JURISDICTION	:	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	:	CORONERS ACT 1996
CORONER	:	MICHAEL ANDREW GLIDDON JENKIN
HEARD	:	6 MAY 2021
DELIVERED	:	10 MAY 2021
FILE NO/S	:	CORC 640 of 2019
DECEASED	:	BOND, ANDRE WALTER

Catchwords:

Nil

Legislation:

Coroners Act 1996 (WA)
Mental Health Act 2014 (WA)

Counsel Appearing:

Mr W. Stops and Ms M. James appeared to assist the coroner.

Ms A. Ishak (State Solicitor's Office) appeared on behalf of South Metropolitan Health Service.

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Michael Andrew Gliddon Jenkin, Coroner, having investigated the death of ***Andre Walter BOND*** *with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, PERTH, on 6 May 2021, find that the identity of the deceased person was* ***Andre Walter BOND*** *and that death occurred on 14 May 2019 at Fiona Stanley Hospital from upper airway obstructive (choking) in an obese man with atherosclerotic heart disease and schizophrenia in the following circumstances:*

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INTRODUCTION

1. Andre Walter Bond (Mr Bond) died on 14 May 2019 at Fiona Stanley Hospital (FSH) from upper airway obstruction. At the time of his death, Mr Bond was subject to a community treatment order (CTO)[1] made under the *Mental Health Act 2014* (WA) (the MHA).[2]

2. Accordingly, immediately before his death Mr Bond was an "*involuntary patient*" and thereby a "*person held in care*".[3] His death was therefore a "*reportable death*"[4] and in such circumstances, a coronial inquest is mandatory.[5]

3. Where, as here, the death is of a person held in care, I am required to comment on the quality of the supervision, treatment and care the person received while in that care.[6] I held an inquest into Mr Bond's death on 6 May 2021.

4. I was greatly assisted by a document setting out relevant issues that Mr Bond's parents forwarded to the Court and by a detailed statement from Mr Bond's sister which contained helpful background information and suggestions relating to Mr Bond's treatment.[7]

5. The Brief of evidence tendered at the inquest consisted of one volume and included a report into Mr Bond's death by Senior Constable Ross Mullaniff,[8] expert reports and medical notes. One witness, namely Dr Antony Davis (a consultant psychiatrist) gave oral evidence at the inquest. Dr Davis had only seen Mr Bond on one occasion, but he reviewed relevant medical notes and prepared a comprehensive report.

6. The inquest focused on the circumstances of Mr Bond's death and the supervision, treatment and care he received while he was the subject of the CTO.

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[1] An order made under the MHA that a person receive treatment on an involuntary basis in the community.
[2] Exhibit 1, Vol. 1, Tab 11A, Community treatment order (16.04.19)
[3] Section 3, *Coroners Act 1996* (WA)
[4] Section 3, *Coroners Act 1996* (WA)
[5] Section 22(1)(a), *Coroners Act 1996* (WA)
[6] Section 25(3) *Coroners Act 1996* (WA)
[7] List of Issues from Mr & Mrs Bond (04.05.21) and Statement from Ms B Bond (04.05.21)
[8] Exhibit 1, Vol. 1, Tab 8, Report - Senior Constable R. Mullaniff (13.11.19)

MR BOND

Background[9,10,11,12]

7. Mr Bond was born in Perth on 12 October 1976 and was 42-years of age when he died on 14 May 2019.[13] He had two sisters, but had never married and had no children. He was reported to have had behavioural issues in Year 11 at school and left in Year 12 to take up a position as checkout operator at Woolworths, where he worked for five or six years.

8. After he left Woolworths, Mr Bond's behaviour reportedly became worse and his parents were obliged to seek a restraining order against him. Mr Bond lived in Subiaco briefly, but returned to live with his parents. In about 1999, he was detained after setting fire to their home.

9. At the time of his death, Mr Bond was receiving the Disability Support pension and was living with his parents in Booragoon. He was described as a very intelligent person who enjoyed building LEGO models, working on boats and outboard motors and supporting the WAFL.

Medical and mental health issues[14,15,16,17]

10. Mr Bond's medical history included high blood pressure and asthma. He weighed 183 kg and his body mass index placed him in the "*very severely obese*" category.[18] He was also variously diagnosed with schizophrenia, schizoaffective disorder, Asperger's syndrome and bipolar affective disorder.

11. Mr Bond's first recorded contact with mental health services was in 1994, when he attended Fremantle Hospital (FH) for a number of medical and mental health issues. At that time, he had diagnoses of schizophrenia and Asperger's syndrome.

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[9] Exhibit 1, Vol. 1, Tab 8, Report - Senior Constable R. Mullaniff (13.11.19), pp2-3
[10] Exhibit 1, Vol. 1, Tab 9, File Note - Senior Constable R. Mullaniff (24.06.19), pp1-2
[11] Exhibit 1, Vol. 1, Tab 10B, Statement - Mr L. Bond, paras 2-4
[12] See also: Exhibit 1, Vol. 1, Tab 14, Letter - Mr A. Bond (26.02.19)
[13] Exhibit 1, Vol. 1, Tab 1, P100 - Report of Death
[14] Exhibit 1, Vol. 1, Tab 22, Report - Dr A. Davis (27.11.20), pp2-5
[15] Exhibit 1, Vol. 1, Tab 18, FH Discharge Summary (17.04.19), pp1-5
[16] Exhibit 1, Vol. 1, Tab 8, Report - Senior Constable R. Mullaniff (13.11.19), pp3-4
[17] ts 06.05.19 (Davis), pp7-8 & 11
[18] Exhibit 1, Vol. 1, Tab 4A, Post Mortem Report (17.05.19), p2

12. Mr Bond first presented to the Alma Street Centre (the ASC), which is part of the Fremantle Hospital Mental Health Service (the Service) in 1999. Although he had two inpatient admissions in April and June of that year, he was mostly managed as an outpatient until September 2016, when his treatment was transferred to a private psychiatrist.

Psychological counselling[19]

13. Mr Bond was referred to a clinical psychologist on 5 February 2019. In addition to his diagnosis of schizophrenia, he reported depression and low self-esteem. During his first session, Mr Bond said his goal was to improve his mood, self-esteem and interpersonal skills. He also said he was lonely and wanted to meet a partner.

14. On 12 February 2019, Mr Bond's clinical psychologist received a telephone call from a doctor at the medical centre Mr Bond attended. It appears that Mr Bond had made his female GP feel uncomfortable during their consultations and had sent her flowers. As a result, Mr Bond was told he was no longer welcome at the medical centre.[20]

15. Mr Bond attended four counselling sessions with the clinical psychologist and on each occasion, he denied self-harm and suicidal ideation. His last counselling session was on 2 May 2019, following his discharge from the ASC (see discussion below). At that session, he said he felt flat and had low self-esteem. Although he had disclosed previous non-compliance with medication, he reported taking his anti-psychotic medication as prescribed.

Admission to Alma Street Centre[21,22]

16. On 19 February 2019, Mr Bond presented to FSH having been referred there by the Service following concerns relating to his behaviour towards his GP and threats of arson. A bed became available at the ASC and he was transferred there on 21 February 2019, as an involuntary patient pursuant to the provisions of the MHA.[23]

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[19] Exhibit 1, Vol. 1, Tab 12, Report - Ms R. Lewis (14.07.19), pp1-2
[20] Exhibit 1, Vol. 1, Tab 13, Report - Dr J. Strahan (18.06.19)
[21] Exhibit 1, Vol. 1, Tab 22, Report - Dr A. Davis (27.11.20), pp2-5
[22] ts 06.05.19 (Davis), pp8-9, 13-14
[23] Exhibit 1, Vol. 1, Tab 17, FSH Emergency Medicine Summary (20.02.19)

17. On admission to the ASC, Mr Bond disclosed that he had recently stopped taking his prescribed quetiapine because he had become convinced that it "*was not good for his heart health*".[24] He was found to have grandiose and tangential thoughts and amongst other things, was fixated on the idea of forming a romantic relationship with a female doctor. It was thought that Mr Bond was experiencing a manic relapse of schizoaffective disorder, which can be described as combination of schizophrenia and mood disorder, such as depression or bipolar affective disorder.[25,26]

18. Dr-Davis saw Mr Bond on 6 May 2019 after he was discharged from the ASC. At the inquest Dr Davis explained that over a period of time a person's mental illness can evolve and the symptoms the person presents with can vary. For this reason, a person's diagnosis can be amended and treatment adjusted as necessary.[27] During the course of Mr Bond's inpatient admission at the ASC, it was determined that there was no good evidence for a diagnosis of schizophrenia at that time because Mr Bond did not have delusions, hallucinations, flattening of affect or negative syndromes.

19. Mr Bond was managed on a locked ward and participated in occupational therapy and group fitness sessions. When he was reviewed on 13 March 2019, it was thought that a large part of his disinhibited behaviour related to his inability to "*read social cues*". His dose of quetiapine was reduced and he was started on an alternative anti-psychotic medication namely, lurasidone. He was subsequently transferred to an open ward where he was closely monitored.

20. On 21 March 2019, Mr Bond presented with nausea, vomiting, sweating, painful urination, blurred vision, drowsiness and fatigue. After blood tests and an electrocardiogram were found to be normal, it was determined that his symptoms were likely to be related to lurasidone and this medication was ceased.

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[24] Exhibit 1, Vol. 1, Tab 18, FH Discharge Summary (17.04.19), p1
[25] See: https://www.mayoclinic.org/diseases-conditions/schizoaffective-disorder/symptoms-causes/syc-20354504
[26] ts 06.05.19 (Davis), pp18-19
[27] ts 06.05.19 (Davis), pp9-11

21. When reviewed on 25 March 2019, it was felt Mr Bond's mood and behaviour were due to a combination of Asperger's syndrome and bipolar affective disorder. As noted, it was decided there was no good evidence for a diagnosis of schizophrenia and Mr Bond's medications had been ceased, however when he became hypomanic, he was restarted on quetiapine.

22. By 27 March 2019, Mr Bond's mental state had deteriorated and he was noted to be agitated and aggressive. He was given intramuscular sedatives with good effect and his medication was reviewed. He continued to exhibit challenging behaviour and declined oral medication.

23. On 31 March 2019, he was found with the cord from a pair of shorts firmly wrapped around his neck. He expressed depressive thoughts and said he had intended to harm himself. He was placed under a close observation regime and his medication was adjusted. Mr Bond's mental state appeared to improve over the next few days and he became "*quite calm and settled*". As a result of this improvement, he was transferred to an open ward on 7 April 2019.

24. At a family meeting on 5 April 2019, Mr Bond's parents agreed to him returning to live at their home on several conditions. These conditions included that: he was respectful of family members; helped with household chores; went to medical appointments; and complied with his medication regime.[28]

25. Following uneventful weekend leave, Mr Bond was discharged to his parents' home on 17 April 2019. He was made the subject of a CTO on 16 April 2019, and his care was transferred to the Melville team of the Service. Mr Bond's CTO, which was due to expire on 15 July 2019, was varied on 9 May 2019, when a different supervising psychiatrist was appointed.[29,30] Mr Bond's treating team was led by Dr Davis as supervising psychiatrist and his allocated care coordinator was an occupational therapist.

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[28] Exhibit 1, Vol. 1, Tab 18, FH Discharge Summary (17.04.19), p2
[29] Exhibit 1, Vol. 1, Tab 11A, Community treatment order (16.04.19)
[30] Exhibit 1, Vol. 1, Tab 11B, Variation to community treatment order (09.05.19)

Community treatment order

26. The MHA provides that a person is not to be placed on a CTO unless: "*[T]he person cannot be adequately provided with treatment in a way that would involve less restriction on the person's freedom of choice and movement than making a community treatment order*".[31]

27. In Mr Bond's case, a CTO was required as a temporary measure after his discharge from the ASC because he had previously been non-compliant with his medication regime and because he lacked capacity to make treatment decisions with respect to his mental health. Placing Mr Bond on a CTO meant that he could be regularly monitored. In this case, Mr Bond's treatment plan provided for regular contact with his care coordinator, monthly reviews by a psychiatric registrar and three monthly reviews with his supervising psychiatrist, Dr Davis.[32,33]

28. Another benefit of Mr Bond being on a CTO following his discharge was that if he became non-compliant with his medication regime, breach action could be taken and he could be required to attend for an assessment and if necessary, the CTO could be revoked and he could be returned to hospital on an involuntary basis.[34]

29. Having carefully reviewed the evidence in this case, I am satisfied that the decision to place Mr Bond on a CTO was justified on the basis that it was the least restrictive way to ensure that he was provided with appropriate treatment for his mental illness.

Management in the community[35,36,37]

30. On 23 April 2019, Mr Bond was reviewed by a psychiatric registrar and reported low mood and some dizziness. It was discovered that due to a misunderstanding, he had been taking a lower dose of sodium valproate than prescribed and this was addressed.

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[31] s25(2)(e), *Mental Health Act 2014* (WA)
[32] Exhibit 1, Vol. 1, Tab 11A, Community treatment order (16.04.19)
[33] ts 06.05.19 (Davis), pp11-12
[34] See: Division 4, Part 8, *Mental Health Act 2014* (WA)
[35] Exhibit 1, Vol. 1, Tab 22, Report - Dr A. Davis (27.11.20), pp3-5
[36] Exhibit 1, Vol. 1, Tab 8, Report - Senior Constable R. Mullaniff (13.11.19), p4
[37] ts 06.05.19 (Davis), pp11-13

31. Mr Bond received regular telephone contact from his care coordinator until he was reviewed by Dr Davis on 6 May 2019. At that time, Mr Bond said he was complying with his medication and was not experiencing any side effects. He said his sleep and appetite were good and he was not experiencing any psychological symptoms. Mr Bond displayed some insight into his condition and was accepting of the need to take oral medication. A further review was scheduled with a psychiatric registrar, but Mr Bond died before this could occur.

32. For the sake of completeness, I note that on 13 March 2019, the Service referred Mr Bond to the Community Forensic Mental Health Team (based at Graylands Hospital) for a risk assessment. Mr Bond was due to see a forensic psychiatrist but he died before this could occur.[38]

Mr Bond's medication regime on discharge[39]

33. When Mr Bond was discharged from the ASC on 17 April 2019, his medication regime was as follows: paroxetine (an anti-depressant, 20 mg in the morning); quetiapine (an antipsychotic, 600 mg in the evening); sodium valproate (a mood stabiliser, 1,500 mg morning and night); and olmesartan (used to treat high blood pressure, 40 mg in the morning).[40]

34. Dr Davis expressed the opinion that Mr Bond's prescribed medication was appropriate, both in terms of the type of medication and the dose. Dr Davis noted that previously, Mr Bond had been prescribed higher doses of sodium valproate and quetiapine. As noted, when Dr Davis reviewed him on 6 May 2019, Mr Bond's mental state was stable and he was not reporting any side effects. On that basis, Dr Davis decided to make no changes to Mr Bond's medication at that time.[41,42]

35. Dr Davis was asked to comment on whether a side effect of the psychotropic medications Mr Bond had been prescribed was difficulty with swallowing.

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[38] Exhibit 1, Vol. 1, Tab 15, Letter - Dr L. Tate (12.06.19)
[39] Exhibit 1, Vol. 1, Tab 22, Report - Dr A. Davis (27.11.20), pp3-4
[40] Exhibit 1, Vol. 1, Tab 18, FH Discharge Summary (17.04.19), p4
[41] Exhibit 1, Vol. 1, Tab 22, Report - Dr A. Davis (27.11.20), pp3-4
[42] ts 06.05.19 (Davis), pp12-13

36. Dr Davis said that swallowing difficulty was a very rare side effect of these medications, however, his review of the available literature suggested that if swallowing difficulty was going to occur, this would happen when a person first started taking the medication. Given that Mr Bond had been taking psychotropic medications for many years, Dr Davis felt it was very unlikely that they played any role in his death.[43]

EVENTS LEADING TO MR BOND'S DEATH[44]

37. Shortly before 7.30 pm on 14 May 2019, Mr Bond was at home having dinner. He was sitting at the dining table alone eating a meal of steak and vegetables. Mr Bond's father heard a choking noise and saw Mr Bond lean forward and put his finger in his mouth. Mr Bond then said "*I'm choking*" before collapsing, unresponsive, to the floor.[45]

38. Mr Bond's father called emergency services and began effective CPR. Ambulance officers arrived and managed to remove several pieces of steak from Mr Bond's throat and to insert an airway. Several brief returns of spontaneous circulation were achieved and with the assistance of fire brigade officers, Mr Bond was removed from the house and taken to FSH by ambulance.[46,47,48]

39. At FSH, resuscitation efforts initially continued, but following discussions with Mr Bond's family, a Catholic priest administered the Last Rites and resuscitation was ceased. Mr Bond was declared deceased at 10.08 pm on 14 May 2019.[49,50,51]

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[43] ts 06.05.19 (Davis), pp12-13 & 20
[44] Exhibit 1, Vol. 1, Tab 8, Senior Constable R. Mullaniff (13.11.19), pp2-3
[45] Exhibit 1, Vol. 1, Tab 10B, Statement - Mr L. Bond (24.06.19), paras 3-11
[46] Exhibit 1, Vol. 1, Tab 19A, FSH Discharge Summary (15.05.19)
[47] Exhibit 1, Vol. 1, Tab 21, St John Ambulance Patient care report (14.05.19), pp2-3
[48] Exhibit 1, Vol. 1, Tab 10B, Statement - Mr L. Bond (24.06.19), paras 12-13
[49] Exhibit 1, Vol. 1, Tab 6, Death in Hospital form (14.05.19)
[50] Exhibit 1, Vol. 1, Tab 19A, FSH Discharge Summary (15.05.19)
[51] Exhibit 1, Vol. 1, Tab 20, FSH ED Progress Notes (14.05.19)

CAUSE AND MANNER OF DEATH[52,53]

40. Two forensic pathologists (Dr Vagaja and Dr Ong), conducted a post mortem examination of Mr Bond's body. There were several possible food particles around his voice box (piriform sinus) and vegetable matter in his airway although there was evidence of aspiration in the small airways and no evidence of pneumonia.

41. Mr Bond's heart was enlarged (cardiomegaly) and microscopic examination of tissues confirmed mild scarring of his heart muscle and hardening and narrowing of the blood vessels supplying his heart (coronary atherosclerosis).

42. Toxicological analysis found therapeutic levels of quetiapine in Mr Bond's system but alcohol and common drugs were not detected. The other medications Mr Bond had been prescribed (i.e.: paroxetine, sodium valproate and olmesartan) were not detected in his system and it is therefore possible that Mr Bond was not compliant with his medication regime at around the time of his death.[54]

43. At the conclusion of the post mortem examination, Dr Vagaja and Dr Ong expressed the opinion that the cause of Mr Bond's death was upper airway obstruction (choking) in an obese man with atherosclerotic heart disease and schizophrenia.[55]

44. I accept and adopt the conclusion of Dr Vagaja and Dr Ong as to the cause of Mr Bond's death and I find that death occurred by way of accident.

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[52] Exhibit 1, Vol. 1, Tab 4A, Post Mortem Report (17.05.19), pp2-5
[53] Exhibit 1, Vol. 1, Tab 4C, Supplementary Post Mortem Report (19.08.19), p1
[54] Exhibit 1, Vol. 1, Tab 5, Toxicology report (22.07.19), p1
[55] Exhibit 1, Vol. 1, Tab 4C, Supplementary Post Mortem Report (19.08.19), p1

QUALITY OF SUPERVISION, TREATMENT AND CARE

45. Mr Bond's mental health was managed by ASC and the Service for many years. During the period Mr Bond was an involuntary patient at the ASC, his medication was reviewed on several occasions and he participated in occupational therapy and personal fitness sessions.

46. During his admission at ASC, Mr Bond's mental state stabilised and improved and his family were involved in his discharge planning. A self-harm incident on 31 March 2019 resulted in a mental state review and a period of close monitoring.

47. In my view, Mr Bond's discharge plan, which included placing him on a CTO and transferring his care to a community mental health service was appropriate. Although he had only been the subject of a CTO for a few weeks prior his death, during that time Mr Bond was reviewed by a psychiatric registrar and a consultant psychiatrist from the Service and he received regular contact from his care coordinator.

48. Mr Bond was also seen by a private clinical psychologist and an appointment had been made for him to be reviewed by a forensic psychiatrist and at the time of his death, he had further sessions booked with his clinical psychologist and a review with the Service's psychiatric registrar.

49. In my view, Mr Bond's management whilst he was an involuntary patient at the ASC and whilst he was the subject of a CTO was reasonable and the standard of supervision, treatment and care he received during that time was appropriate.

50. Prior to the inquest, Mr Bond's sister forwarded a statement to the Court in which she made a number of suggestions about possible enhancements to Mr Bond's care. In broad summary, she suggested that it would have been appropriate for a support person to have worked with Mr Bond to assist him to better integrate into the community and to help him make positive changes to his lifestyle.[56]

[56] Statement from Ms B Bond (04.05.21)

51. A recent study of 618 people diagnosed with schizophrenia identified that personalised interventions aimed at promoting cognition and independent living should be an integral part of management programs for schizophrenia (the Study).[57]

52. Personalised intervention of this nature, or "*individual placement support*", requires support workers with specialised skills and an intensive interaction with the person in order to be effective.[58]

53. As noted, as an outpatient of the Service, Mr Bond's care was provided by a treatment team that included psychiatrists and allied health professionals. Mr Bond had been allocated a care coordinator who, in his case, was an occupational therapist.

54. Dr Davis confirmed that Mr Bond's care coordinator was able to recommend referrals to outside agencies (such as employment services) as well as engaging other members of the treating team, such as dieticians and physiotherapists, to provide input on well-being issues.[59]

55. Dr Davis said that the Service worked in conjunction with a person's GP who was generally responsible for the person's physical health. Where a person did not have a GP, they could be referred to the Service's Wellness clinic.[60]

56. Dr Davis agreed that early intervention and treatment was appropriate, especially with schizophrenia and related illnesses but that the resources of the Service did not allow the type of intensive intervention referred to in the Study.[61]

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[57] See: https://jamanetwork.com/journals/jamapsychiatry/article-abstract/2776050
[58] See: Real-life treatments for schizophrenia - Health Report - ABC Radio National
[59] ts 06.05.19 (Davis), p19
[60] ts 06.05.19 (Davis), p19
[61] ts 06.05.19 (Davis), pp17-18

CONCLUSION

57. Mr Bond had a long-standing history of mental illness and was 42-years of age when he died as a result of choking on 14 May 2019. He had been an involuntary patient at the ASC for just under two months and at the time of his death he had been the subject of a CTO for just under four weeks.

58. For the reasons I have set out, it is my view that the supervision, treatment and care Mr Bond received whilst he was an involuntary patient at the ASC and later whilst he was the subject of a CTO was of a reasonable standard.

MAG Jenkin
Coroner
10 May 2021