JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	PHILIP JOHN URQUHART
HEARD	**:**	12 MAY 2021
DELIVERED	**:**	29 JUNE 2021
FILE NO/S	**:**	CORC 1 of 2017
DECEASED	**:**	WALSH, SAMUEL MARK

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:
Mr W Stops assisted the Coroner
Ms R Paljetak appeared on behalf of Department of Justice (Corrective) and the North Metropolitan Health Services

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 ***Samuel Mark WALSH*** *with an inquest held at Perth Coroner's Court, Central Law Courts, Court 85, 501 Hay Street, Perth, on 12 May 2021, find that the identity of the deceased person was* ***Samuel Mark WALSH*** *and that death occurred between 5 October 2014 and 12 October 2014 near Karalee Rocks Pumping Station, Yellowdine Nature Reserve, from carbon monoxide toxicity in the following circumstances:*

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INTRODUCTION

1. On 11 January 2017, a Water Corporation maintenance worker was checking the Perth to Kalgoorlie pipeline. He was within the Yellowdine Nature Reserve, approximately 400 km east of Perth, when he discovered a parked car in remote bushland. There was a hose running from near the car's exhaust to the front passenger window. A key was in the car's ignition which was switched on. Human remains were in the driver's seat. Those remains were later identified as belonging to Mr Walsh. He had not been positively sighted since 5 October 2014.

2. At the time of his disappearance, Mr Walsh was subject to a custody order pursuant to section 21(a) of the *Criminal Law (Mentally Impaired Accused) Act 1996* (WA).

3. Accordingly, immediately before his death, Mr Walsh was a *"person held in care"* within the meaning of the *Coroners Act 1996* (WA) and his death was a "*reportable death*".[1] In such circumstances, a coronial inquest is mandatory.[2]

4. 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 whilst in that care.[3]

5. I held an inquest into Mr Walsh's death on 12 May 2021. The documentary evidence produced at the inquest comprised of three volumes which were tendered as Exhibit 1. A further exhibit was tendered during the inquest (Exhibit 2). At my request, Ms Paljetak, counsel for North Metropolitan Health Service and Department of Justice, provided further information to the court by letters dated 26 May 2021 and 8 June 2021.

6. Dr Peter Morton, a consultant psychiatrist at Fiona Stanley Hospital, and Dr Elizabeth Tate, a consultant forensic psychiatrist at State Forensic Mental Health Service, were called as witnesses at the inquest.

7. The inquest focused on the care provided to Mr Walsh when he was compliant with the custody order, with an emphasis on the weeks before his unauthorised absconding.

[1] Sections 3 and 22(1)(a) *Coroners Act 1996* (WA)
[2] Section 22(1)(a) *Coroners Act 1996* (WA)
[3] Section 25(3) *Coroners Act 1996* (WA)

THE DECEASED

Background [4] [5] [6]

8. Mr Walsh was born on 9 July 1976. He was named Enoch Samuel Wright; however, he formally changed his name to Samuel Mark Walsh on 31 July 2012. Mr Walsh's parents were married in 1972 and separated in 1987. Mr Walsh had three siblings: an older sister, Kathy Wright and two younger siblings, Benjamin Wright and Hazel Beattie.

9. Mr Walsh's parents were both deaf, with varying levels of education and limited communication skills.

10. Mr Walsh attended South Kalgoorlie Primary School and briefly, Eastern Goldfields High School. He completed Year 8 and then Years 9 to 11 at Como Senior High School.[7]

11. After his parents' separation, Mr Walsh lived with his grandmother, mother and two younger siblings at his paternal grandmother's house in Como. His mother was diagnosed with schizophrenia and at one stage, went into a care facility for several years.

12. Mr Walsh's older sister committed suicide in Sydney by carbon monoxide inhalation when she was about 18 years old. She was living with her maternal grandmother at the time.

13. When he was about 22 years old, Mr Walsh quit his job to become his mother's primary carer. He lived with his mother and brother in the former family home in Kalgoorlie.

14. It is clear from the evidence before me that Mr Walsh was a hardworking, kind, and generous man who was described by his sister as "*the rock of the family*". However, it is also readily apparent that Mr Walsh began having his own significant mental health issues which remained undiagnosed until after his mother's death in October 2005.

[4] Exhibit 1, Volume 1, Tab 6A, Statement - Hazel Beattie dated 10 February 2017
[5] Exhibit 1, Volume 1, Tab 2, WAPOL Report - Sergeant Dave Thirlwell dated 13 December 2019
[6] Exhibit 1, Volume 1, Tab 3B, Confirmation of change of name dated 13 January 2017
[7] This is the name of the high school as recalled by Ms Beattie in her statement, however the school was most likely named Como Secondary College.

The death of Mr Walsh's mother

15. By July 2005, Mr Walsh could no longer cope with looking after his mother. Although Mr Walsh's father agreed to look after his ex-wife in Perth, that only lasted for a short period of time before he asked Mr Walsh to resume caring for his mother. Mr Walsh refused, telling his father he could not cope with his mother's on-going care. Mr Walsh's father then contacted his other son who drove to Perth, collected his mother, and left her at the front door of Mr Walsh's house in Kalgoorlie on 16 October 2005.

16. Early the next morning, Mr Walsh killed his mother in the house by cutting her throat with an ornamental sword. He then buried his mother in a hole in the backyard of his house, before handing himself in at the Kalgoorlie Police Station.

17. Mr Walsh was charged with the wilful murder of his mother and remanded in custody at Eastern Goldfields Regional Prison. On 18 October 2005, he was refused bail and transferred on a hospital order to the Frankland Centre[8] at Graylands Hospital pursuant to section 5 of the *Criminal Law (Mentally Impaired Accused) Act 1996* (WA).[9]

Psychiatric assessment of Mr Walsh [10] [11]

18. Mr Walsh had no previous psychiatric history prior to his admission to the Frankland Centre. However, his behaviour as observed by family and friends for some time prior to his mother's death suggested his emotional state had been markedly disturbed for some time.

19. Upon admission to the Frankland Centre, Mr Walsh was assessed as "*floridly psychotic*". He expressed bizarre, grandiose, and religious delusions; describing a multi-national conspiracy directed against him which involved the police. His thought form was rambling and over-inclusive with looseness of association. Mr Walsh had no insight into his legal situation and his judgement was assessed as impaired.

20. However, Mr Walsh showed signs of improvement when he was commenced on the anti-psychotic medication, clozapine. Later, he was also prescribed the anti-depressant, mirtazapine.

[8] A high security psychiatric facility within the grounds of Graylands Hospital.
[9] Exhibit 1, Volume 1, Tab 25, Report - Dr Gosia Wojnarowska dated 27 February 2017
[10] Exhibit 1, Volume 1, Tab 25, Report - Dr Gosia Wojnarowska dated 27 February 2017
[11] Exhibit 1, Volume 3, Tab 1, Death in Custody Review Report - Richard Mudford date 11 April 2018

21. On 7 June 2006, Mr Walsh's mental state had stabilised to the extent that his treating psychiatrist was of the view he could be returned to prison, on remand. He remained at Hakea Prison until he was referred back to the Frankland Centre on 20 September 2006, following a deterioration of his mental state, which included a refusal to eat or drink.

22. Although for the first four weeks of his readmission to the Frankland Centre he refused to eat (eventually having to be force-fed), Mr Walsh slowly responded to treatment with clozapine and his mental state improved significantly. He was then returned to Hakea Prison, pending his Supreme Court trial.

Mr Walsh's Supreme Court trial [12]

23. On 26 March 2007, Mr Walsh had a trial in the Supreme Court of Western Australia held in Perth, charged with wilfully murdering his mother on 17 October 2005.[13] Pursuant to section 27 of the *Criminal Code* (WA), Mr Walsh pleaded not guilty on account of unsoundness of mind at the time of doing the act that killed his mother.[14] The facts of the case were not in dispute and the only issue for determination by Miller J, who was sitting without a jury, was Mr Walsh's state of mind at the time of his alleged offending.

24. The court heard evidence from two consultant psychiatrists who were of the opinion Mr Walsh was mentally impaired, with untreated paranoid schizophrenia, at the time he killed his mother.

25. In written reasons for decision delivered on 30 March 2007, Miller J made the following findings and orders:

> I accept the opinions of both Dr Srna and Dr Schineanu that, at the time of the commission of the offence alleged against him, the accused was in such a state of mental impairment as to deprive him of the capacity to control his actions and the capacity to know that he ought not to do the act that he did because it was wrong. Those matters have been proven on the balance of probability.
>
> It follows that the accused should be found not guilty on count 1 on the indictment on account of unsoundness of mind. It is unnecessary to consider count 2, which is the alternative to count 1.

[12] *The State of Western Australia v Enoch Samuel Wright* [2007] WASC 80
[13] He was also charged with the alternative offence of the murder of his mother.
[14] Pleas were entered pursuant to section 125(1)(d) of the *Criminal Procedure Act 2004* (WA)

> Pursuant to s 147 (s) of the Act [*Criminal Procedures Act 2004* (WA)], I enter a judgment of acquittal of the offence charged in count 1 on the indictment on account of unsoundness of mind of the accused.
>
> Pursuant to s 149 (1) of the Act, I am required to deal with the accused under the provisions of the *Criminal Law (Mentally Impaired Accused) Act.* Section 21 of that Act requires me to make a custody order in respect to the accused, and I make that order. The consequence of it is that the accused is to be kept in custody in accordance with the provisions of Pt 5 of that Act. Pursuant to s 24, he is to be detained in an authorised hospital, a declared place, a detention centre or a prison, as determined by the Mentally Impaired Accused Review Board, until released by an order of the Governor.

CARE OF MR WALSH DURING THE CUSTODY ORDER

Frankland Centre and Romily House

26. On 5 April 2007, Mr Walsh was transferred from Hakea Prison to the Frankland Centre at Graylands Hospital.[15]

27. The prescribing of clozapine to Mr Walsh was maintained. His medical records indicate he continued to make a very good recovery. There were no reported incidents and he was compliant with his medication. By 2010, his paranoid schizophrenia was considered to have been in remission with the treatment he had received for many years.[16] Mr Walsh's risk to others was assessed regularly using the validated structure risk judgement tool, HCR20, and he was judged to present a low risk of re-offending.[17]

28. Mr Walsh's progress was so significant that on 10 March 2009, the Governor made an order pursuant to section 27(2)(a) of the *Criminal Law (Mentally Impaired Accused) Act 1996* (WA) that allowed Mr Walsh to be granted a Leave of Absence from the Frankland Centre for periods not to exceed 14 days at any one time, and on the terms and conditions determined by the Mentally Impaired Accused Review Board (the Board).[18]

29. The Board gradually increased Mr Walsh's Leave of Absence periods from the Frankland Centre; from one night per week to three nights per week in February 2011, to six nights per week in August 2011 and eventually, for 13 days per fortnight following a Leave of Absence Order dated 1 May 2012.

[15] Exhibit 1, Volume 3, Tab 1, Death in Custody Report - Richard Mudford dated 11 April 2018, p.7
[16] Exhibit 1, Volume 1, Tab 31, Report - Dr Elizabeth Tate dated 6 May 2021, p.2
[17] Exhibit 1, Volume 1, Tab 31, Report - Dr Elizabeth Tate dated 6 May 2021, p.2
[18] Exhibit 1, Volume 2, Tab 1, Executive Council Minute dated 10 March 2009

This Order stated that Mr Walsh was entitled to stay over-night at Romily House for "*13 consecutive days providing he returns on the 14th day to Graylands Hospital for one overnight stay before the next group of 13 consecutive stays at Romily House*."[19]

30. Romily House is a long established, licensed psychiatric hostel in Claremont which provides accommodation for up to 70 persons who have a diagnosed mental illness.[20] Mr Walsh had, in fact, been attending Romily House since 2008 as part of his reintegration program into the community.[21]

31. The overnight stay required at Graylands Hospital was at the Frankland Centre where Mr Walsh was reviewed by the Inpatient Forensic Mental Health Team. From 13 September 2013, he was under the care of the Community Forensic Mental Health Service whilst in the community. Mr Walsh's State Forensic Mental Health Service (SFMHS) case manager visited him regularly at Romily House and liaised with staff regarding his mental health and well-being.[22]

Mr Walsh's medication during the term of the custody order

32. Mr Walsh remained taking clozapine throughout the duration of his custody order. Clozapine is taken either by tablet or liquid. In Mr Walsh's case, he was taking it in tablet form. At the inquest, Dr Morton gave the following evidence regarding this drug:[23]

> Clozapine is classified as an atypical antipsychotic. I think most psychiatrists would consider it to be the best antipsychotic that there is. Its treatment is reserved for people with severe illnesses who don't respond to other atypical antipsychotics. So there's a history of non-response. It has got a very good track record. There's probably two thirds chance that you will improve on clozapine as compared to other medications. It comes with a very comprehensive program of supervision because of the nature of its side-effects. There are weekly blood tests for the first 18 weeks and then as long as you're on clozapine you have monthly blood tests. What this does mean is that people on clozapine do have a lot more supervision, perhaps, than people on other antipsychotic medications.

[19] Exhibit 1, Volume 2, Tab 1, Mentally Impaired Accused Review Board, Leave of Absence Order dated 1 May 2012 at [8]
[20] Exhibit 1, Volume 1, Tab 9, Statement - Emma Watson dated 20 October 2014, p.1
[21] Exhibit 1, Volume 1, Tab 9, Statement - Emma Watson dated 20 October 2014, pp.1-2
[22] Exhibit 1, Volume 1, Tab 31, Report - Dr Elizabeth Tate dated 6 May 2021, p.2
[23] ts 12.5.21 (Dr Morton), p.7

33. The reason for regular blood testing is because of the health risks associated with taking clozapine. The main two health risks are myocarditis (an inflammation of the heart that can lead to cardiac failure) and neutropenia (a diminution of the body's white blood cells).[24] Blood testing of those who are prescribed clozapine is mandatory and done to measure the white cells in the blood and to also measure the clozapine serum level (serum level) to ensure people are adhering to treatment regimes. Psychiatrists regard a serum level from 350-450 as being an adequate level to treat schizophrenia. A serum level up to 1000 is an appropriate threshold, however if the serum level exceeds 1000, the patient can experience significant side-effects.[25]

34. By 2014, Mr Walsh had been collecting his medication for some time from the pharmacy at Graylands Hospital on his fortnightly return from Romily House. He would personally collect his fortnightly medication packs, was responsible for taking his medication without it being dispensed to him by staff and he took it without staff supervision.[26]

Mr Walsh's progress under the custody order

35. It is evident from all the material before me that, prior to his disappearance, Mr Walsh represented the gold standard for someone on a custody order with respect to compliance with their medication and gradual reintegration into the community.

36. As early as July 2011, his treating psychiatrist had assessed his mental illness as being in "*full remission*".[27] By 2013, Mr Walsh was attending church and had regular visits from his sister. He had developed friendships in Romily House and had started working as a storeman.[28]

37. Mr Walsh's treating psychiatrist prepared a report dated 1 February 2013 addressed to the Board. This report recommended that Mr Walsh was suitable to be released on a conditional release order, under section 35 of the *Criminal Law (Mentally Impaired Accused) Act 1996* (WA), with the specification he was to reside full-time at Romily House. On 12 April 2013, the Board accepted the psychiatrist's recommendation and prepared a report to the Attorney General, recommending that the Governor be advised to grant a

[24] ts 12.5.21 (Dr Morton), p.8
[25] ts 12.5.21 (Dr Morton), pp.9-10
[26] Exhibit 1, Volume 1, Tab 31, Report - Dr Elizabeth Tate dated 6 May 2021, p.3
[27] Exhibit 1, Volume 1, Tab 25, Report - Dr Wojnarowska dated 27 February 2017, p.4
[28] Exhibit 1, Volume 1, Tab 25, Report - Dr Wojnarowska dated 27 February 2017, p.5

conditional release order to Mr Walsh.[29] Mr Walsh was reported to be "*very excited*" about this development.[30]

THE PERIOD PRIOR TO MR WALSH'S ABSCONDING

38. Those medical staff treating Mr Walsh in the months and weeks prior to his absconding did not note any difference in his appearance, demeanour, or behaviour. Dr Wojnarowska conducted the last psychiatric review of Mr Walsh on 17 June 2014. Dr Wojnarowska stated that:[31]

> Mr Walsh presented as pleasant, cooperative with good eye contact. His thought process was linear and there were no delusion or perceptual abnormalities present. He appeared to be motivated and displaying a good insight. He was happy with casual work in a maintenance department at Fiona Stanley Hospital. There were no changes to his management plan made.

39. Mr Walsh was reviewed on a further eight occasions by medical staff between 17 June 2014 and 29 September 2014. Those reviews all assessed him as stable, with no evidence of deterioration in his mental state. At no stage did he present as depressed, suicidal, or psychotic.[32]

40. The only matter for potential concern that arose in the four weeks prior to Mr Walsh's absconding was his serum levels from blood tests undertaken in September 2014.

Mr Walsh's serum levels for September 2014

41. Between 20 January 2014 and 26 August 2014, Mr Walsh's serum levels following blood tests were between the acceptable ranges of 582-894.[33] However, that level of consistency was not achieved in the following six blood tests in September 2014:[34]

[29] Letter from Ms Paljetak to Counsel Assisting dated 8 June 2021
[30] Exhibit 1, Volume 1, Tab 24, Forensic Psychiatrist - Client Profile for Mr Walsh, p.16
[31] Exhibit 1, Volume 1, Tab 25, Report - Dr Wojnarowska dated 25 February 2017, p.5
[32] Exhibit 1, Volume 1, Tab 25, Report - Dr Wojnarowska dated 25 February 2017, p.5
[33] Exhibit 1, Volume 1, Tab 31, Report - Dr Tate dated 6 May 2021, p.5
[34] Exhibit 1, Volume 1, Tab 31, Report - Dr Tate dated 6 May 2021, p.5

Date	Clozapine Serum Level
9 September 2014	1063
16 September 2014	998
19 September 2014	1217
22 September 2014	1185
23 September 2014	636
30 September 2014	309

42. The three serum levels above 1000 were cause for some concern due to the increased potential for side-effects while the single reading of 309 was concerning as it was below the minimum optimal serum level of 350. As a result of these discrepancies, changes were made to Mr Walsh's dosages and he was given a weekly dosage of his medication, rather than fortnightly.

43. Prior to the elevated serum level on 9 September 2014, Mr Walsh had a clozapine night time dose of 600 mg and a morning dose of 150 mg.[35] Following a second elevated serum level above 1000 on 19 September 2014, Mr Walsh's night time dose was reduced to 300 mg on 22 September 2014 and his usual morning dose was withheld the following day, pending the results of another blood test.[36] His serum level from that blood test on 22 September 2014 was 1185. That result was not yet available when he was reviewed by his medical team on 23 September 2014,[37] so his morning dose of clozapine was ceased all together and his night time dose reinstated at 600 mg.

44. When the serum level from 22 September 2014 became available, Mr Walsh's clozapine dose at night was reduced to 500 mg for one week from 24 September 2014.[38] On that date, he was provided a one-week supply of clozapine with nightly doses of 500 mg.

[35] Exhibit 1, Volume 1, Tab 31, Report - Dr Tate dated 6 May 2021, p.4
[36] Exhibit 1, Volume 1, Tab 31, Report - Dr Tate dated 6 May 2021, p.4
[37] The results from these blood tests can take anywhere from two days to five days to come back: ts 12.5.21 (Dr Morton) pp.11-12
[38] Exhibit 1, Volume 1, Tab 31, Report - Dr Tate dated 6 May 2021, p.4

45. As already noted, the serum level from Mr Walsh's final blood test on 30 September 2014 was 309, below the therapeutic range.

46. Mr Walsh was due to return to Graylands Hospital for a blood test and to collect another weekly medication pack on 30 September 2014. Mr Walsh did attend for a blood test that day, as evidenced by the pathology results. However, there are now no hard copies of collection records from the pharmacy at Graylands Hospital to establish whether Mr Walsh collected his medication pack on this day. This is due to the lapse of time.[39] As noted by Dr Tate in her report:[40]

> There was no record in either the inpatient or community mental health files regarding his [Mr Walsh's] medication pack to indicate whether this was dispensed and/or collected.

What is the explanation for the sub-therapeutic serum reading?

47. The next entry in Mr Walsh's medical records was dated 6 October 2014. This was a Monday. The screenshot taken from Mr Walsh's record on the Stocca Clinical Management System that was completed by the pharmacist at Graylands Hospital read:[41]

> Discussed low clozapine level with Dr Zawadzki. Plan: blister-pack 1 week's supply of medications; clozapine dose 600 mg n[ightly]. Samuel is to have a clozapine level on Thursday 9/10/14; when its result is available on Monday, we can reassess before dispensing the next supply.

48. It is evident from other details on that screenshot that the "*low clozapine level*" was the 309 serum level from the blood test on 30 September 2014.

49. Dr Morton was of the view this low serum level could be evidence that Mr Walsh was taking his medication, "*in partial doses rather than full doses*".[42] On the other hand, Dr Tate was of the view that the reduction to 500 mg clozapine each morning from 24 September 2014:[43]

> "… could have been sufficient to result in a level of 309 just on its own. So I don't think that in itself necessarily says that he definitely wasn't compliant with his treatment. I think a dosage change of that magnitude could well

[39] Exhibit 1, Volume 1, Tab 31, Report - Dr Tate dated 6 May 2021, p.4
[40] Exhibit 1, Volume 1, Tab 31, Report - Dr Tate dated 6 May 2021, p.4
[41] Letter from Ms Paljetak to Counsel Assisting dated 26 May 2021
[42] ts 12.5.21 (Dr Morton), p.11
[43] ts 12.5.21 (Dr Tate), p.27

> have resulted in a sufficient under swing, if you like, of the level of clozapine".

50. I have decided it is not possible to make a conclusive finding as to why Mr Walsh had that low serum level of 309 on 30 September 2014. Apart from the views held by Dr Morton and Dr Tate, a third scenario is that Mr Walsh was taking his medication as directed and the reading was what Dr Morton described as a "*rogue result*".[44] Although there is now no record of Mr Walsh being dispensed with his weekly medication pack on 30 September 2014, it would be most unusual if he was not given this pack when he attended Graylands Hospital on 30 September 2014. Accordingly, I am not prepared to make a finding that Mr Walsh was not given his medication pack on 30 September 2014.

51. However, what I can find is that within a short space of time after he absconded on 5 October 2014, Mr Walsh had a psychotic relapse.

THE EVENTS OF 5 OCTOBER 2014

52. The day that Mr Walsh absconded was a Sunday. At about 8.30 am that morning, the Duty Supervisor at Romily House spoke to Mr Walsh. She had known him for about seven years; first when she was a welfare officer at the Frankland Centre and then in her position at Romily House. He was planning to leave that day, which was not uncommon as he was permitted to be absent from Romily House for up to eight hours. She described him as follows:[45]

> Sam was the same as he always was, friendly, basically the same old Sam.
>
> Nothing seemed different on the day, nothing seemed out of place, Sam did not seem different, there was nothing for me to think he would not be coming back.
>
> …
>
> He was happy as he always was and his demeanour was the same as well.

53. The subsequent police investigation into Mr Walsh's absconding was able to trace his following movements on this day after he drove from Romily House. At 11.57 am, Mr Walsh's car was recorded driving on Great Eastern Highways in Hines Hill by a police vehicle equipped with an Automatic

[44] ts 12.5.21 (Dr Morton), p.13
[45] Exhibit 1, Volume 1, Tab 8, Statement - Josephine Potts, p.2

Number Plate Recognition system.[46] Hines Hill is a location approximately 20 km west of Merredin.

54. At 12.09 pm, Mr Walsh and his car were observed on CCTV camera footage at the BP service station on Great Eastern Highway in Merredin. Mr Walsh refuelled his car, went to the toilet, and purchased a chocolate bar with cash. He then drove away in an easterly direction on Great Eastern Highway towards Southern Cross.[47]

55. There were no other confirmed sightings that were reported of Mr Walsh or his car after this point.[48]

THE EVENTS OF 11 JANUARY 2017

56. On 11 January 2017, a Water Corporation maintenance worker was repairing air valves on the Perth to Kalgoorlie water pipeline. He was at a location on the pipeline in the Yellowdine Nature Reserve approximately 45-47 km east of Southern Cross. At this point, the pipeline was roughly 1.5 km north of Great Eastern Highway and running roughly parallel to the road.

57. At about 12.40 pm, the maintenance worker saw a car parked on the northern side of the pipeline. He approached the car and noticed a hose, similar to a vacuum cleaner hose, coming from the front passenger window. The window was partially open with clothing pushed into the gap between the window and the hose. The hose went along the ground to the rear of the vehicle, near the exhaust pipe. When the maintenance worker opened the driver's side front door, he saw a badly decomposed body in the driver's seat. The maintenance worker used his two-way radio to arrange contact with emergency services.[49]

58. Police attending the scene observed no visible tracks around the car to indicate how it came to be at the location. The car was dusty and appeared to have been stationary for a significant period. Police described the human remains as "*mummified*" and noted that the key was in the ignition, which had been turned on. Personal items were in the car and on the front passenger seat were items in the name of Mr Walsh. A handwritten note in a notepad was also located on the front passenger seat. A fingerprint identification

[46] Exhibit 1, Volume 1, Tab 20, Vehicle Information dated 5 October 2014
[47] Exhibit 1, Volume 1, Tab 4, Email from Acting Sergeant Paul Carrier with attached images
[48] Exhibit 1, Volume 1, Tab 2, WAPOL Report - Sergeant Dave Thirlwell dated 13 December 2019
[49] Exhibit 1, Volume 1, Tab 12, Statement - George Boso dated 11 January 2017

confirmed the body was that of Mr Walsh.[50] Investigating police were satisfied that there were no suspicious circumstances and expressed a view that Mr Walsh had committed suicide by carbon monoxide poisoning.

59. Amongst the items in the car included a portable hard drive and two electronic navigational devices. These items were forwarded to Police Technology Crime Services for analysis; however, no information could be retrieved from these devices relating to Mr Walsh's movements between his absconding from Romily House and the final location of his car.

60. Police also examined all other items from the car. However, apart from the contents of the handwritten note, no evidence was found to explain why Mr Walsh had absconded from Romily House or why he had driven to such a remote location.[51]

CAUSE AND MANNER OF DEATH

Cause of Death

61. Dr White, a forensic pathologist, conducted a post mortem examination on the body of Mr Walsh on 16 January 2017.[52] Dr Buck, an anthropologist, also attended the post mortem examination.

62. The post mortem examination was very limited because Mr Walsh's body was largely skeletonized. There was no suitable tissue available for histology (microscopic examination) due to the degree of decomposition. The unavailability of suitable toxicology samples meant that no toxicological analysis could be performed.

63. On 25 October 2017, Dr White and Dr Buck expressed the opinion that the cause of death was unascertained.

64. The opinion of the forensic pathologist and the anthropologist as to the cause of death must necessarily be confined to an examination of the body. In contrast, I can examine all the evidence to determine if I can make a finding as to the cause of death. It will be a rare occasion that a coroner will make a finding as to the cause of death that is not the same as the forensic pathologist's opinion. This, however, is one such case.

[50] Exhibit 1, Volume 1, Tab 2, WAPOL Report - Sergeant Dave Thirlwell dated 13 December 2019, pp.8-9
[51] Exhibit 1, Volume 1, Tab 2, WAPOL Report - Sergeant Dave Thirlwell dated 13 December 2019, p.9
[52] Exhibit 1, Volume 1, Tab 5A-C, Interim, Post Mortem and Supplementary Post Mortem Reports - Dr J White and Dr A Buck dated 16 January 2017

65. Considering all the evidence, I am satisfied to the requisite standard that the cause of Mr Walsh's death was carbon monoxide toxicity. I can make that finding based on the physical evidence found in and about Mr Walsh's car. Significantly, there was a hose extending from the rear of the car into the front passenger window which was wound up as far as it could be and then had clothing items blocking any air flow through the gap. All other windows had been wound up. The ignition key was still in the ignition which had been switched on.[53] I also note that Mr Walsh had purchased fuel in Merredin which was approximately 150 km from the car's location. Finally, there is the contents of the handwritten note located in the car by police, which supports a finding that Mr Walsh intended to end his own life.

Manner of Death

66. Based on all the evidence before me, I am satisfied that Mr Walsh parked his car at a remote location, attached a hose to the exhaust pipe of his car and placed the end of it into his car through a small gap in a window. He then sealed the gap with items of clothing, before sitting in the driver's seat and turning the engine on.

67. The contents of the handwritten note found on the front passenger seat of the car demonstrate that Mr Walsh intended to end his life. Included in that two page note, which he had addressed to his sister, Mr Walsh stated that he will help his sister "*from the other side*" and that she should not be sad for him as he was "*with Kathy*".[54] He also referred to Jesus and a hope "*that He will let me go home*". Finally, there was a request for certain songs be played at his funeral.[55]

68. Accordingly, I find that Mr Walsh's death occurred by way of suicide.

TIME OF DEATH

69. I am satisfied that although Mr Walsh's body was not found for more than two years after his absconding from Romily House, he died sometime in the week after he had absconded.

[53] Exhibit 1, Volume 1, Tab 18, Forensic Disclosure Report dated 8 December 2019
[54] I am satisfied that this is a reference to the older sister of Mr Walsh who had died.
[55] Exhibit 1, Volume 1, Tab 22, Photograph of hand-written note; Exhibit 2, Type-written version of the hand writing

70. I have made that determination based the following facts. First, there was no sighting of Mr Walsh following his purchases at the service station in Merredin just after mid-day on 5 October 2014. With the prevalence of CCTV footage at service stations and other retail outlets, it would be expected there would be other images or evidence of Mr Walsh purchasing items. Second, there is no evidence he had booked accommodation or had the necessary clothing and supplies to be absent for any length of time. Third, the biblical references in his hand-written note showed that he was, at the time, "*descending into a psychotic state*".[56] Dr Tate agreed that the possibility of a very quick psychotic relapse after ceasing to take clozapine was very real.[57] I note that had Mr Walsh taken his medication as prescribed, he would have had no clozapine after 5 October 2014. As a ballpark figure, Dr Tate indicated such as relapse could occur in the order of one to two weeks after ceasing the medication.[58] Finally, there is some consistency in the colour and type of shorts and shoes that Mr Walsh was wearing when he visited the service station in Merredin on 5 October 2014 and the shorts and shoes on his body when it was found.[59]

QUALITY OF SUPERVISION, TREATMENT AND CARE OF MR WALSH

Before the Supreme Court trial

71. Based on all the evidence before me, I am satisfied that the supervision, treatment and care of Mr Walsh by police, prison staff and mental health clinicians from the time of his arrest on 17 October 2005 to his Supreme Court trial on 26 March 2007 was appropriate. The day after his arrest, he was transferred on a hospital order to the Frankland Centre at Graylands Hospital. Given his delusional behaviour when he handed himself into police at Kalgoorlie, that course of action was entirely appropriate. By November 2005, he was placed on clozapine which became the mainstay of his treatment for the next nine years.[60] Although there was a relapse in September 2006 following his return to Hakea Prison, I am satisfied that his treatment and care were dealt with appropriately upon his readmission to the Frankland Centre. I am also satisfied that once his mental state improved it

[56] ts 12.5.21 (Dr Morton), p.16
[57] ts 15.2.21 (Dr Tate), p.29
[58] ts 15.2.21 (Dr Tate), p.29
[59] Exhibit 1, Volume 1, Tab 21, Attached Images; Exhibit 1, Volume 1, Tab 3B, Post Mortem Report - Dr J White and Dr A Buck, p.2. Although it does not appear he was wearing the same coloured shirt.
[60] Exhibit 1, Volume 1, Tab 27A, Report - Dr Peter Morton, p.3

was appropriate for him to be returned to Hakea Prison, pending his Supreme Court trial.

After the Supreme Court trial

72. Within a week of the handing down of the decision in his Supreme Court trial, Mr Walsh was transferred from Hakea Prison back to the Frankland Centre at Graylands Hospital. He then had a prolonged psychiatric hospitalisation for the next 7 years and 6 months. Aside from the delay in reporting the absconding, I am satisfied that the supervision, treatment, and care provided to Mr Walsh by those mental health clinicians who treated him over this period was of a high standard. As stated by Dr Morton:[61]

> During this time his condition improved and there was a progressive relaxation on restrictions as he made his way from acute care settings to rehabilitation wards. All of this occurred following alterations to conditions of Mr Walsh's custody order after reviews by the MIARB Board. It is of note in the reports forwarded to the MIARB ward [sic-Board] that he was compliant with all the management plans and medical treatment. Further he achieved a clinical remission from symptoms of a schizophrenic illness. There are some suggestions that although positive symptoms of his illness had remitted (delusions, thought disorder and hallucinations) he did display some negative symptoms (avolition, blunt of affect), according to some reports. Apart from the relapse of symptoms in 2006 whilst in prison he maintained health for a number of years.
>
> …
>
> Mr Walsh was seen regularly by medical staff at the Frankland Centre and his monthly blood tests were performed. He was on a stable dose of clozapine until his dosage was lowered. This was done because he recorded higher than expected results from two consecutive blood tests (17 [sic - 19] and 22 of September).

The week before Mr Walsh's absconding

73. Notwithstanding the drop in Mr Walsh's serum level to 309 from his blood test on 30 September 2014, I am satisfied of the care that was being taken to adjust his clozapine intake so that it fell below a serum level of 1000. He had six blood tests over a three-week period from 9 September to 30 September 2014, with another one scheduled for 9 October 2014. I accept that it can be a difficult exercise to adjust the clozapine dosage to the correct amount following unanticipated high serum levels.

[61] Exhibit 1, Volume 1, Tab 27A, Report - Dr Peter Morton, pp.4-5

74. I am also satisfied that on 30 September 2014, Mr Walsh was exhibiting no signs that would cause any concern about his mental well-being. He was reviewed on that day by his case manager. That review stated:[62]

> There were no concerns about his mental state. SW was noted to be clean, calm, chatty, friendly, talking about how he enjoyed his job, he was enthusiastic about gaining employment through the same agency. His affect was warm and reactive. He enquired again about his current status under the Mental Health Act and said he looked forward to the possibility of getting an independent unit from Romily House. He was future orientated. A plan was put in place for him to go out on 9 October for a social outing with his case manager.

75. For reasons I have been unable to precisely identify, at or shortly before his death, Mr Walsh's clozapine level in his system had dropped to a point where he experienced a psychotic relapse. However, I am satisfied that Mr Walsh did not present with any changes in his behaviour prior to or on 5 October 2014 that would have caused any concern for those who were looking after him. As stated by Dr Morton:[63]

> Other supervision occurred [apart] from the staff at Romily House; the observation of nursing staff at the Frankland Centre where he would spend one night a fortnight and by the weekly visits from his community forensic mental health physician. This is very comprehensive and involves many people most of whom will have had a professional knowledge of Mr Walsh. Such longitudinal knowledge of his case and mental state is often good at picking up subtle changes in presentation that may be a harbinger of relapse. It is apparent that there was no concern about an alteration in his presentation prior to him absconding. Most individuals on long term clozapine medication would not have had such a comprehensive formal supervision and care. There were adequate checks on his mental state and compliance with his treatment regime. I have past personal experience with Romily House and its staff through previous employment and believe them to be highly professional in their approach.

76. Similarly, Dr Tate reported:[64]

> Based on the medical records available it appears that Mr Walsh was considered to be psychiatrically stable at the time of his disappearance. Notwithstanding some changes to his clozapine treatment in the preceding weeks his mental state was assessed on several occasions by various clinicians both in the hospital and the community prior to his

[62] Exhibit 1, Volume 1, Tab 30, Clinical Review dated 10 October 2014, p.5
[63] Exhibit 1, Volume 1, Tab 27A, Report - Dr Peter Morton, p.5
[64] Exhibit 1, Volume 1, Tab 31, Report - Dr Tate dated 6 May 2021, p.3

> disappearance and no evidence of relapse or concerning features were observed. Additionally, no concerns were reported by staff at his licensed psychiatric hostel some of whom by that time known him for approximately four years.

77. Accordingly, I find there was no evidence that Mr Walsh was behaving in a manner to suggest he was no longer in clinical remission on or before 5 October 2014 or that he was intending to abscond.

The delay in reporting the absconding

78. Mr Walsh would normally return to Romily House on a Sunday between 9.30 pm and 10.00 pm.[65] When he had not returned by 10.30 pm on 5 October 2014, the assistant manager contacted the manager at Romily House to inform her of his absence.[66] The concern at that stage was something had happened to him rather than he had absconded. Graylands Hospital was not notified of Mr Walsh's non-appearance that night. The explanation given for that was it was after hours and there was no one at Graylands Hospital to make a report to. Hence, Mr Walsh's disappearance was not reported to Graylands Hospital until the next morning.[67]

79. The following details regarding the events of 6 October 2014 are from the clinical review by North Metropolitan Health Service.[68] Mr Walsh's case manager was notified of his absence on the morning of 6 October 2014. The Frankland Centre was contacted by the case manager at 8.40 am to determine if Mr Walsh had stayed overnight there. The Frankland Centre confirmed that he had not. The case manager then contacted the assistant manager at Romily House to advise that Mr Walsh did not stay overnight at the Frankland Centre. The case manager told the assistant manager to contact the Frankland Centre and advise that Mr Walsh had not returned from his planned leave. That call was made by Romily House to the Frankland Centre just after 8.45 am. At about 9.15 am, Romily House advised Mr Walsh's treating doctor at Graylands Hospital (the doctor) of his absconding. The doctor then advised the Registrar of the Board, stating it was an urgent matter and requesting an arrest warrant for Mr Walsh.[69] At 4.05 pm, the Board advised SFMHS that it

[65] Exhibit 1, Volume 1, Tab 9, Statement - Emma Watson dated 20 October 2014
[66] Exhibit 1, Volume 1, Tab 9, Statement – Emma Watson dated 20 October 2014
[67] Exhibit 1, Volume 1, Tab 9, Statement - Emma Watson dated 20 October 2014
[68] Exhibit 1, Volume 1, Tab 30, Clinical Review dated 10 October 2014
[69] The Board has no power under the *Criminal Law (Mentally Impaired Accused) Act 1996* (WA) to issue an arrest warrant.

should inform the police. By this stage, Mr Walsh had been identified by the doctor, "*as a potential high risk of assault and harm to self, as a result of him not having access to medication*".[70] Formal AWOL procedures began at 4.20 pm by the senior nurse at the Frankland Centre under the direction of the service manager. Police were not informed of Mr Walsh's absconding by SFMHS staff until 4.50 pm.[71] Police stated they were concerned that (i) Mr Walsh's disappearance had not been reported earlier and (ii) little detail had been given of his description, such as the last time he was seen, his clothing and general appearance.

80. North Metropolitan Health Service's Standard Operating Procedure 6 was in existence at the time and governed what Romily House should do if a Leave of Absence patient was away without leave.[72] Mr Walsh was one such patient. Step 3 in that document required Romily House staff to telephone a forensic nurse at the Hutchison Ward at Graylands Hospital to report "*an incident of AWOL*" regarding any Leave of Absence patients.[73] Although the document identifies two contact numbers for the forensic nurse at the Hutchison Ward, it is not clear whether either of those were after-hours numbers. However, Steps 4 and 5 indicate who the forensic nurse and/or shift coordinator at the Hutchison Ward can contact when the matter is "*out of hours*". That infers the procedure in Step 3 can also be implemented out of hours should the AWOL incident occur then.

81. I share the concerns expressed by police regarding the delay in reporting Mr Walsh's absconding to them. It is also unfortunate that staff at Romily House did not make any attempt to notify Graylands Hospital of Mr Walsh's absence on the evening of 5 October 2014 after he had failed to return on time. Even if staff at Romily House had concerns that something had happened to Mr Walsh (as distinct from concerns that he had absconded), Graylands Hospital ought to have been notified. The policy statement in the version of SFMHS's Absconders Absent Without Leave that existed at the time supports my comments. It read: "*SFMHS will ensure that robust systems*

[70] Exhibit 1, Volume 1, Tab 30, Clinical Review dated 10 October 2014, p.3
[71] However, police had been notified by email from a Senior Advisory Officer from the Board at 2.12 pm on 6 October 2014 and at 4.37 pm a police alert had been placed on Mr Walsh to be apprehended if located and returned to Graylands Hospital : Exhibit 1, Volume 2, Running Sheet - Sergeant Dave Thirlwell, pp.89-90
[72] Exhibit 1, Volume 1, Tab 29, Standard Operating Procedure 6 - Clinical Deterioration or any Other Incidents of Concerns (including AWOL) of Forensic Patients at Romily House dated 10 June 2014
[73] Exhibit 1, Volume 1, Tab 29, Standard Operating Procedure 6 - Clinical Deterioration or any Other Incidents of Concerns (including AWOL) of Forensic Patients at Romily House dated 10 June 2014

are in place to identify any incident of absconding and take immediate and appropriate action to locate and return any missing patients."[74]

82. Nevertheless, even if Mr Walsh's absconding had been reported to Graylands Hospital and the police on the night of 5 October 2014, it is unlikely he would have been apprehended prior to his death as there was a real possibility he had already died by then.

AN EXPLANATION FOR MR WALSH'S SUICIDE

83. I have been able to determine the cause of death, the manner of death and an approximate time of death, however I have not been able to find, to the required standard, an explanation for Mr Walsh's suicide. Although I am not required by the *Coroners Act 1996* (WA) to make such a finding, the contents of the statement prepared by Mr Walsh's sister may provide one possible explanation. In that statement, she said:[75]

> Sam was really excited that he could live a normal type lifestyle again and I know he was really hoping to be released so he could start his life again.
>
> Sam was in the process of being reviewed for release by the Mental Health Board [sic – Mentally Impaired Accused Review Board], and I remember writing a letter for him.
>
> …
>
> Sam's matter was reviewed and he wasn't released from Romily House.
>
> Sam took this really badly and stopped being positive about his future. I could see Sam gave up all hope and stopped trying as much.
>
> Sam used to say to me, 'what's the point in trying to fix himself if he was never going to get out'.
>
> I noticed a massive change in Sam once this decision was made.

84. This attitude and comments attributed to Mr Walsh are at odds with what his case manager noted following Mr Walsh's final review on 30 September 2014. Those notes indicate that he appeared to be very positive.[76] It is also not entirely consistent with the recommendation made by the Board to the Attorney General. That recommendation was not that Mr Walsh be unconditionally released from his custody order, rather it was a

[74] Exhibit 1, Volume 1, Tab 28C, Absconders Absent Without Leave Policy SF-IP-CL-01 dated September 2013
[75] Exhibit 1, Volume 1, Tab 6, Statement - Hazel Beattie, pp.12-13
[76] Exhibit 1, Volume 1, Tab 30, Clinical Review dated 10 October 2014, p.5

recommendation that he be subject to a conditional release order. That condition was that he was to reside full-time at Romily House.

85. Nevertheless, the observations made by Mr Walsh's sister are consistent with the explanation that Mr Walsh ended his life due to the lack of progress towards an unconditional release order. As stated by Dr Morton at the inquest:[77]

> I read an affidavit from his sister who said he was frustrated by the continuing restrictions. It could have been – again, this would be speculation on my part – that he felt he had complied with his medication regime and done everything that had been asked of him and become frustrated and may have done this on an impulse.

86. It was unfortunate that the Board's recommendation to the Attorney General that the Governor be advised to grant a conditional release order to Mr Walsh had made no progress for nearly 18 months. That statutory report from the Board was forwarded to the Office of the Attorney General on 24 April 2013. Nearly one year later, on 4 March 2014, the Office of the Attorney General requested additional information from the Board: namely an update on Mr Walsh's progress since the Board's first report. On 22 July 2014, the Board decided to prepare a second statutory report to the Attorney General, advising that it maintained its recommendation from the previous year. On 29 August 2014, the Board provided the Office of the Attorney General with its second statutory report, again recommending that Mr Walsh be released on a conditional release order. The Board had not received a response from the Attorney General when Mr Walsh absconded on 5 October 2014.[78]

87. Based on the evidence before me, I am not prepared to make a finding that the delay in releasing Mr Walsh from his custody order (either conditionally or unconditionally) was the reason why he committed suicide. To do so would be, to quote Dr Morton, "*speculation on my part*". In reaching this decision I have also had regard to the fact that the note left by Mr Walsh did not refer to this delay as the reason he was intending to end his life.

CONCLUSION

88. All too frequently, the Coroners Court encounters cases in which, through no fault of their own, a person's life and the lives of their loved ones are

[77] ts 12.5.21 (Dr Morton), p.17
[78] Letter from Ms Paljetak to Counsel Assisting dated 8 June 2021

devastated by the scourge of a serious mental health illness. Mr Walsh's case can now be added to that list. He was at the mercy of an undiagnosed paranoid schizophrenic disorder which was responsible for him having a delusional belief that he had to violently kill his own mother. Once that disorder had been treated and was in remission, one can readily appreciate the magnitude of the feelings of shame and guilt that Mr Walsh would have felt.

89. To his credit, and with the assistance of some excellent psychiatric care, Mr Walsh was able to successfully manage his mental health issues and once again become the caring and good-natured man that he was when he was younger. It is a tragedy that having kept his paranoid schizophrenia in remission for eight years and possibly being just a few short steps away from an unconditional release from his custody order, Mr Walsh decided to end his life after apparently experiencing a single psychotic relapse.

P J Urquhart
Coroner
29 June 2021