight.[47]

50. The deceased's parents became aware of his return during the afternoon of 18 June 2015 when they received a telephone call from the Manager of the deceased's favourite Chinese restaurant in Perth, which he commonly frequented. The Manager rang to inform them that the deceased was dining there. The deceased's parents quickly went to the restaurant and joined him for dinner. During dinner the deceased informed them that he had lost his keys and his luggage.[48]

51. After dinner the deceased's parents took the deceased home and used their spare key to help him enter his unit. They arranged to meet the deceased the following day for lunch with the plan to then take him to the airport to collect his car.[49]

52. The deceased's parents informed the staff at the Avro Clinic the next day that the deceased had returned to his apartment in Perth and was looking reasonably well.[50] Clinic staff immediately went to his apartment and made other attempts to contact the deceased, without success.[51]

53. On 19 June 2015 the deceased had a late lunch with his parents and then his father took the deceased to the airport. They retrieved the deceased's car at about 6.00 pm and paid the parking fee with the deceased's father's credit card. The deceased's father then left the deceased alone while he went to the toilet. He was expecting the deceased to wait for him as the deceased was still holding his father's credit card. However, when he returned he found the

[45] Exhibit 1, Tab 16 [29].
[46] Exhibit 1, Tab 15, Email from Federal Agent Bruce Segrave dated 7 July 2015.
[47] T 19.
[48] Exhibit 1, Tab 16.
[49] Exhibit 1, Tab 16.
[50] T 19.
[51] T 20.

deceased had left. The deceased's father also left the airport and drove to collect his wife from the city. He collected her at 7.15 pm and they drove together to the deceased's unit. They saw that the deceased's car was not in the car park of the units so they did not go to his unit.[52]

54. During the time that the deceased's parents spent with him after his return to Perth, the deceased appeared in a good mood and there was nothing significant about his behaviour that concerned them.[53] He had been discussing future plans to accompany his parents on a cruise and seemed to be happy and forward thinking.[54] However, Dr Fletcher noted that the evidence suggests the deceased had been unwell in the last days he was in Melbourne, had probably not been taking his oral medication and was overdue for his depot medication, so he was very likely more unwell than was visible at the time he returned to Perth.[55]

DISCOVERY OF THE CRASH

55. At 4.21 am on Sunday, 20 June 2015 a report was received at Police Operations Centre of a large tree branch having fallen across Jarrahdale Road, near Balmoral Road in Jarrahdale. The report was made by a truck driver who was passing through the area and observed the tree blocking the roadway in a gully at the bottom of a steep decline. At the time he observed the fallen tree the truck driver noted that the weather was "atrocious with wet roads and very windy conditions."[56] The driver did not see a vehicle in the area, but he was concerned that a vehicle may have hit the tree and caused it to fall. He was unable to stop his truck in that location as it was in a gully on a single lane, narrow, winding road.[57]

56. Two police officers were tasked to attend the area, with the report from the truck driver being that there was an obstruction on the road.[58] First Class Constable Aveling and Constable Ginbey attended the location of the fallen tree on Jarrahdale Road at approximately 5.45 am that same morning. They exited their police vehicle and shone a torch down towards the nearby brook, which immediately revealed a vehicle on its roof. The two police officers ran down to the vehicle and observed the deceased in the driver's seat, still held in by his seatbelt. First Class Constable Aveling requested an ambulance attend over the radio and then climbed in through the open driver's window to check on the deceased. She found he was unresponsive and cold to the touch and it appeared he had died some time before. They confirmed that there were no other persons in the vicinity and then kept the area secure until the ambulance arrived and his death was confirmed.[59]

57. Police officers from the Major Crash Investigation Section of WA Police examined the scene and observed that the speed limit in the location was

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[52] Exhibit 1, Tab 16.
[53] Exhibit 1, Tab 16.
[54] T 20, 24; Exhibit 1, Tab 13B, p. 14.
[55] Exhibit 1, Tab 13B, p. 14.
[56] Exhibit 1, Tab 17 [12].
[57] Exhibit 1, Tab 17.
[58] T 8 – 9.
[59] Exhibit 1, Tab 18.

80 km/hr and the road surface was still wet when they attended but in otherwise good condition. There are no street lights in the area. A series of tyre marks were visible on the roadway's southern verge leading towards the deceased's black Toyota hatch vehicle, which was upside down about six metres from the southern edge of the road to the eastern side of a tree. The Toyota had sustained extensive impact damage to its front end.[60]

58. The deceased's vehicle was later examined by police vehicle investigators and found to have sustained crash caused impact damage to the front but had nil defects that might have contributed to the crash.[61]

59. The physical evidence at the scene caused the investigators to conclude that the deceased's vehicle the Toyota travelled southwest along Jarrahdale Road and entered a left hand bend. The vehicle failed to negotiate the bend and left the roadway, travelling onto the southeast verge. The vehicle has then rolled to its left side as it 'launched' over the gully before landing back on the ground and striking a tree. The vehicle then rebounded and rolled onto its roof, where it came to rest. There were no signs of braking prior to the vehicle becoming airborne.[62]

60. Data from the vehicle's airbags, which deployed after impact, indicated the deceased's vehicle was travelling at or in excess of 126 km/hr as it approached the collision area. The deceased was applying steering input, which caused the vehicle to slide slip and leave the carriageway. The deceased did not brake. A crash reconstruction officer, Senior Constable Callaghan, concluded the initial speed of the vehicle, which was approximately 46 km/hr above the posted speed limit, in combination with the undulating and sinuous carriageway and wet road surface, resulted in a loss of lateral stability and control.[63]

CAUSE OF DEATH

61. At the request of the deceased's family a full post mortem examination was not conducted. On 23 June 2015 a Forensic Pathologist, Dr Jodi White, performed an external examination of the deceased. Dr White also received some information on the deceased's past medical history and the circumstances of the crash. At the conclusion of the initial external examination the cause of death was given as undetermined, pending limited toxicology, radiology and review of significant further medical information.[64]

62. The radiology results demonstrated an evident skull fracture consistent with the external findings, as well as possible fractures to the upper thoracic spine, left-sided ribs and right-sided pelvis. Limited toxicology showed no evidence of alcohol or drugs.[65]

[60] Exhibit 1, Tab 9, Tab 11 and Tab 20.
[61] Exhibit 1, Tab 10.
[62] T 7, 9; Exhibit 1, Tab 11.
[63] T 7, 10; Exhibit 1, Tab 9 and Tab 11.
[64] Exhibit 1, Tab 4.
[65] Exhibit 1, Tabs 5 – 7.

63. At the conclusion of these limited investigations, Dr White formed the opinion the cause of death was consistent with multiple injuries.[66]

64. I accept and adopt the conclusion of Dr White as to the cause of death and find that the death occurred as a result of multiple injuries.

MANNER OF DEATH

65. Looking at the circumstances of the crash and the events leading up to the day of the crash, both suicide and accident appear open on the evidence. Accordingly, I made further enquiry of the witnesses at the inquest, to see if their evidence could assist me to be satisfied that one was more likely than the other.

66. Senior Constable Mawdesley, who was the investigating officer in this matter, concluded that the crash resulted from a combination of factors, including speed, the poor weather conditions and the road layout. He stated it was "a classic case of just travelling ... too fast on a wet, winding road that's in the dark"[67] and there was no evidence to suggest it was an intentional act, in the sense of the deceased deliberately intending to cause the car to leave the roadway. As Senior Constable Mawdesley observed, "[p]eople make poor judgments all the time when they're driving"[68] and there was nothing about the circumstances of this case that suggested it was anything other than an ordinary case of poor judgment.[69]

67. In that regard, I also take note that Mainroads Western Australia investigated the matter and prepared a report, which indicated that while no road environment issues directly related to crash causation were identified, there were some findings in relation to insufficient guide posts to delineate the road section, particularly at night time, as well as no curve warning signs to adequately warn drivers of the presence, and the severity, of the curve, which could possibly have contributed to the crash. An accompanying Crash Patterns Report also suggested that the area was prone to single vehicle collisions. These findings support the conclusion that the road layout may have contributed to the crash, particularly when considered in the context that the deceased was driving on a wet road in the dark at an excessive speed.[70]

68. The deceased had no significant history of self harm, such as occurs with people with emotional dysregulation due to personality disorders. He did once burn himself with a cigarette while in hospital, but this was thought to be related to psychotic symptoms rather than deliberate self harm or suicidal ideation.[71] There were also reports that he had told relatives he had thought of jumping off a building[72] and he had threatened to kill himself if

[66] Exhibit 1, Tabs 5 - 7.
[67] T 11.
[68] T 11.
[69] T 11.
[70] Exhibit 2, Tab 12.
[71] Exhibit 1, Tab 13B.
[72] Exhibit 2, Tab 1, NOCC/PSOLIS, letter to Registrar Mental Health Review Board 22.5.2015 from Dr Fletcher; Exhibit 2, Tab 1, Discharge Summaries, Westminster Adult Mental Health Services, 31.12.2013, pp. 2 – 3.

given depot medication while he was hospitalised in the United Kingdom, but neither threat had led to any actual attempt to harm himself.

69. Dr Fletcher, who was his last treating psychiatrist, was asked his opinion as to the likelihood that the deceased had an intention to take his life at the time of the crash. Dr Fletcher observed that the deceased "was very, very seldom suicidal,"[73] but acknowledged that the deceased had mentioned to him on 29 May 2015 that he "wanted to ask some people what it was like to be dead."[74] Dr Fletcher noted that this was a very unusual thing for him to ask as he was not generally thought to be a strong suicide risk, other than many years before when he was treated at a different clinic.[75] Dr Fletcher noted that the deceased did, however, notoriously have a fluctuating level of judgment, which could result in him behaving recklessly.[76]

70. The deceased's parents told Dr Fletcher that they were aware that the deceased liked looking into the sky and liked to travel into the countryside to look at the stars, the moon and the sun. Therefore, it was not unusual for the deceased to be out in his car at that time of night on a country road. They believe the deceased was cheerful and behaving relatively normally when they saw him not long before his death and it is their belief that he did not commit suicide.[77]

71. With the caveat that the deceased had not been psychiatrically assessed in the days before his death, Dr Fletcher also expressed the view that it was unlikely the deceased had deliberately caused his vehicle to crash. Based upon his knowledge of the deceased's mental illness, Dr Fletcher expressed the opinion the deceased's behaviour was more likely to be impulsive and reckless rather than done with a deliberate intention to take his life.[78]

72. On the evidence before me, placing particular emphasis upon the deceased's lack of suicidal behaviour in the past, known habit of driving into the countryside at night and the difficult road conditions in that location at that time, I am satisfied that there is no persuasive evidence the deceased had an intention to take his life at the time of the crash and I find his death occurred by way of accident.

QUALITY OF SUPERVISION, TREATMENT AND CARE

73. Under s 25(3) of the *Coroners Act 1996*, where a death investigated by a coroner is of a person held in care, the coroner must comment on the quality of the supervision, treatment and care of the person while in that care.

[73] T 25.
[74] T 25.
[75] T 25; Exhibit 1, Tab 13B.
[76] T 25.
[77] Exhibit 1, Tab 13, p. 15.
[78] T 25.

General supervision, treatment and care

74. Consultant Psychiatrist Dr Murray Chapman, who has extensive experience in clinical psychiatry and also has an Adjunct Associate Professorship within the School of Psychiatry and Clinical Neurosciences at the University of Western Australia, was requested by the Court to review this case as an independent expert and provide an opinion on the quality of the care provided to the deceased and the appropriateness of him being placed on a Community Treatment Order given his lack of compliance with taking his prescribed medication. Dr Chapman prepared a detailed written report and also gave oral evidence at the inquest.[79]

75. Having reviewed the medical records, Dr Chapman observed that following the deceased's initial diagnosis in 1993, it is likely that he was never fully well again.[80] Dr Chapman agreed that final diagnosis of Schizoaffective Disorder appeared reasonable.[81]

76. Dr Chapman noted that after several years the deceased's treatment had moved from the private sector into the state-run system, which he observed often reflects a degree of lack of insight or agreement between the person affected and the treating person or team. Dr Chapman also observed that the change to the state-run system coincided with a change from predominantly oral medication delivery to depot medication delivery, which he considered was a difficult place to start a relationship with a patient as depot medication is a "hard sell."[82] Establishing a therapeutic relationship would also have been made more difficult by the deceased persecutory delusional beliefs when unwell, as they extended to include various members of his mental health staff.[83]

77. From his experience Dr Chapman is aware community clinics in the city environment are besieged by needy patients and have limited and finite resources, so he acknowledged that there has to be an element of triaging and identifying people at times of increased risk. He thought this was reflected in the notes in the case of the deceased, but agreed that when the deceased experienced an escalation of symptoms, it was always dealt with in a prompt manner.[84]

78. In looking at the care provided by the most recent psychiatric care team, Dr Chapman expressed the view that it showed a consistent attempt to work with the deceased and his family to try to balance the deceased's autonomy and dignity with an attempt to treat and, if not cure, at least ameliorate the symptoms of his severe mental illness. Dr Chapman thought this was done with good intent to try to maintain some sort of therapeutic relationship, and in the spirit of the *Mental Health Act*. He noted there were also attempts by the treating team to modify the deceased's medication regime in order to minimise unwanted effects whilst maximising any therapeutic response,

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[79] Exhibit 1, Tab 8.
[80] Exhibit 1, Tab 8, p. 9.
[81] Exhibit 1, Tab 9, p. 9.
[82] T 31.
[83] Exhibit 1, Tab 8, p. 9.
[84] T 32.

which was a difficult exercise.[85] Dr Chapman expressed the view that the attempts by the treating team to try and find a medication regime that was acceptable to the deceased were very good, but sadly he did not think that this was ever quite possible.[86]

79. Dr Chapman acknowledged that the records showed the deceased recurrently became increasingly unwell, not always for very clear reasons but often because he discontinued or avoided his medication. In Dr Chapman's experience this is not an unusual situation with someone with this type of disorder.[87]

80. When he was hospitalised the duration of the deceased's admissions were long, particularly the last one, which Dr Chapman thought indicated the severity of the deceased's illness. He observed that these sorts of disorders can become progressively harder to treat over time, particularly with the re-emergence of symptoms, which appeared to be the case here.[88]

81. In Dr Chapman's opinion it was reasonable for the deceased to be discharged from Graylands Hospital on the last occasion under the terms of a Community Treatment Order (as had occurred before) as this would have been the least restrictive option available, which was an important principal under the Act. At that time the deceased no longer warranted admission, but there was a very high likelihood of him being non adherent to medications if released into the community voluntarily, which the Community Treatment Order might avoid. Dr Chapman also noted the CTO was upheld by the Mental Health Review Board.[89]

82. Dr Chapman was asked his opinion about allowing the deceased's Community Treatment Order to continue when he had claimed that he had left the jurisdiction. Dr Chapman agreed that the approach of the deceased's treating team was reasonable, for the same reasons as given by Dr Fletcher.[90] He also considered that the description of the deceased's behaviour and appearance on his return to Perth suggested there would have been no basis to revoke the Community Treatment Order if the deceased had been able to be assessed.[91]

Fitness to hold a driver's licence

83. In addition to an opinion on the level of treatment and care provided to the deceased, Dr Chapman was also asked his opinion on whether it was appropriate for the deceased to hold a driver's licence, given his level of mental illness. Further, Dr Chapman was invited to comment on current practices for the assessing of fitness to drive in patients with chronic psychiatric problems, and whether these practices need to be reviewed.

[85] T 30 – 31; Exhibit 1, Tab 8, p. 9.
[86] T 32.
[87] T 31.
[88] T 31.
[89] Exhibit 1, Tab 8, p. 10.
[90] T 32 – 33.
[91] Exhibit 1, Tab 8, p. 10.

84. The components of assessment of fitness to drive, from a psychiatric perspective, are generally restricted to the issues as set out in the text of the Austroads 'Assessing Fitness to Drive for commercial and private vehicle drivers' guidelines, which sets out the medical standards for licensing and clinical management guidelines. The document is produced by the National Transport Commission.[92] Dr Chapman explained the guidelines are quite general and make it clear that there is wide variation within diagnostic groups and that any assessment needs to be tailored to the individual, taking into account multiple sources of information if possible.[93]

85. The Department of Transport was aware that the deceased suffered from a psychiatric illness and that he was treated for these conditions with various psychotropic medications.[94] The deceased's fitness to drive was required to be assessed annually because he had a psychiatric disorder.[95] Dr Chapman noted that a number of psychiatrists had been involved in the deceased's care over the years and a number of them had occasion to address the issue of his fitness to drive.

86. The only mention in the notes of any concern in relation to the deceased's driving was an occasion in 2011 when he was pulled over by police for driving erratically and it was identified he was driving without a valid licence, and also an occasion when he 'stalked' Dr Fletcher by following his car.[96] There had been a suggestion in 2011 that the deceased might benefit from an occupational therapist driver's examination, but it had not been pursued.[97] The deceased's father, who had driven with the deceased a lot, reported that the deceased was a good driver.[98] He did not have a history of minor accidents, speeding tickets or anything that would make anyone wary of his driving ability.[99]

87. Dr Fletcher had last assessed the deceased's fitness to drive in 2014 , using the Department of Transport's March 2012 guidelines, 'Assessing Fitness to Drive for commercial and private drivers'. Dr Fletcher formed the view the deceased was not fit to hold an unconditional licence due to his significant psychiatric disorder and medication. However, he also formed the view that the deceased was fit to drive on a conditional driver's licence, with the conditions being that he should be compliant with his medications and attend psychiatric appointments. Dr Fletcher considered the deceased's physical illnesses in making this assessment, but did not think any of these needed to be taken into account in terms of conditions on his licence.[100]

88. In forming his view about the deceased's fitness to drive, Dr Fletcher explained that he took into account that taking away a motor driver's licence reduces the person's autonomy extensively and reduces their quality of life. Indeed, the deceased's father had written to Dr Fletcher at that time and

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[92] Exhibit 1, Tab 8, p. 11 and Tab 23.
[93] Exhibit 1, Tab 8, p. 11.
[94] Exhibit 1, Tab 8, p. 11.
[95] T 21.
[96] T 21 – 22; Exhibit 1, Tab 8, p. 11.
[97] T 22.
[98] T 21; Exhibit 1, Tab 8, p. 11.
[99] T 23.
[100] T 21.

expressed his view that the deceased was a good driver and careful driver and having the ability to drive was very important to him as it enabled him to be mobile.[101] In that regard, Dr Fletcher described the decision making as a balancing act between the duty of care to the public and the patient.[102]

89. Dr Chapman agreed it was a balancing act with a need to not think in terms of broad diagnostic categories but rather to focus on the individual before the psychiatrist at the time. Dr Chapman expressed the opinion that psychiatrists face an often difficult task in trying to assess their patient's fitness to drive as it is unusual for them to ever have any direct observation of the patient's driving performance.[103] However, in this case, Dr Fletcher had actually seen the deceased driving, when he had been followed by him for a period, and he also had the personal account given by the deceased's father.

90. Dr Chapman also reflected on real time constant variables in the deceased's life, noting he was sure there would have been moments where the deceased would not have been fit to drive, but also noting that this applies to most people. Dr Chapman commented that from the records he had reviewed it appeared that the deceased was a very intelligent person, capable of making assessments about his risk when driving.[104] Dr Chapman did not therefore express any criticism of the decision to allow the deceased to hold an unconditional driver's licence, based upon what was known at the time.

91. As to the practice of fitness to drive assessment generally, Dr Chapman noted that there are currently no practice guidelines available for psychiatrists on the Royal Australian and New Zealand College of Psychiatrists website. Dr Chapman also noted that there is no periodic practical assessment of the deceased's driving skills by a trained assessor, although he was not aware of what resources are currently available that could provide such assessment.[105] Dr Fletcher described an occupational therapist driving examination, which would seem to address some of the practical features that Dr Chapman thought desirable, but Dr Fletcher also observed that due to fluctuations in mental state, the result of such an assessment might not reflect the general fitness of the patient to drive.

92. I accept that the assessment of fitness to drive in such cases is a difficult exercise, that requires a balancing of the interests of the patient in maintaining a level of independence against the safety of the community generally (and indeed the safety of the patient). In the other matter that was heard jointly with this case, the witnesses gave evidence that while the current guidelines have their limitations, there is little benefit to be gained from trying to adapt the guidelines, but it might be worth reminding doctors to be more cautious in their assessments. I have noted in that finding that I will send a copy of the finding to the Royal Australian College of General Practitioners. For the sake of completeness, I will also arrange for a copy of this finding to also be sent to the RACGP.

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[101] Exhibit 1, Tab 8, p. 11.
[102] T 21.
[103] Exhibit 1, Tab 8, p. 12.
[104] T 33 – 34.
[105] Exhibit 1, Tab 8, p. 12 – 13.

CONCLUSION

93. The deceased had a longstanding psychotic illness which, despite the efforts of his family and community mental health team, was difficult to manage due to his recurring pattern of non-adherence to medication and disengagement with his treatment team. This resulted in frequent episodes of acute deterioration in his mental state, which eventually led to readmission to hospital.

94. In late May 2015 it appeared to his treating psychiatric team that the deceased was again relapsing and was likely to require another involuntary hospital admission. However, given the deceased's fear of readmission, his known tendency to fluctuate in his symptoms and the timing of events over a long weekend, the deceased was given an opportunity to voluntarily re-engage with his medication regime before a final decision was made. The deceased took this opportunity to abscond from the State.

95. When the deceased eventually returned he was seen by his parents but his treating team were unable to locate him. Before further efforts could be made to locate him and perform a psychiatric assessment, the deceased died in a car accident. I have found that his death occurred by way of accident.

96. The circumstances of the death raised questions about whether the deceased should have been permitted to drive, given his psychiatric illness. As I have stated above, I accept that it is a difficult balancing exercise between the independence of the patient and the safety of the patient and the general public. I do not find in this case that there was any evidence that suggests that an error was made in permitting the deceased to continue to drive.

S H Linton
Coroner
6 September 2017