JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	PHILIP JOHN URQUHART, CORONER
HEARD	**:**	4 OCTOBER 2022
DELIVERED	**:**	12 DECEMBER 2022
FILE NO/S	**:**	CORC 2445 of 2020
DECEASED	**:**	WESTON, LEWIS HENRY MARK

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:

Mr J. Tiller assisted the Coroner
Ms H. Richardson (State Solicitor's Office) appeared on behalf of the East Metropolitan Health Service

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 ***Lewis Henry Mark WESTON*** *with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, Perth, on 4 October 2022, find that the identity of the deceased person was* ***Lewis Henry Mark WESTON*** *and that death occurred on 3 November 2020 at Higgins Park, East Victoria Park, from ligature compression of the neck (hanging) in the following circumstances:*

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INTRODUCTION

1 The deceased (Mr Weston) died on 3 November 2020 at Higgins Park, a public reserve in East Victoria Park, from ligature compression of the neck (hanging). He was 22 years old.

2 At the time of his death, Mr Weston was subject to a Community Treatment Order (CTO), pursuant to section 23 of the *Mental Health Act 2014* (WA). He was therefore an involuntary patient as defined in that Act.[1]

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

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

5 I held an inquest into Mr Weston's death at Perth on 4 October 2022. The following witnesses gave oral evidence at the inquest:

i. Dr Elvin Kay Feng Ko, (Consultant Psychiatrist for the Bentley Community Mental Health Clinic);

ii. Dr Daniel Hacking, (Consultant Psychiatrist, Osborne Park Headspace Early Psychosis).

6 The documentary evidence at the inquest comprised of a volume of material which was tendered by Counsel Assisting as exhibit 1. Ms Richardson, counsel appearing for the East Metropolitan Health Service, also tendered a report from Dr Elvin Ko (with three attachments) and that material became exhibit 2.1-2.4.

[1] Section 4 and section 21 of the *Mental Health Act 2014* (WA)
[2] Section 3 of the *Coroners Act 1996* (WA)
[3] Section 22(1)(c) of the *Coroners Act 1996* (WA)
[4] Section 25(3) of the *Coroners Act 1996* (WA)

7 My primary function at the inquest was to investigate the quality of Mr Weston's supervision, treatment and care that was provided to him when he was placed under various CTOs in 2019 and 2020.

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

9 I am also mindful not to assert hindsight bias into my assessment of the actions taken by Mr Weston's mental health service providers in their treatment of him when the CTOs were in place. Hindsight bias is the tendency, after an event, to assume the event was more predictable or foreseeable than it actually was at the time.[5]

MR WESTON

Background [6]

10 Mr Weston was born on 3 June 1998 in South Africa. He had one older brother. In 2008, Mr Weston's family moved to the United Kingdom, with Mr Weston's parents separating the following year. In 2010, Mr Weston's mother and her two sons moved to Western Australia, where Mr Weston's mother was raised. At the time of his death, Mr Weston was living in the Perth suburb of Kensington with his mother, her partner and her partner's daughter. Mr Weston's older brother was living in the United States and his father was residing in South Africa.

[5] Dillon H and Hadley M, *The Australasian Coroner's Manual* (2015) 10
[6] Exhibit 1, Tab 2, WAPF Coronial Investigation Squad Report by 1st Class Constable Sean Larson-Pearse; Exhibit 1, Tab 24, Notes and Correspondence from Dr Roger Paterson

11 Mr Weston attended Hale School, completing Year 12 in 2015. He was a popular student amongst his teachers and his peers. He was also a very good rugby player and he had represented the school in that sport.

12 In 2014, Mr Weston was diagnosed with Attention Deficit Hyperactivity Disorder (ADHD). He was prescribed dexamphetamine and his ADHD responded well to that treatment. By this stage, Mr Weston was also using cannabis and the psychiatrist who was treating the ADHD emphasised the need for Mr Weston to monitor his cannabis use carefully.

13 After successfully completing his Australian Tertiary Admission Rank (ATAR) subjects at the end of 2015, Mr Weston took a 'gap year' in 2016. He went to England and worked at a boys' college in South London which specialised in sport. There, he continued playing rugby.

14 After returning to Perth, Mr Weston commenced a commerce degree in 2017 at the University of Western Australia (UWA) and lived at a residential college on the campus. Although he abstained from using cannabis when he was in England, Mr Weston began regular cannabis use once he had returned.

Mental health issues [7]

15 By mid-2017, Mr Weston's self-care had deteriorated and he was not sleeping well due to exam stress. He had also increased his use of cannabis and ADHD medication. At his mother's insistence, Mr Weston was taken to the emergency department of Sir Charles Gairdner Hospital (SCGH) at 5.20 am on 24 June 2017.

[7] Exhibit 1, Tab 17, Report of Dr Daniel Hacking dated 16 November 2020; Exhibit 1, Tab 22.10, Letter from Dr Daniel Hacking to the Mental Health Tribunal dated 24 July 2020; Exhibit 1, Tab 23, Sir Charles Gairdner Hospital Medical Records; Exhibit 1, Tab 25, Graylands Hospital Medical Records

16 It quickly became evident to emergency department medical staff at SCGH that Mr Weston was experiencing psychosis. He maintained he was able to communicate with a swan, that he could hear the thoughts and voices of people talking about him and that his friends' voices were inside his head. He was also pre-occupied with the supernatural. A urine drug screen was positive for amphetamine, cannabis and MDMA, which was consistent with his prescription for dexamphetamine and his admission of illicit drug use that included the daily smoking of up to five cannabis joints.

17 Unfortunately, Mr Weston, despite the overwhelming evidence, would not accept that he was unwell, and he had to be sedated after he refused to remain in hospital.

18 At 10.15 am on 24 June 2017, a doctor at SCGH completed a '*Form 1A – Referral for Examination by Psychiatrist*' (Form 1A) pursuant to the *Mental Health Act 2014* (WA). This examination was to take place at Graylands Hospital. The Form 1A stated:[8]

> First-episode psychosis with prominent thought disorder, paranoid delusions and auditory hallucinations. Plane ticket to South Africa booked for 27-06 with plans to also travel alone to Nigeria. At risk to self, voicing suicidal ideation and intent with vague plan. Risk of harm to others in the context of psychotic features. Aware something is amiss regarding his mental state, however unwilling to remain in hospital for further input. Requiring IV sedation with security presence at triage.

19 Mr Weston was admitted to Graylands Hospital on the same day, where he remained until his discharge on 5 July 2017.

20 During his stay at Graylands Hospital, Mr Weston gained an improving insight into his psychotic experiences. He was prescribed an oral antipsychotic medication, olanzapine, and the principal diagnosis was identified as substance-induced psychosis. Accordingly, his dexamphetamine medication was ceased and he was advised to continue taking the

[8] Exhibit 1, Tab 23, Sir Charles Gairdner Hospital Medical Records

antipsychotic medication. Mr Weston was discharged into the care of Youth Hospital In The Home and was referred to a community mental health service for follow-up.

The involvement of Osborne Park Headspace Early Psychosis [9]

21 The service that Mr Weston was referred to following his hospital discharge was Osborne Park Headspace Early Psychosis (Headspace). Headspace is operated by Black Swan Health, a non-government organisation (NGO). It provides a community mental health service for young people experiencing first-episode psychosis, or who are at risk of developing a psychotic illness. It is a care coordinated model within a multidisciplinary community mental health team comprised of psychiatrists, nurses, social workers, occupational therapists and psychologists. Treatment and care coordination can be given for a period of up to five years if the young person is admitted to the First Episode Psychosis stream, as Mr Weston was in 2017.

22 Dr Daniel Hacking (Dr Hacking), a consultant psychiatrist at Headspace, became Mr Weston's treating psychiatrist when he was referred to Headspace on 12 July 2017.

23 Mr Weston found daily doses of oral olanzapine over 10 mg as highly sedating, and he also developed sexual dysfunction with a raised prolactin. A switch to the oral antipsychotic medication, aripiprazole, was ineffective as he developed akathisia (inner and motor restlessness). Mr Weston did consider taking risperidone, another antipsychotic medication. However, due to his concerns regarding sexual dysfunction if his prolactin was raised again, he stopped taking all antipsychotic medication in December 2017.

[9] Exhibit 1, Tab 17, Report of Dr Daniel Hacking dated 16 November 2020

24 In the five months that followed, Mr Weston had no symptoms of psychosis, even though he admitted using cannabis during this period.

25 Over Christmas 2017, Mr Weston went to visit his father in South Africa. Whilst there, he saw a general practitioner who prescribed him escitalopram, an antidepressant medication. Upon his return, Mr Weston wanted to continue taking escitalopram and Dr Hacking agreed to monitor his progress on this prescribed drug without antipsychotic medication.

26 Mr Weston successfully managed his mental health for most of 2018. He stopped socialising with his drug-taking friends and studied hard whilst living with his mother and her partner. His mother noted that he was "*back to his old self*."

27 Although Mr Weston passed his end of year university examinations in 2018, this period led to a relapse of his mental health disorder. Once again, he became stressed in the lead up to his examinations and, to improve his performance, he started using cannabis and left-over dexamphetamine tablets that he had retained. Mr Weston displayed the tell-tale signs of a relapse; speaking rapidly, becoming grandiose, irritable and disinhibited.

28 On 8 December 2018, Mr Weston allowed his mother to take him to the emergency department of SCGH as he was certain there was nothing wrong with him. He was prepared to appease his mother as he was also looking forward to an upcoming holiday in Thailand with his father.

29 Mr Weston presented at the emergency department of SCGH as over familiar with clinicians, hyper-vigilant, distracted and evasive. He had grandiose delusions with disordered thoughts regarding an ability to read people's body language.

30 Unsurprisingly, he was diagnosed with a psychotic episode and treating doctors arranged for Mr Weston to be transferred to Graylands Hospital. He was treated with olanzapine before that transfer.

31 Mr Weston was discharged from Graylands Hospital several days later on 12 December 2018. Dr Hacking had seen him the previous day and Mr Weston agreed to recommence his olanzapine medication. Treating doctors also agreed that Mr Weston should fly to Thailand so that he could spend time with his father. After denying any thoughts of self-harm, Mr Weston was discharged home in the care of his mother and subsequently went to Thailand over the Christmas period.

32 Unfortunately, Mr Weston was reluctant to take his medication in Thailand. He was once again elevated, irritable and grandiose; describing he was a god who was destined for greatness and that his purpose was to change the world.

33 On 4 January 2019, Dr Hacking saw Mr Weston following his return to Perth. Mr Weston presented as speaking rapidly, being elevated in mood and having grandiose beliefs that he had a special purpose. He lacked insight into his illness and maintained he was not unwell. As Mr Weston was refusing to take his medication, Dr Hacking formed the view that he had no option other than to place him on a CTO.

What is a Community Treatment Order? [10]

34 A CTO is an order made under the *Mental Health Act 2014* (WA) for a person to receive treatment as an involuntary patient in the community.

[10] Sections 55, 56, 61, 72, 75, 76, 89, 90, 120, 123, 131 of the *Mental Health Act 2014* (WA)

35 A CTO can only be made by a psychiatrist completing a '*Form 5A – Community Treatment Order*' under the *Mental Health Act 2014* (WA). To make a CTO, the psychiatrist must be satisfied that:

- the patient has a mental illness that requires treatment;
- there is a significant risk to the patient or another person if the patient does not get treatment;
- the patient is not well enough to make a decision about treatment;
- the patient need not be admitted to a hospital to get the required treatment; and
- there is no less restrictive way of providing the patient with treatment other than a CTO.

36 As a person who is subject to a CTO is an involuntary patient, they must accept the treatment that has been planned for them. The supervising psychiatrist (or another mental health practitioner if the psychiatrist is unavailable) must conduct an examination of the person at least once a month.

37 The patient must follow all directions made by the supervising psychiatrist as set out in the terms of the CTO. If there is a failure to comply with the CTO with respect to attending an examination, the psychiatrist may make a transport order by completing a '*Form 4A – Transport Order*' under the *Mental Health Act 2014* (WA) to ensure that the patient is brought to the place specified in the transport order to be provided with treatment.

38 A CTO can be in place for up to three months and it may be extended for up to three months by the supervising psychiatrist as many times as it is deemed necessary. This is done by the psychiatrist completing a '*Form 5B – Continuation of Community Treatment Order*' under the *Mental Health Act 2014* (WA).

39 An application for a review of any decision made under a CTO that affects a person's rights under the *Mental Health Act 2014* (WA) may be made to the Mental Health Tribunal.

40 A CTO will no longer apply if:

- it expires and it is not continued;
- the supervising psychiatrist determines that the patient is well enough for the CTO to be cancelled;
- the supervising psychiatrist determines that the patient requires treatment in a hospital and completes a '*Form 6A – Inpatient Treatment Order in an Authorised Hospital*' under the *Mental Health Act 2014* (WA); or
- the Mental Health Tribunal reviews the case and decides the patient no longer needs to be an involuntary patient.

Mr Weston's first CTO [11]

41 As referred to above, Mr Weston was placed under a CTO by Dr Hacking on 4 January 2019. The CTO was for a period of three months and Dr Hacking was named as the supervising psychiatrist. To his credit, Mr Weston agreed to be prescribed a daily dose of 10 mg of olanzapine wafers under the supervision of his mother. Accordingly, his mental state gradually improved.

42 On 23 January 2019, Mr Weston sought a second opinion regarding the diagnosis of his mental health disorder from Dr Gordon Shymko, a psychiatrist with the Rockingham Mental Health Service. Dr Shymko was also the medical director of Headspace.

43 Dr Shymko expressed the opinion that Mr Weston was most likely manic in the context of a Bipolar Affective Disorder; however, he was also of the view that Schizoaffective Disorder should be considered as a differential diagnosis.

[11] Exhibit 1, Tab 17, Report of Dr Daniel Hacking dated 16 November 2020

44 Mr Weston was then commenced on the mood stabilising medication, lithium carbonate. His mental state improved with this medication and Dr Hacking cancelled the CTO on 26 March 2019 on the basis that Mr Weston now had the necessary mental capacity to make informed decisions about his treatment.

Admission to SCGH [12]

45 Unfortunately, it was not long before Mr Weston had another relapse with psychosis when he started using cannabis again. On 16 April 2019, he was admitted to SCGH under a '*Form 1A – Referral for Examination by Psychiatrist*'. It was noted Mr Weston held the belief that he was:[13]

> At the top of the Illuminati, grandiose beliefs he is top of everyone, expressing delusions that clinician is part of a cult and that staff will be killed. Unable to control head movements, turning head from side-to-side reporting that he is possessed.

46 On admission to SCGH, Mr Weston presented as elevated and irritable with rapid speech. He was laughing and smiling inappropriately, responding to unseen stimuli and maintained there was nothing wrong with him. Mr Weston also said that he did not need medication and refused to take olanzapine when it was offered to him. His sleep patterns were also poor during the initial stages of his admission. Mr Weston was placed on a '*Form 6A – Inpatient Treatment Order in Authorised Hospital*' under the *Mental Health Act 2014* (WA) and was admitted to the locked ward of the mental health unit at SCGH. Once there, he expressed a belief that patients were being sexually assaulted and, at one point, even telephoned the police to report this belief.

47 During his admission at SCGH, Mr Weston was trialled on several antipsychotic medications. After repeatedly asserting that he would not take

[12] Exhibit 1, Tab 17, Report of Dr Daniel Hacking dated 16 November 2020; Exhibit 1, Tab 23, Sir Charles Gairdner Hospital Medical Records
[13] Exhibit 1, Tab 17, Report of Dr Daniel Hacking dated 16 November 2020, p.3

oral antipsychotic medications after he was discharged, a decision was made that the antipsychotic medication, paliperidone, would be administered by depot injection. This commenced on 29 April 2019.

48 With the commencement of paliperidone depot injections and ongoing daily lithium carbonate doses, Mr Weston's mental state steadily improved during his hospital admission. However, the assessment of his grandiose delusions remained difficult as he refused to answer questions relating to these beliefs throughout his stay at SCGH. He was discharged on 14 May 2019 under another CTO.

Mr Weston's second CTO [14]

49 The second CTO was for a period of three months, with Dr Hacking as the supervising psychiatrist. This CTO was deemed necessary as Mr Weston continued to maintain he did not have a mental illness. Although he agreed to continue taking lithium carbonate, he did not want to take any antipsychotic medications, stating he would cease doing so if he had a choice.

50 Nevertheless, Mr Weston engaged well with Dr Hacking and Headspace after his discharge. However, the paliperidone depot injections had to be ceased after he developed severe akathisia following the first injection after his discharge from SCGH.

51 With the mood stabilising lithium carbonate being his only medication, Mr Weston was able to successfully return to continue his commerce studies at UWA. On 11 June 2019, Dr Hacking cancelled Mr Weston's second CTO on the basis that he had the mental capacity to manage his conditions.

[14] Exhibit 1, Tab 17, Report of Dr Daniel Hacking dated 16 November 2020

52 However, shortly after this, Mr Weston stopped engaging with Dr Hacking and Headspace. He also stopped taking his lithium carbonate medication. Notwithstanding that, Mr Weston's family reported that his mental health was good and that he was able to achieve high distinction grades in his end of year university examinations. Unfortunately, as in the previous year, Mr Weston had a relapse in December 2019.

Another admission to SCGH [15]

53 Just after midnight on 30 December 2019, Mr Weston was taken by ambulance, with accompanying police, to the emergency department of SCGH. He had been behaving erratically whilst boarding a plane at Perth Airport that was flying to South Africa. He was expressing various delusional beliefs that his father had "*killed a man*". Upon admission to the emergency department, he required intravenous sedation due to his behaviour. Although at the time of his admission Mr Weston denied using drugs, a urine analysis tested positive for cannabis.

54 Mr Weston's mother reported that his mental health had declined over a period of two weeks leading up to his attendance at SCGH. After being assessed at the emergency department by a registered nurse, Mr Weston was admitted under a '*Form 1A – Referral For Examination by a Psychiatrist*'.

55 During his admission at SCGH, Mr Weston's lithium carbonate medication was restarted. Yet another antipsychotic medication was trialled, however, he developed akathisia after the first dose. He was therefore restarted on oral olanzapine; however, he developed side-effects, with increased appetite, weight gain, deceased libido and sedation. He was subsequently switched from oral olanzapine to olanzapine depot injections prior to his discharge.

[15] Exhibit 1, Tab 17, Report of Dr Daniel Hacking dated 16 November 2020; Exhibit 1, Tab 23, Sir Charles Gairdner Hospital Medical Records

56 On 17 February 2020, Mr Weston was discharged from SCGH under another CTO.

Mr Weston's third CTO [16]

57 During his admission at SCGH, Mr Weston's principal diagnosis had become Schizoaffective Disorder, with manic psychosis as a complication. At the time of his discharge, he was noted to have, "*good insight into his affective illness but no insight into the psychotic aspects of his illness.*"[17]

58 The CTO dated 17 February 2020 was for the maximum period of three months and was due to end on 16 May 2020. One of the terms of this CTO was that Mr Weston was, "*to comply with medication, currently depot olanzapine 405 mg every four weeks… and oral lithium*".[18] Dr Hacking was the nominated supervising psychiatrist.

59 In order to have Mr Weston comply with his depot injections, Dr Hacking was prepared to accept an arrangement that Mr Weston would continue his olanzapine depot injections for six months, at which time consideration would be given as to whether he should continue with antipsychotic medication. Mr Weston maintained that he did not want to take olanzapine, and that the amount prescribed should be reduced as he found it sedating and slowed his thought processes. He stated this was having a negative impact on his studies.

60 Two attempts were made to reduce the dose of the olanzapine depot injection to a level below the oral equivalent of 10 mg daily. However, on both occasions, there was a clear deterioration in Mr Weston's mental state. He became more psychotic, describing how spirits could communicate with him,

[16] Exhibit 1, Tab 17, Report of Dr Daniel Hacking dated 16 November 2020; Exhibit 1, Tab 13.1-13.5, Community Order Treatment Forms; Exhibit 2.1-2.4, Letter dated 3 October 2022 from Dr Elvin Ko with attachments
[17] Exhibit 1, Tab 23, Sir Charles Gairdner Hospital Medical Records
[18] Exhibit 1, Tab 13.1, Form 5A – Community Treatment Order dated 17 February 2020.

control his movements and speak through him. A switch to a different and more effective type of antipsychotic medication that could only be taken orally (clozapine) was consistently refused by Mr Weston.

61 On 12 May 2020, Dr Hacking completed a '*Form 5B – Continuation of Community Treatment Order*' under the *Mental Health Act 2014* (WA). This was for another period of three months from 16 May 2020 to 15 August 2020. On 11 August 2020, another Form 5B was completed by Dr Hacking extending the CTO for a further three months from 15 August 2020 to 14 November 2020. On each occasion, Dr Hacking deemed the continuation of the CTO was necessary as Mr Weston was maintaining his objection to take antipsychotic medication, and was only consenting to the depot injections to prevent a breach of the CTO.

Transfer of the CTO [19]

62 On or about September 2020, Mr Weston's family moved to live within the catchment area of the Bentley Health Service, which was part of the Department of Health's East Metropolitan Health Service (EMHS). Hence Mr Weston's mental health care had to be handed over from Headspace to Bentley Community Mental Health Clinic (BCMHC), which operated at the Bentley Health Service, E Block outpatient clinic.

63 When he was advised of this transfer, Mr Weston said he was pleased as he wanted a review from a consultant psychiatrist who was independent from Dr Hacking and Headspace. Mr Weston had frequently expressed his frustrations that his treating team at Headspace had labelled his experiences as 'psychotic'. He felt that his spirituality had been misunderstood by Headspace

[19] Exhibit 1, Tab 17, Report of Dr Daniel Hacking dated 16 November 2020; Exhibit 1, Tab 13.1-13.5, Community Order Treatment Forms; Exhibit 2.1-2.4, Letter dated 3 October 2022 from Dr Elvin Ko with attachments

and he placed more emphasis on the views of mediums he had seen. These mediums had supported his beliefs about communicating with spirits.

64 On 13 October 2020, Mr Weston had a meeting with his care coordinator at Headspace. He was irritable and reported that he had not slept the previous night. Mr Weston stated that he continued to communicate with spirits and that although this distracted him from his studies, the spirits were positive and enhanced his life.

65 Despite his best endeavours, Dr Hacking could not persuade Mr Weston to take clozapine. Although clozapine is regarded as the most effective antipsychotic medication, it is also known for its side-effects and the need for the patient to have greater contact with mental health service providers.[20]

66 By October 2020, Mr Weston was not only refusing to consider taking an alternative oral antipsychotic medication, but asserted that he would only take one more olanzapine depot injection.

67 Mr Weston's psychiatrist at BCMHC was to be Dr Elvin Ko (Dr Ko). Dr Ko was a consultant psychiatrist for BCMHC. The referral process to BCMHC began on 15 October 2020.[21]

68 The transfer of Mr Weston's CTO happened simultaneously with the transfer of his mental health treatment from Headspace to BCMHC. A senior social worker from BCMHC made telephone contact with Mr Weston on 19 October 2020 and a triage was performed. At an Assessment and Treatment team meeting the next day, BCMHC made Mr Weston an active patient of the service. He was allocated a care coordinator, and an appointment was scheduled to take place between Mr Weston and Dr Ko on

[20] ts 4.10.22 (Dr Hacking), p.52
[21] Exhibit 1, Tab 22.6, Email Correspondence between Headspace and Bentley Community Mental Health Clinic dated 15 October 2020

4 November 2020. This was intentionally scheduled for the day after Mr Weston's attendance at a Mental Health Tribunal hearing regarding the continuation of his third CTO for another three months from 15 November 2020, as had been recommended by Dr Hacking.

69 By the time of Mr Weston's last olanzapine depot injection on 20 October 2020, it was at a level of 300 mg every four weeks. This was the equivalent of a daily oral dose of about 10 mg. Testing showed that Mr Weston was compliant with his oral lithium carbonate medication. He had also been prescribed metformin to reduce the side-effect of weight gain from the antipsychotic medication.

70 On 28 October 2020, Dr Hacking completed a '*Form 5C – Variation of Terms of Community Treatment Order*' under the *Mental Health Act 2014* (WA) which advised that Dr Ko would be replacing him as Mr Weston's supervising psychiatrist.

EVENTS LEADING TO MR WESTON'S DEATH [22]

71 The last risk assessment carried out by Headspace for Mr Weston was on 14 October 2020. His suicide risk was assessed to be 'low' with a score of three out of 19. Similarly, a risk assessment conducted by a senior social worker at BCMHC in the telephone conversation with Mr Weston on 19 October 2020 assessed him as being at a low risk of suicide. On both occasions, he denied any thoughts of harming himself.

[22] Exhibit 1, Tab 17, Report of Dr Daniel Hacking dated 16 November 2020; Exhibit 1, Tab 7, Statement of Christine Weston dated 3 November 2020; Exhibit 1, Tab 8, Statement of Abdulkarim Yassin dated 3 November 2020; Exhibit 1, Tab 1, Coronial Investigation Squad Report of 1st Class Constable Sean Larson-Pearse (undated); Exhibit 1, Tab 20.1-20.1, Letters from Mr Weston; Exhibit 1, Tab 22.1, Brief Risk Assessment by BCMHC social worker on 19 October 2020; Exhibit 1, Tab 21.1-21.3, Screenshots of conversations between Mr Weston and others; Exhibit 2.1, Letter dated 3 October 2022 from Dr Elvin Ko

72 Dr Hacking last saw Mr Weston on 20 October 2020, following his olanzapine depot injection. Dr Hacking's risk assessment at the time was: "*Currently presents low risk to self or others. Level of risk will escalate if relapses into previous harmful use of illicit drugs or non-compliant with medication*".[23] Mr Weston confirmed he was not using any illicit drugs, which was consistent with a urine drug test conducted the month before.

73 On 23 October 2020, Mr Weston liaised with his Headspace care coordinator regarding further prescriptions for lithium carbonate and metformin after he had run out of those medications. Although this demonstrated evidence of future planning by Mr Weston and supported the three latest risk assessments that had been made by his mental health service providers, there was other evidence that suggested this was not the case.

74 About two weeks before Mr Weston's death,[24] his mother saw a transaction from Bunnings on his bank account for approximately $7. When she checked Mr Weston's car, she found some nylon rope. She took the rope and hid it.

75 Although Mr Weston had previously spoken to his mother about voices promising the afterlife for him would be better, and that he would see his deceased grandparents and friend there, his mother noticed his behaviour in the week before his death had become "*increasingly fatalistic*".[25] He told his mother that he did not want to be here anymore and that he would probably kill himself. However, at about the same time, Mr Weston had told his father he would wait until he completed his commerce degree as he wanted people in the afterlife to think that he was clever.

[23] Exhibit 1, Tab 17, Report of Dr Daniel Hacking dated 16 November 2020, p.9
[24] The date two weeks before Mr Weston's death was 20 October 2020
[25] Exhibit 1, Tab 7, Statement of Christine Weston dated 3 November 2020, p.5

76 On 1 November 2020, Mr Weston's mother noticed another transaction on Mr Weston's bank records from a different Bunnings store. It was dated the previous day, and although she checked Mr Weston's car, she could not find any rope or a receipt.

77 Also on 1 November 2020, Mr Weston communicated with his father through Facebook, saying he would rather be dead than go to hospital again. He also said he was "*sad*" that he was schizophrenic.

78 On 2 November 2020, Mr Weston had lunch with his mother, during which he spoke about the afterlife and wanting to end his life. He then said he wanted his mother to be okay. When she told him that she would not be okay without him, he indicated that he would wait and that he would think about going on a proposed road trip over Christmas with his mother.

79 At 5.30 pm on 2 November 2020, Mr Weston was communicating with a person named 'Ella' on a social media application. When Ella asked him, "*How's it going?*", he responded, "*I'm good I'm leaving Australia tomorrow tho*", and then added, "*sad times*". When he was asked where he was going, Mr Weston replied, "*going away for a while*" and "*not allowed back in if I do sadly*". When then asked why he was leaving, Mr Weston replied, "*my family and srufd* [sic-stuff]" and, "*I got a while away so it's all good.*"

80 Mr Weston spent the evening of 2 November 2020 at home. He was last seen by his mother at about 11.00 - 11.30 pm. He had come downstairs from his bedroom, and she gave him a hug and said goodnight before she retired to bed. Mr Weston's mother did not notice anything out of the ordinary or unusual regarding Mr Weston's behaviour at that time.

81 Later extraction of data by police from Mr Weston's mobile phone found that at 12.52 am on 3 November 2020, Mr Weston made an internet search of "*noose to.kill.yourself*."

82 At 1.56 am, Mr Weston accessed YouTube and searched "*Hangmans not* [sic-knot]". He was directed to a video titled "*How to Tie a Hang Man's Noose*".

83 At about 5.00 am on 3 November 2020, Mr Weston's mother woke up. A short time later, she looked out of her bedroom window and noticed that Mr Weston's car was not where he usually parked it. She went into Mr Weston's bedroom and found he was not there. On the bed was a handwritten letter addressed to Mr Weston's mother and a type-written letter addressed to Mr Weston's parents and his brother. Both letters indicated that Mr Weston intended to end his life. The partner of Mr Weston's mother then called police.

84 Just before 6.00 am on 3 November 2020, a motorist in East Victoria Park was driving past a public reserve named Higgins Park. He saw Mr Weston hanging from a tree by a piece of rope that had been suspended from one of the tree's branches. At 5.57 am, the motorist telephoned emergency services. Ambulance officers attended the scene a short time later. CPR was not performed as Mr Weston had obviously died.

85 Attending police observed a small step ladder near the tree and located Mr Weston's car in a nearby car park. An examination of the car found a half empty 500 ml bottle of Midori liqueur on the front passenger seat and another Midori liqueur bottle (which was empty) in the front passenger seat's foot well.

CAUSE AND MANNER OF DEATH

Cause of death [26]

86 Dr Nina Vagaja, a forensic pathologist, conducted an external post mortem examination on Mr Weston's body on 11 November 2020. A post mortem computerised tomography (CT) scan was also undertaken.

87 The external examination found the presence of a ligature mark around Mr Weston's neck. This marking corresponded with a new-looking woven rope that had accompanied Mr Weston's body. There was no evidence of any internal neck injury on the post mortem CT scan. No other significant injuries were identified externally or radiologically by the forensic pathologist.

88 Toxicological analysis detected olanzapine and lithium in Mr Weston's system. The level of lithium was below the therapeutic range. Alcohol was detected in Mr Weston's blood at a level of 0.085%, and in his urine at a level of 0.103%.

89 At the conclusion of her investigations, Dr Vagaja expressed the opinion that the cause of death was ligature compression of the neck (hanging).

90 I accept and adopt the conclusion expressed by Dr Vagaja as to the cause of Mr Weston's death.

Manner of death

91 In the early hours of 3 November 2020, Mr Weston drove to a public reserve that was several kilometres from his home with the intention of ending his life. This intention had been premeditated as he had taken a length of rope and

[26] Exhibit 1, Tab 5.1-5.3, Supplementary Post Mortem Report, Post Mortem Report, Interim Post Mortem Report; Exhibit 1, Tab 6.1-6.2, ChemCentre Toxicological Report dated 1 December 2020, ChemCentre Inorganic Chemistry Testing dated 23 November 2020

a step ladder with him. Mr Weston had also left in his bedroom, letters addressed to his parents and his brother explaining his intention. In addition, he had conducted an internet search at 1.56 am on his mobile phone as to the tying of a noose.

92 I find that after 1.56 am, and some time before 5.57 am, on 3 November 2020, Mr Weston's death occurred by way of suicide when he tied a rope around a tree branch at a public reserve and then used it as a ligature around his neck.

ISSUES RAISED BY THE EVIDENCE

The unpredictability of suicide

93 Suicide is extremely unpredictable. It is rare and it is impossible to predict rare events with any certainty. Factors complicating a prediction are that a person's suicidal ideation can fluctuate, sometimes in a relatively short time frame. It is also not correct to say that a person who has taken their life was necessarily at a 'high risk' of suicide at the relevant time.[27]

94 The accuracy of these observations was confirmed in the evidence of Dr Ko and Dr Hacking at the inquest. Dr Ko stated that, "*the risk of suicide is always unpredictable*".[28] Dr Hacking noted that predicting suicide was "*very challenging*".[29]

95 In 2017, the Department of Health published a document called *Principles and Best Practices for the Care of People Who May Be Suicidal* (the Document).[30] Although primarily aimed at clinicians, the Document contains

[27] Dr Kathryn Turner, Executive Director, Metropolitan North Mental Health, Queensland Department of Health, 'Restorative Just Culture in Reviewing Critical Incidents' (Address delivered to the Asia Pacific Coroners Society Conference, Gold Coast, 9 November 2022)
[28] ts 4.10.22 (Dr Ko), p.10
[29] ts 4.10.22 (Dr Hacking), p.39
[30] https://ww2.health.wa.gov.au/~/media/Files/Corporate/general%20documents/Mental%20health/PDF/Best-Practice-for-the-Care-of-People-Who-May-Be-Suicidal.pdf

useful observations and guidance for the care of suicidal people which, in my view, are more generally applicable.

96 The Document points out that clinicians faced with the onerous task of assessing a person who may be suicidal will confront two issues. First, suicide is a rare event and second, there is no set of risk factors that can accurately predict suicide in an individual. As the Document states, the use of risk assessment tools which contain checklists of characteristics have not always been found to be very effective:[31]

> The widespread belief within the community that suicide is able to be accurately predicted, has led to the assumption that suicide represents a failure of clinical care and that every death is potentially preventable if assessment and risk management were more rigorously applied. However, the evidence is clear that, even with the best risk-assessment practices and care, it is not possible to foresee and prevent all deaths by suicide.

97 Headspace and BCMHC each conducted a suicide risk assessment with Mr Weston that used a series of questions that had a 'yes' or 'no' answer. These questions are designed to elicit information about factors tending to make it more likely that the person will attempt suicide. A score is given for each answer and the total score determines whether the suicide risk level is 'low', 'moderate' or 'high'.

98 However well-intentioned these risk assessments are, the fact remains there is no sure way of determining suicidal intentions or predicting the degree of risk. The only fail-safe predictor is when a person genuinely discloses they are contemplating suicide. Otherwise, assessments can only be of a temporary value because a person experiencing mental health issues can have their mood and situation quickly and significantly change.

[31] https://ww2.health.wa.gov.au/~/media/Files/Corporate/general%20documents/Mental%20health/PDF/Best-Practice-for-the-Care-of-People-Who-May-Be-Suicidal.pdf, p.3

Should Mr Weston's death have been anticipated by Headspace?

99 Mr Weston had previously indicated to health service providers an intention to self-harm. At his very first presentation to the emergency department at SCGH on 24 June 2017, he stated he had "*a plan to drive his car off a bridge*".[32] However, he also denied any current suicidal ideation on that occasion.[33]

100 It should be noted that Mr Weston was not under the care of Headspace or under a CTO at this time. Nevertheless, when he was under Headspace's care and asked directly by Headspace staff whether he had any thoughts of harming himself, Mr Weston would consistently deny such thoughts.[34] However, as Dr Hacking explained regarding a risk assessment that took place in the lead up to Mr Weston's death:[35]

> The risk assessment documents that he stated he would "kill myself" if he was found to be mentally ill and not gifted with the ability to talk to the spirits. The risk assessment documents that Lewis had disclosed to his mother that although at times he had felt like ending his life, he would not do it to her. The risk assessment documents that Lewis' mother believes that Lewis would not harm himself or others [as at 24/7/20].

101 As to the risk assessment conducted on 14 October 2020 by Headspace, it is documented that Mr Weston's care coordinator at Headspace discussed with Mr Weston's mother his risk regarding possible suicidal ideation if he developed increased insight into his mental illness. The care coordinator noted that Mr Weston's mother, "*was sure that Lewis was not at risk of self-harm and that on asking Lewis, he states that he would not harm himself.*"[36]

[32] Exhibit 1, Tab 23, Sir Charles Gairdner Hospital Medical Records
[33] Exhibit 1, Tab 23, Sir Charles Gairdner Hospital Medical Records
[34] Exhibit 1, Tab 17, Report of Dr Daniel Hacking dated 16 November 2020, p.7
[35] Exhibit 1, Tab 17, Report of Dr Daniel Hacking dated 16 November 2020
[36] Exhibit 1, Tab 17, Report of Dr Daniel Hacking dated 16 November 2020, p.8

102 At the inquest, Dr Hacking testified:[37]

> But yes, with hindsight we called it wrong, but at the time I can understand why [it] didn't lead to escalation of – because there was other, there [sic – he] was, you know, still engaging with us, he was still making plans, calling the mental health advocate to speak, he was clarifying when he was going to be seen by our colleagues at Bentley. So, there was evidence of future planning in my opinion. Clearly, I called that wrong.

103 Dr Hacking's concession that he and Headspace "*called it wrong*", must be read in the context of the very considerable advantage of hindsight. I would be inserting impermissible hindsight bias to now find that Dr Hacking and other mental health service providers who were caring for Mr Weston at Headspace should have anticipated Mr Weston's death on 3 November 2020. Accordingly, I make no such finding. There was no information available to Headspace that would cause its staff to reasonably anticipate Mr Weston would be at an immediate risk of self-harming.

104 In reaching that conclusion, I also have regard to the fact that Headspace were unaware of the observations made by Mr Weston's mother, and the conversations she had with him, in the two weeks prior to his death.[38]

105 In making that observation, I wish to make it abundantly clear that I make no criticism of Mr Weston's mother for not communicating these matters to Headspace. I find that it was entirely reasonable for her to be satisfied that Mr Weston was not at an immediate risk of self-harm in the fortnight before he died. Similarly, I find she was completely justified in believing nothing seemed out of the ordinary or unusual when she saw Mr Weston just before she went to bed on the night of 2 November 2020.[39]

106 Based on all the information available to Headspace during the transfer of Mr Weston's care to BCMHC, I find it was reasonable for Dr Hacking to

[37] ts 4.10.22 (Dr Hacking), p.42
[38] ts 4.10.22 (Dr Hacking), pp.42-43
[39] Exhibit 1, Tab 7, Statement of Christine Weston dated 3 November 2020, p.9

conclude that Mr Weston would only be a significant risk to himself if he did not accept his treatment.[40] As of 3 November 2020, Mr Weston had been compliant with his prescribed doses of the antipsychotic depot injections and lithium carbonate.

107 A further obstacle for mental health service providers is whether the patient is entirely forthcoming in their answers during a risk assessment. At or about the same time Mr Weston's mother found a newly purchased length of rope in his car, Dr Hacking saw Mr Weston and concluded that he presented as a "*low risk to self*".[41] Dr Hacking stated at the inquest:[42]

> I've got to trust what he tells me and what I see. He did present as well. He came. He accepted his depot. He subsequently, even though he was making his plans, rang up to try and get more prescriptions of lithium and metformin. He rang up to get the mental health advocate. All of these could have been to make sure we didn't interfere with his plan, you know. He was that clever.
>
> …
>
> I really felt he was, you know, safe to walk away … I was expecting to do the [Mental Health] Tribunal and to transfer the care. I was still expecting that at that time.

Should Mr Weston's death have been anticipated by BCMHC?

108 I find that Dr Ko and Mr Weston's other mental health service providers at BCMHC had no prior information that would have led them to reasonably anticipate his death. He had only been spoken to once over the telephone by a senior social worker at BCMHC on 19 October 2020. During that conversation a risk assessment was carried out and Mr Weston gave no indication he was experiencing suicidal ideation or thoughts of self-harm.[43]

[40] Exhibit 1, Tab 22.10, Letter form Dr Daniel Hacking to the Mental Health Tribunal dated 24 July 2020, p.6
[41] This was on 20 October 2020 when Mr Weston received his final depot inject at Headspace: Exhibit 1, Tab 17, Report of Dr Daniel Hacking dated 16 November 2020, p.9
[42] ts 4.10.22 (Dr Hacking), p.51
[43] Exhibit 1, Tab 22.1, Brief Risk Assessment by BCMHC social worker on 19 October 2020

109 Unsurprisingly, there was no material provided to BCMHC from Headspace during the transfer of care that indicated Mr Weston was at an immediate risk of harm to himself.

Mr Weston's handover from Headspace to BCMHC

110 EMHS conducted a Clinical Incident Investigation Report into the death of Mr Weston.[44] The authors of the report (the Panel) included a number of health professionals.

111 Although the Panel acknowledged that the care provided by Headspace "*appeared to be exemplary*"[45], it found that (i) the third CTO had not been transferred to BCMHC and (ii) the absence of standardised guidelines and procedures "a*ffected the optimal preparatory work required to undertake the safe transition of care during a phase of increased clinical risk, which may have contributed to the clinical incident*".[46]

112 With the greatest respect to the Panel, I do not agree with these conclusions. I will deal with each in turn.

113 Based on all the evidence before me, it is clear that there had been a transfer of the third CTO from Headspace to BCMHC.

114 The transfer of care between health services (in this case Headspace and BCMHC) is a referral and process between health services. In contrast, the transfer of a CTO is a referral and process directly between two individual psychiatrists.[47]

[44] Exhibit 1, Tab 19, East Metropolitan Health Service – SAC1 Report dated 22 December 2020
[45] Exhibit 1, Tab 19, East Metropolitan Health Service – SAC1 Report dated 22 December 2020, p.5
[46] Exhibit 1, Tab 19, East Metropolitan Health Service – SAC1 Report dated 22 December 2020, P.7
[47] Exhibit 2.1, Letter dated 3 October 2022 from Dr Elvin Ko, p.4

115 On 16 October 2020, Dr Hacking emailed Dr Ko regarding Mr Weston and the transfer of the third CTO due to his move to a different residence.[48]

116 On 19 October 2020, Dr Ko responded to Dr Hacking via email, advising that he was happy to receive the CTO transfer for Mr Weston and that he would be the supervising psychiatrist for the CTO.[49]

117 Further email correspondence between Headspace and BCMHC occurred on 28 October 2020, Dr Hacking completed a '*Form 5C – Variation of Terms of Community Treatment Order*', transferring care to Dr Ko as the new supervising psychiatrist.[50] As Dr Ko explained:[51]

> In spite of this, the formal review of Mr Weston's CTO remained scheduled on 3 November 2020 at Headspace. This was to provide a formal bookend to Mr Weston's care at that service, and the first appointment with Bentley CMHC had been scheduled with myself the following day.

118 I find that it was appropriate for the two psychiatrists to arrange the transfer in that manner. It was only logical for Dr Hacking to appear at the Mental Health Tribunal hearing on 3 November 2020 as he had been Mr Weston's psychiatrist for over three years and Dr Ko had not even met with Mr Weston.

119 A likely explanation for the Panel's error in finding that the CTO had not been transferred to BCMHC is that neither Dr Ko or Dr Hacking were contacted by the Panel.[52] Another explanation may be that the Form 5A for the third CTO was not sighted by the Panel, as it had not been logged onto the clinical information database used by government mental health services in Western Australia. This database is known as the Psychiatric Services Online Information System (PSOLIS).

[48] Exhibit 1, Tab 22.6, Email Correspondence by Dr Daniel Hacking to Dr Elvin Ko dated 16 October 2020
[49] Exhibit 2.2, Email Correspondence from Dr Elvin Ko to Dr Daniel Hacking dated 19 October 2020
[50] Exhibit 1, Tab 13.5, Form 5C – Variation of Terms of Community Treatment Order dated 28 October 2020
[51] Exhibit 2.1, Letter dated 3 October 2022 from Dr Elvin Ko, p.4
[52] ts 4.10.22 (Dr Ko), p.24; ts 4.10.22 (Dr Hacking), p.57

120 Contrary to the Panel's conclusion, I am also satisfied with the transition of care for Mr Weston from Headspace to BCMHC. The only potential problem would have been the scenario identified by Dr Ko; namely, any difficulty with the arrangements would only have arisen if someone encountered Mr Weston in a health care setting outside of Headspace and BCMHC during the transition period. As Dr Ko stated regarding the Panel's observation of the transition of Mr Weston's care:[53]

> In my view this comment is about a clear delineation of clinical responsibility. The concern in Mr Weston's case was that, at the time of his death, on paper it appeared that Bentley CMHC had clinical responsibility for Mr Weston. This was because he was an active patient of Bentley CMHC as of 20 October 2020, and his CTO had been transferred to me as of 28 October 2020. In practical terms that was not the case. The relevant stakeholders in Mr Weston's care management (including myself, Suzie Smith[54] and Dr Hacking) were aware that Headspace was still taking primary clinical responsibility until Mr Weston's CTO Tribunal Hearing on 3 November 2020.
>
> However, if anyone who was not a direct stakeholder in Mr Weston's care were to encounter him in a health care setting during that transition period, the records on PSOLIS would not reflect the accurate status of Mr Weston's care. How practically this would have made a difference to Mr Weston's care in those settings is conjecture only, but it is obviously not ideal for records to not accurately reflect a patient's current treatment arrangements.

121 The implementation of my recommendation (which is outlined later in this finding) ensures that a third party stakeholder in health care would be aware of the status of Mr Weston's care, as that stakeholder would have access to the clinical database at Headspace.

122 As to whether the transition "*may have contributed to the clinical incident*" as found by the Panel,[55] Dr Ko stated at the inquest: "*I don't believe that it contributed to or increased the risk or that any change in that would have*

[53] Exhibit 2.1, Letter dated 3 October 2022 from Dr Elvin Ko, pp.5-6
[54] Ms Smith was to be Mr Weston's treating practitioner at BCMHC
[55] Exhibit 1, Tab 19, East Metropolitan Health Service – SAC1 Report, p.7

otherwise prevented this [Mr Weston's death] *from happening*".[56] I agree with Dr Ko's assessment.

123 As to the manner in which the transfer took place, Dr Hacking said:[57]

> I had no issue with Bentley. They accepted the transfer absolutely. It felt like normal practice to what I had experienced previously with other services. I communicated, I felt Dr Ko was very good and making himself available for communication, and we communicated both prior to the event and following, unfortunately, Lewis' [death], so I didn't feel anything was different from any transfer I've been involved in since being here in Western Australia since 2014.

124 I also agree with this assessment by Dr Hacking. Accordingly, I am satisfied that the manner in which the transition of Mr Weston's care took place was appropriate and there is no evidence before me that it contributed, in any way, to Mr Weston's death.

QUALITY OF MR WESTON'S SUPERVISION, TREATMENT AND CARE

By Headspace

125 As I have already noted, Mr Weston was a person held in care at the time of his death as he was subject to a CTO under section 25(3) of the *Coroners Act 1996* (WA). Accordingly, I must comment on the quality of his supervision, treatment and care whilst he was subject to a CTO.

126 To summarise, Mr Weston's first CTO commenced on 4 January 2019 and was cancelled by Dr Hacking on 26 March 2019. The second CTO commenced on 14 May 2019 and was then cancelled by Dr Hacking on 11 June 2019. Mr Weston's third and final CTO was dated 17 February 2020 and was subsequently extended by Dr Hacking on two occasions, until 14 November 2020.

[56] ts 4.10.22 (Dr Ko), p.27
[57] ts 4.10.22 (Dr Hacking), p.56

127 I am satisfied that it was appropriate for Mr Weston to be placed on all three CTOs. I am also satisfied it was appropriate to extend the third CTO on the two occasions that Dr Hacking did. I find that the CTOs and the extensions to the third CTO were necessary, as Mr Weston continued to maintain his objection to taking antipsychotic medication. On all the evidence before me, it was clear that Mr Weston had been experiencing psychotic episodes since 2017. There were also occasions when he experienced psychosis even though he was taking an antipsychotic medication.

128 I am satisfied it was appropriate for Dr Hacking to cancel the first and second CTOs when he did. Unsurprisingly, Mr Weston did not like being the subject of a CTO, and Dr Hacking's decision to cancel each one when he determined that Mr Weston was well enough not to be under a CTO, were understandable and based on the known facts at the time. Unfortunately, each time the CTO was cancelled, Mr Weston lapsed into further episodes of psychosis requiring hospitalisation. It was therefore appropriate for a CTO be reimposed once Mr Weston was discharged from hospital, as he still did not want to voluntarily take any antipsychotic medication.

129 Having carefully considered the documents tendered into evidence and the evidence of Dr Hacking at the inquest, I am satisfied that Mr Weston's mental health was very well-managed by Headspace. Accordingly, I am satisfied that the standard of supervision, treatment and care Mr Weston received from Dr Hacking and the other mental health service providers at Headspace when he was subject to the CTOs was not merely appropriate, but "*appeared to be exemplary"*.[58]

[58] Exhibit 1, Tab 19, East Metropolitan Health Service – SAC1 Report dated 22 December 2020, p.5

130 In addition, I note that Ms Weston, in her communications with Counsel Assisting before the inquest, spoke very highly of the treatment and care that Dr Hacking had provided to her son.[59]

By BCMHC

131 Dr Ko and the mental health service providers at BCMHC had very limited contact with Mr Weston before his death. He had only been spoken to once over the telephone by a senior social worker at BCMHC on 19 October 2020. As already noted, a risk assessment was carried out on this occasion with Mr Weston which gave no indication he was experiencing suicidal ideation or thoughts of self-harm at that time.[60]

132 I find that the transfers of Mr Weston's care between Headspace and BCMHC and of the third CTO between Dr Hacking and Doctor Ko were appropriately performed at all times. For the short duration that Mr Weston was transitioning to BCMHC before his death, I am satisfied that the supervision, treatment and care provided to Mr Weston by Doctor Ko and the other mental health service providers at BCMHC was also appropriate.

RECOMMENDATION

133 Although not directly related to Mr Weston's death, a question was raised during the course of the inquest regarding the sharing of clinical information held by government mental health services and clinical information held by NGOs that provide mental health services. The question arose in the context of the Panel not being aware of the transfer of the third CTO from Dr Hacking to Dr Ko. The explanation given by Dr Ko for this was because the Form 5C completed by Dr Hacking that advised of the transfer had not been

[59] ts 4.10.22, pp.61-62
[60] Exhibit 1, Tab 22.1, Brief Risk Assessment by BCMHC social worker on 19 October 2020

downloaded onto PSOLIS by BCMHC.[61] As the Panel only had access to PSOLIS, and not the clinical information database from Headspace, it did not have access to the Form 5C.[62]

134 Dr Ko and Dr Hacking both gave evidence that mental health service providers at NGOs did not have access to PSOLIS.[63] Both doctors saw considerable merit in NGOs that provide mental health services having access to PSOLIS.[64]

135 Dr Hacking said that the sharing of patient information between PSOLIS and the clinical information databases of NGOs would be "*massively helpful*".[65] As he explained: [66]

> You just look at Headspace patients … [they are] high risk for a number of risk factors, and out of hours, they present at very overrun Emergency Departments across the city and those colleagues in those Emergency Departments … don't have access to the Headspace database, so they can't read our recent risk assessments, our management plans, our contacts … If there was a system where the non-government organisations could put up their vital information, that would greatly support our colleagues in other department parts of the health service. But likewise, we get referrals of young people and don't have access to their PSOLIS, where PSOLIS is a fantastic database with important risk factors, and colleagues within Headspace can't see the whole risk events or the huge amount of work that goes into these young people. So there's thousands of dollars of work and assessments, but that information is not shared, so I think it's a global problem of people using different databases and IT systems, and then, obviously, there are laws in place about who can access them.

136 At the conclusion of the inquest, and in light of the evidence from the two doctors regarding this lack of sharing, I asked Ms Richardson, counsel for EMHS, to ascertain if she could extend the parameters of her instructions so that I could hear from not just EMHS but also the Department of Health (the

[61] ts 4.10.22 (Dr Ko), p.28
[62] Dr Ko explained that the Form 5C would have been transcribed onto PSOLIS in the following week but for the death of Mr Weston: ts 4.10.22 (Dr Ko), p.28
[63] ts 4.10.22 (Dr Ko), p.28; ts 4.10.22 (Dr Hacking), p.57

[64] ts 4.10.22 (Dr Ko), p.30
[65] ts 4.10.22 (Dr Hacking), p.57
[66] ts 4.10.22 (Dr Hacking), pp.57-58

Department) regarding its view of an arrangement to share database information as suggested by Dr Hacking.

137 By email dated 1 November 2022 to Counsel Assisting, Ms Richardson attached (i) a letter dated 21 October 2022 from Mr Rob Anderson (the Department's Assistant Director General, Purchasing and System Performance), (ii) the Department's *Information Security Policy* dated 18 February 2021 and (iii) the Department's *Information Access, Use and Disclosure Policy* dated 29 November 2021.

138 In his letter, Mr Anderson advised that although PSOLIS is generally restricted to mental health facilities located within the WA public health system, "*there have been occasions where access has been provided to organisations outside the WA health system*."[67] Mr Anderson stated that NGOs such as Headspace may apply to the Department for access to PSOLIS. He explained:[68]

> All organisations external to the WA health system that require access to WA health information systems for project, business or maintenance purposes must submit formal requests to the Department and Health Support Services (HSS), with final approval being determined by the Data Steward.
>
> …
>
> On receipt of such an application, the Department will consider whether the request is consistent with the lawful purposes permitted under the *Health Services Act 2016* as prescribed in the Department's *Information Access, Use and Disclosure Policy*, and HSS will consider the technical viability of the proposal. Access may then be provided subject to the condition that the organisation ensures that appropriate governance models are in place to control, monitor and audit health information access, use and disclosure.

139 Although I was pleased to hear from the Department that NGOs such as Headspace could apply for access to PSOLIS, I was somewhat concerned that Dr Hacking (who had worked at Headspace from 2016 to the beginning of 2022) was unaware that Headspace and/or he could apply to the Department

[67] Letter from Mr Rob Anderson dated 21 October 2022, p.2
[68] Letter from Mr Rob Anderson dated 21 October 2022, pp.1-2

for such access. In making that observation, I am not criticising Dr Hacking as I have no evidence before me that he was ever informed such an application could be made. Given that Dr Ko was also unaware NGOs that provide mental health services could apply to have access to PSOLIS, it would appear it is not universally known amongst mental health service providers.

140 I fully agree with Dr Hacking's view that the sharing of patient information between PSOLIS and the clinical information databases of NGOs that provide mental health services to the community would be "*massively helpful*". I also agree with the reasons he gave as to why it would be beneficial. Such an arrangement would only improve the clinical care and treatment of those in the community with mental health issues. I completely accept that the implementation of a sharing of information will necessitate tight controls around individual and organisational access to PSOLIS.[69] However, those controls would already be in place with organisations outside the public health system that already have access to PSOLIS.[70] There may also be potential teething issues with organisations using different databases and IT systems. However, it remains my firm view that the advantages of the sharing of this information will considerably outweigh any costs or inconvenience involved in the implementation of it.

141 A draft of my proposed recommendation regarding this matter was forwarded to the State Solicitor's Office (SSO) on 30 November 2022 and an invitation was extended to EMHS and the Department to comment on it.

[69] Letter from Mr Rob Anderson dated 21 October 2022, p.1
[70] These organisations include clinicians working in the Next Step Drug and Alcohol Services and in the Department of Justice's Mental Health, Alcohol and Other Drugs branch: Letter from Mr Rob Anderson dated 21 October 2022, p.2

142 By email dated 7 December 2022 to Counsel Assisting, Ms Robyn Hartley, from SSO, advised that my proposed recommendation had been considered by Mr Rob Anderson and that he supported it. Ms Hartley also advised that EMHS had deferred to the Department's response in relation to the proposed recommendation.

143 I am very grateful that the Department has expressed its support for my recommendation. That support reflects the observation made by Mr Anderson that: "*The Department acknowledges the work of these organisations* [that are outside the WA health system] *to provide quality mental health care to people and recognises the benefits of enabling PSOLIS access to a broader range of mental health clinicians.*" [71] Of course, those mental health clinicians working within the Department will also benefit from the reciprocal sharing of information that I am suggesting in my recommendation.

144 Although I have not sought any feedback regarding my recommendation from NGOs that provide mental health services, I would be very surprised if they did not agree with Dr Hacking in regard to the benefits of the sharing of information between their databases and PSOLIS.

Recommendation

In order to enhance patient care, the Department of Health introduces, with appropriate safeguards to protect patient confidentiality, a reciprocal sharing of information between its clinical information database (PSOLIS) and the clinical databases of NGOs that provide mental health services to the community.

[71] Letter from Mr Rob Anderson dated 21 October 2022, p.2

145 I should emphasise that the intention of my recommendation is for the Department to be proactive and take the initiative by inviting each relevant NGO to participate in the reciprocal sharing of information between its clinical database and PSOLIS. If an NGO agrees to participate, then I would expect the Department to organise the implementation of the arrangement. I would also hope the Department would be prepared to underwrite any costs that are involved.

CONCLUSION

146 Mr Weston was an intelligent young man who was afflicted with a serious mental health disorder, Schizoaffective Disorder. A major complication of this disorder was that he experienced manic psychosis.

147 The clinical recommendation for a schizophrenia-based illness is for life-long treatment with antipsychotic medication, so that the person can take control of the illness, rather than the illness taking control of the person.[72]

148 Mr Weston never accepted that he was psychotic, and therefore did not believe he required antipsychotic medication. I can understand Mr Weston's reluctance to accept his illness. As Dr Hacking stated at the inquest: "*There was an element of his psychosis that wasn't all negative for him. There were elements of the voices he heard that weren't negative for him, that he felt gave him special meaning."*[73]

149 By agreeing that he was actually communicating with spirits, mediums who saw Mr Weston provided him with encouragement not to take his antipsychotic medication.[74] This served to complicate the clinical treatment

[72] ts 4.10.22 (Dr Hacking), pp.54-55
[73] ts 4.10.22 (Dr Hacking), p.46
[74] ts 4.10.22 (Dr Hacking), p.46

that Mr Weston's mental health service providers were trying to implement for his Schizoaffective Disorder.

150 I am of the view that Mr Weston genuinely believed that he was destined for a better life once he could "*join the afterlife*"[75], even though he would have been aware of the unbearable pain his death would cause his family. Mr Weston's explanations to his parents and his brother as to why he took his life were heart-rending to read.[76]

151 Because of his refusal to accept he required antipsychotic medication, it was difficult to effectively treat Mr Weston. It was that non-acceptance which required the three CTOs that he was subjected to. As I have already outlined above, I am satisfied with the supervision, treatment and care provided to Mr Weston by Headspace and BCMHC when he was under these CTOs.

152 All too frequently, the Coroner's Court encounters cases in which a person's life and the lives of their loved ones are devastated by the scourge of a serious mental health disorder. Sadly, Mr Weston's death must now be added to that lengthy list.

153 It is clear to me that Dr Hacking and Mr Weston's other mental health service providers at Headspace and BCMHC were dedicated in their efforts to help him manage his Schizoaffective Disorder.

154 It is also very clear to me that the family of Mr Weston loved him dearly, and that his mother and father were always striving to help him with his mental health issues and to protect him from harming himself.

155 I have made a recommendation that I believe will enhance the future care and treatment provided to those people in our community who have a serious

[75] Exhibit 1, Tab 20.2, Typewritten letter from Mr Weston addressed to his family, p.2
[76] Exhibit 1, Tab 20.2, Typewritten letter from Mr Weston addressed to his family

mental health illness. I hope that Mr Weston's mother and father can take some small solace from the fact that this recommendation was generated by the evidence I had heard at their son's inquest.

156 I extend my sincere condolences to the family of Mr Weston.

PJ Urquhart
Coroner
12 December 2022