JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	PHILIP JOHN URQUHART, CORONER
HEARD	**:**	23 APRIL 2024
DELIVERED	**:**	28 AUGUST 2024
FILE NO/S	**:**	CORC 3245 of 2022
DECEASED	**:**	BOLTON, PETER JONATHON REX

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:

Ms S. Markham assisted the Coroner.

Ms A. N. Kildea (State Solicitor's Office) appearing on behalf of the Mental Health Commission, Department of Justice, and East Metropolitan Health Service.

Mr J. L. Winton (DLA Piper) appearing on behalf of St John of God Healthcare Inc., Dr. Adam Stevens and Dr. Michael Verheggen.

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 ***Peter Jonathon Rex BOLTON*** *with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, Perth, on 23 April 2024, find that the identity of the deceased person was* ***Peter Jonathon Rex BOLTON*** *and that death occurred on 20 November 2022 at St John of God Midland Hospital, 1 Clayton Street, Midland, from ligature compression of the neck (hanging) in the following circumstances:*

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INTRODUCTION

"Schizophrenia cannot be understood without understanding despair."
R.D. Laing – Scottish psychiatrist

1. On 20 November 2022, Peter Jonathon Rex Bolton (Mr Bolton) died from ligature compression of the neck (hanging) in the locked mental health ward at St John of God Midland Hospital (SJGMH). He was 36 years old.

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

3. Accordingly, Mr Bolton 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 Bolton was, immediately before his death, "*a person held in care*".[3] Where the death is of a person in care, I am required to comment on the quality of the supervision, treatment and care the person received while in that care.[4]

5. I held an inquest into Mr Bolton's death at Perth on 23 April 2024. Three witnesses gave oral evidence at the inquest:

i. Dr Adam Stevens (Consultant Psychiatrist at SJOGMH);
ii. Dr Michael Verheggen (Head of Department for Psychiatry at St John of God Health Care Inc.); and
iii. Dr Sophie Davison (Chief Medical Officer – Mental Health Commission).

6. The documentary evidence at the inquest comprised of two volumes of material which were tendered by counsel assisting at the commencement of the inquest and became exhibit 1.

7. My primary function at the inquest was to investigate the quality of the supervision, treatment and care provided to Mr Bolton when he attended

[1] *Mental Health Act 2024* (WA) s 4 and s 21(1)
[2] *Coroners Act 1996* (WA) s 3
[3] Coroners Act 1996 (WA) s 22(1)(c)
[4] Coroners Act 1996 (WA) s 25(3)

the ED at SJOGMH on 5 January 2022, and his subsequent admission to the Mental Health Unit at SJOGMH until his death on 20 November 2022.

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 adverse in nature has been proven on the balance of probabilities (the ***Briginshaw*** principle).

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

MR BOLTON

Background [6]

10. Mr Bolton was born in Perth on 22 February 1986. He was one of seven children.

11. As a child, Mr Bolton experienced trauma in the family home, including domestic violence. In 1997, when he was 11 years old, Mr Bolton sustained a traumatic brain injury which resulted in lifelong impulsivity and impaired judgement.

12. As an adult, Mr Bolton had a relationship with an ex-partner and they had one daughter together.

13. Mr Bolton owned a unit in Midland which he had purchased from proceeds of the compensation payout he received for his brain injury. His finances were administered by the Public Trustee. His aunt, Nyra Bolton (Ms Bolton), was involved in decisions relating to his treatment and care. Ms Bolton was a great advocate for Mr Bolton and was very supportive of him.[7]

14. On 26 October 2018, Mr Bolton was sentenced to 2½ years' imprisonment in the Perth District Court for offences that included an attempted armed robbery. Whilst in jail he assaulted two prison officers

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[5] Dillon H and Hadley M, *The Australian Coroner's Manual* (2015) 10
[6] Exhibit 1, Volume 1, Tab 2, Report of the Coronial Investigator dated 14 March 2023
[7] Ts (Dr Stevens), p.15

on 4 January 2021. He was subsequently charged and received further terms of imprisonment.

15. On 30 November 2021, Mr Bolton was released from prison and placed on a Community Treatment Order (CTO). The community service responsible for the CTO was Midland Community Mental Health Clinic.

Mr Bolton's mental health [8]

16. Mr Bolton had a long history of involvement with mental health services that began when he was a teenager. From 2011, he was admitted to mental health wards at Bentley Health Service, Graylands Hospital, Swan Districts Hospital, Royal Perth Hospital and SJOGMH.

17. Mr Bolton was diagnosed with various psychiatric conditions including schizophrenia, schizoaffective disorder, drug-induced psychosis, organic personality disorder (arising from his head injury) and mood disorder. He regularly consumed alcohol, and frequently used methylamphetamine and cannabis.

18. Mr Bolton had chronic relapses in psychosis, was impulsive, had tendencies towards aggression and violence, and was unable to self-regulate his emotions. He also had a history of repeatedly engaging in self-harming behaviours which included self-strangulation.

19. Mr Bolton was managed on depot antipsychotic medications, mood stabilisers, antidepressants, and medications for his impulsive behaviour.

Mr Bolton's physical health [9]

20. In addition to his various mental health conditions, Mr Bolton's medical history included hepatitis C, sleep apnoea, obesity, right sided hemiparesis (secondary to his traumatic head injury) and ADHD.

21. In the weeks after he was released from prison in late 2021, Mr Bolton presented to hospital EDs on a number of occasions with suicidal ideation, and alcohol and methylamphetamine intoxication.

[8] SJOGMH medical records
[9] SJOGMH medical records; Swan Medical Group medical records

MR BOLTON'S ADMISSION TO SJOGMH [10]

22. On 5 January 2022, Mr Bolton attended Midland Community Mental Health Clinic for an appointment. He was agitated and expressing suicidal thoughts. Prior to being seen, Mr Bolton left and deliberately ran into oncoming traffic in front of the clinic. He was struck by a car, and was taken to the ED at SJOGMH.

23. Mr Bolton remained overnight in the ED and although he was medically cleared, the psychiatry registrar placed him on a "*Form 1A – Referral for Examination by Psychiatrist*", pursuant to section 26(1) of the *Mental Health Act 2014* (WA). This provided authority for Mr Bolton to be detained on a suspicion he was experiencing a mental disorder that required an examination by a psychiatrist.

24. On the morning of 7 January 2022, Dr Adam Stevens (Dr Stevens), a psychiatrist at SJGMH, conducted a consultant review of Mr Bolton. During this review, Mr Bolton admitted he had been suicidal and that he had used methylamphetamine four days earlier. Dr Stevens noted Mr Bolton's issues related to low mood, thoughts of his life not worth living, and thoughts of worthlessness.

25. On the basis of previous episodes of psychosis and a current episode of depression, Dr Stevens diagnosed Mr Bolton with schizoaffective disorder[11] on a background of traumatic brain injury and methylamphetamine use disorder. Consequently, Dr Stevens completed a "*Form 6 A - Inpatient Treatment Order in Authorised Hospital*", pursuant to section 55(1)(a) of the *Mental Health Act 2014* (WA). This enabled Mr Bolton to be placed as an involuntary patient in an authorised mental health unit for assessment and treatment. He was subsequently admitted to the locked mental health ward at SJOGH and he remained an involuntary patient in that ward until his death on 20 November 2022.

26. During his prolonged admission, Mr Bolton's management was extremely challenging. He self-harmed on numerous occasions, continued to use illicit drugs when allowed on leave and assaulted other patients. He was frequently placed on continuous observations by nursing staff or placed in seclusion. Due to his behaviour, numerous Code Blacks were called requiring hospital security attendance.

[10] Exhibit 1, Volume 1, Tab 10, Report of Dr Adam Stevens dated 8 February 2024
[11] A mental health condition marked by a range of symptoms of schizophrenia such as hallucinations and delusions, and mood disorder symptoms such as depression

27. Mr Bolton's medications were monitored and adjusted in an effort to better control his psychosis, mood, and behaviour. These medications comprised of antidepressants, antipsychotic depot injections, mood stabilisers, impulsive behaviour control medications and other medications to help with acute distress on an "as needed" basis.

28. In addition to Dr Stevens' regular psychiatric reviews, Mr Bolton was seen by allied health services which included an occupational therapist, an Aboriginal liaison officer, a specialist Aboriginal Mental Health Service provider for drug and alcohol counselling, a psychologist and social workers.

29. Throughout Mr Bolton's admission, attempts were made to reduce his level of restrictions and reintegrate him back into the community. These attempts were in line with the recovery model of mental health care. Mr Bolton was regularly granted periods of leave with family members or support workers. However, frequently his leave had to be cancelled due to his abuse of alcohol and/or illicit drugs. On occasions, overnight leave went well but at other times Mr Bolton felt overwhelmed and overdosed on his prescribed medications. On one occasion, this resulted in an ICU admission for aspiration pneumonia.

30. A social worker at SJGMH had applied for National Disability Insurance Scheme (NDIS) funding to provide Mr Bolton with supportive care and placement in the community upon his discharge. However, these applications for supportive living and specialist disability accommodation were declined as it was determined by NDIS that Mr Bolton did not meet the criteria for such funding.

EVENTS LEADING TO MR BOLTON'S DEATH [12]

31. On 17 November 2022, a relative of Mr Bolton visited him. After that visit, Mr Bolton punched a fellow patient in the face several times before staff were able to intervene. He later tested positive for methylamphetamine after a urine drug screen. As it was likely the methylamphetamine was supplied by Mr Bolton's relative, that relative was prohibited from visiting him.

32. On 19 November 2022, Mr Bolton was settled in the morning and reported that his mood was "good". He denied thoughts of self-harm or

[12] Exhibit 1, Volume 1, Tab 10, Report of Dr Adam Stevens dated 8 February 2024, Exhibit 1, Volume 1, Tab 13, SAC1 Clinical Incident Investigation Report dated 9 January 2023

harm to others. A progressive risk assessment rated his risk of self-harm as low, and he was deemed a moderate risk of harm to others. Mr Bolton was also rated as a moderate risk of impulsivity and his psychosocial risk was noted to be high. He did not voice any concerns or present any behavioural issues during the course of this day.

33. On 20 November 2022, Mr Bolton was observed to be settled in bed the night before, and was sleeping when checked. At this time, he was on hourly observations. Mr Bolton had a late breakfast that morning and described his mood as "good". Again, he denied any thoughts of self-harm or perceptual disturbances. At 1.00 pm, Mr Bolton was provided haloperidol and clonazepam following his request. The progressive risk assessment conducted at 1.35 pm recorded that Mr Bolton was at a "low self-harm risk" and "moderate" regarding impulsivity.

34. At 2.00 pm, nursing staff attended Mr Bolton's room for his hourly observation. As Mr Bolton was in the ensuite bathroom with the door closed, he was checked verbally through the closed door without a visual sighting. As he had answered appropriately during that check, nursing staff held no concerns for Mr Bolton's safety.

35. At 3.00 pm, the nurse conducting Mr Bolton's hourly observation saw he was not in his room and noted a knot from a bed sheet protruding from the top of the closed door to the ensuite bathroom. With some difficulty, nursing staff opened the door and Mr Bolton was observed slumped against the door with a bed sheet tied around his neck. He was unresponsive, not breathing and was cyanosed.[13] CPR was immediately commenced after the bed sheet was removed from around Mr Bolton's neck, and a Medical Emergency Team call was made.

36. Despite concerted efforts at resuscitation which included the attachment of a defibrillator, administering of adrenaline and the use of a mask ventilator, Mr Bolton could not be revived. A decision was made to cease resuscitation attempts after about one hour and Mr Bolton was subsequently certified life extinct at 4.08 pm on 20 November 2022.[14]

[13] A blueish-purple skin colour indicating decreased oxygen levels in the blood
[14] Exhibit 1, Volume 1, Tab 5, Death in Hospital Form by ICU Registrar at SJOGMH

CAUSE AND MANNER OF DEATH [15]

37. Following an objection to an internal post mortem examination by the family of Mr Bolton, Dr Dan Moss (Dr Moss), a forensic pathologist, conducted an external post mortem examination on Mr Bolton's body. This took place on 23 November 2022. Part of the external examination included a CT scan and Dr Moss noted a faint broad ligature mark to Mr Bolton's neck consistent with the bed sheet that Mr Bolton had used. There was no other significant recent injury identified.

38. A toxicological analysis of blood and urine samples from Mr Bolton detected multiple prescription-type medications in keeping with his hospital care. These medications were at therapeutic levels. Alcohol and common illicit drugs were not detected in Mr Bolton's system.

39. At the conclusion of his investigations, the forensic pathologist expressed the opinion that the cause of death was ligature compression of the neck (hanging).

40. I accept and adopt the opinion expressed by the forensic pathologist as to the cause of Mr Bolton's death.

41. I am satisfied that Mr Bolton had schizoaffective disorder, traumatic brain injury and methylamphetamine use disorder. These conditions meant he was frequently low in mood with thoughts of worthlessness. This led to frequent self-harm incidents and suicide attempts. In addition, Mr Bolton often became anxious and easily overwhelmed. When he experienced those feelings his brain injury caused acts of impulsivity and lack of consequential thinking to occur.

42. Based on all the information available, I find that Mr Bolton's death occurred by way of suicide when he used a torn bed sheet to create a ligature at one end and a knot at the other end. On 20 November 2022, between his hourly observations by nursing staff at 2.00 pm and 3.00 pm, Mr Bolton placed the knot of the bed sheet over the top of his room's ensuite bathroom door so that the bed sheet could be anchored when the door was closed. He then placed the ligature around his neck which obstructed his airways until such time as the door was opened and it was untied.

[15] Exhibit 1, Volume 1, Tabs 7, 7.1 and 7.2, Supplementary Post Mortem Report, Post Mortem Report, and Interim Post Mortem Report; Exhibit 1, Volume 1, Tab 8, Final Toxicology Report dated 25 November 2022; Exhibit 1, Volume 1, Tab 10, Report of Dr Adam Stevens dated 8 February 2024

THE CLINICAL INCIDENT INVESTIGATION OF MR BOLTON'S DEATH [16]

43. A clinical incident in a hospital that has caused harm or death to a patient which may be attributable to the patient's health care (rather than their underlying condition or illness) is known as a SAC1 clinical incident. Such an incident always becomes the subject of an investigation by the hospital in question.

44. The goal of a SAC1 investigation is to find out what happened, why it happened, and what can be done to prevent it from happening again. The investigation focuses on these considerations, rather than the individuals involved, in order to understand the system-level factors that may have contributed to the incident.

45. The SAC1 investigation into Mr Bolton's death concluded:[17]

> A 36 year old male patient with complex history died by ligature while being treated as an inpatient in the Mental Health Unit, under the *Mental Health Act* as an involuntary patient. It was determined that there were significant complexities in care provision for the patient, with patient factors significantly contributing to the events which resulted in death. The panel have completed the investigation and identified opportunities for improvement to increase patient safety within the Mental Health Unit, including the expedition of interventions identified in the EMHS Mental Health Units Ligature Risk Remediation Program report, and the review of the organisational policy for the need for visual sighting on Clinical Observation for all patients in the Mental Health Unit.
>
> The panel were not able to determine a single root-cause of this incident, in the context of an extremely complicated presentation for a patient with complex needs and a long history of acquired brain injury, medical and psychiatric complications, drug use and other determinants of health which limited available treatment and discharge options.

46. The SAC1 investigation also made recommendations in several areas.[18] These recommendations are considered later in this finding under the heading, "Improvements Since Mr Bolton's Death".

[16] Exhibit 1, Volume 1, Tab 13, SAC1 Clinical Incident Investigation Report dated 9 January 2023
[17] Exhibit 1, Volume 1, Tab 13, SAC1 Clinical Incident Investigation Report dated 9 January 2023, pp. 20-21
[18] Exhibit 1, Volume 1, Tab 13, SAC1 Clinical Incident Investigation Report dated 9 January 2023, pp. 29-32

QUALITY OF MR BOLTON'S SUPERVISION, TREATMENT AND CARE

In the ED at SJOGMH

47. I am satisfied with the supervision, treatment and care Mr Bolton received in the ED at SJOGMH during his short stay there. The decision by the psychiatry registrar to place Mr Bolton on a "*Form 1 – Referral for Examination by Psychiatrist*" was entirely appropriate as the evidence clearly showed that given his suicidal ideation, he was in urgent need of a psychiatric examination. The high levels of observations and supervision for Mr Bolton when he was in the ED were also appropriate.

In the Mental Health Unit at SJOGMH

48. I am satisfied that the supervision, treatment and care Mr Bolton received during his long admission in the locked ward at the Mental Health Unit at SJOGMH was of a high standard. Dr Stevens' decision to make Mr Bolton the subject of a "*Form 6A – Inpatient Treatment Order in Authorised Hospital*" on 7 January 2022 was undoubtedly necessary. I am also satisfied that the ongoing extension of this order through various "*Form 6C – Continuation of Inpatient Treatment Order*" was also appropriate.

49. I accept the following views expressed by Dr Stevens:[19]

> Of all of Mr Bolton's symptoms, impulsivity and acts of aggression were the most difficult to treat. The following staff/agencies were involved in Mr Bolton's care; medical staff, nursing staff, occupational therapy, psychology, neuropsychology, aboriginal liaison, Wungening, welfare officer, social workers, forensic mental health risk assessors and the mental health advocacy team. In and around November 2022, I believed Mr Bolton's mental health was at a reasonable baseline and that from a psychiatric point of view he was ready to be discharged and continue his mental health care in the community. However, due to the highly complex nature of Mr Bolton's presentation it was extremely challenging to discharge him with an adequate discharge plan. This was compounded by funding for supported independent living being declined by NDIS. This led to Mr Bolton becoming increasingly frustrated by remaining in hospital with the knock-on effect of acts of aggression towards others, which made both granting him leave from the ward and discharging him even more challenging.
>
> …
>
> For patients whose presentations involve forensic histories, particularly with aggression and violence towards others, ongoing drug use, head injuries and comorbid psychosis, options are very limited. This patient cohort are often unable

[19] Exhibit 1, Volume 1, Tab 10, Report of Dr Adam Stevens dated 8 February 2024, pp.48-49

to live in group settings outside of an acute mental health unit environment and therefore need 24 hours a day, 7 days a week highly specialised residential care in bespoke environments. This kind of setup is both very expensive and very time consuming to set up, often leading to lengthy admissions for the patients.

50. Although Mr Bolton was on the lowest level of observations on the day of his death (one hourly observations), I am satisfied that this level was appropriate. In the days before his death, Mr Bolton had denied thoughts of self-harm and had given no indication of an intention to end his life. In those circumstances, the one hourly observations in place were appropriate.

51. I also note that previous self-harm attempts by Mr Bolton during this admission that involved self-strangulation with his hands and/or using torn clothing or bed sheets around his neck, were done as a means of seeking help as he would always draw attention to these actions by either pressing the call button in his room or doing these acts in a public area.[20] However, on the day of his death, Mr Bolton gave no prior warning of what he was about to do.

52. In addition, I note Dr Stevens' oral evidence at the inquest that Mr Bolton's suicide risk, "*was unpredictable, very quick - moving between fine to not fine, it was ... in my view, very, very difficult to predict.*"[21]

53. Suicide is generally very unpredictable. It is a rare event and it is impossible to predict rare events with any certainty. Factors complicating a prediction are that a person's suicidal ideation can fluctuate, sometime in a relatively short time frame. It is also not correct to say that a person who has taken their life is necessarily at a "high risk" of suicide at the relevant time.[22]

54. 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).[23] Although primarily aimed at clinicians, the Document contains useful observations and guidance for the care of suicidal people, which in my view, are more generally applicable.

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[20] Ts (Dr Stevens), p.13
[21] Ts (Dr Stevens), p.26
[22] 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 Coroner's Society Conference, Gold Coast, 9 November 2022)
[23] https:\\www.2.Health.wa.gov.au\~media\files\Corporate\General%20documents\Mental%20Health\PDF\Best-Practice-For-The-Care-Of-People-Who-May-Be-Suicidal.pdf

55. 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 individuals. As the Document states, the use of risk assessment tools which contain checklists of characteristics have not always been found to be very effective:[24]

> 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, even with the best risk assessment practices and care, it is not possible to foresee and prevent all deaths by suicide.

56. I also accept the following observation by the SAC1 investigation into Mr Bolton's death:[25]

> It was evident throughout the investigation that the patient received a high level and high quality care to address the complex needs and challenging behaviours. The patient experienced strong therapeutic relationships with caregivers (including security personnel) during his admission, evident during the review, where he had a sense of belonging and community within the Mental Health Unit. It is believed that his interactions and care seeking behaviours demonstrated his feelings of safety within the environment (often representing for readmission while on leave).

IMPROVEMENTS SINCE MR BOLTON'S DEATH

57. One recommendation made by the SAC1 investigation into Mr Bolton's death was: "*Replacement of all the bedroom and ensuite doors within the Mental Health Unit to ensure the high risk of ligature is reduced.*"[26]

58. Dr Michael Verheggen (Dr Verheggen), Head of Department for Psychiatry at St John of God Health Care Inc., provided an update for the implementation of this recommendation. Replacement doors have already been ordered from the United Kingdom which have an alarm strip at the top that is activated if pressure is applied to the top of the door.[27]

[24] https:\\www.2.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
[25] Exhibit 1, Volume 1, Tab 13, SAC1 Clinical Incident Investigation Report dated 9 January 2023, p.20
[26] Exhibit 1, Volume 1, Tab 14, SAC1 Clinical Incident Investigation Report dated 9 January 2023, p.29
[27] Ts (Dr Verheggen), p.34

59. All doors to rooms and ensuites in the Mental Health Unit at SJOGMH are being changed over, with an expected completion date of November 2024.[28]

60. With respect to the SAC1 investigation's second recommendation, it was identified:[29]

> There is no current requirement for a patient to be visually sighted on Level 3[30] clinical observations in the Mental Health Unit in accordance with the Clinical Observation Levels Mental Health Unit Procedure.

61. It was recommended that the relevant policy be updated to include the visual sighting of patients at all levels of observations.[31] These recommended changes were implemented in May 2023.[32]

62. The SAC1 investigation also recommended a quality improvement activity which it described as: "*Develop or amend current policy to include guidelines for the prescription, use and review of agitation and arousal medication in the psychiatric setting at the hospitals.*"[33] This suggested quality improvement was implemented in August 2023 in the Mental Health Unit at SJOGMH.[34]

63. I commend SJOGMH for introducing these changes. Accordingly, I have not found it necessary to make any recommendations for improvements arising from the circumstances of Mr Bolton's death.

CONCLUSION

64. Mr Bolton was a mental health patient with extremely complex care needs. He had a traumatic brain injury from childhood which had affected his personality and behaviour, and he repeatedly engaged in self-harming and aggressive conduct. In addition, Mr Bolton had been diagnosed with schizoaffective disorder and methylamphetamine use disorder.

65. Sadly, from October 2018 until his death, Mr Bolton had become institutionalised. He spent more than three years in prison during this period and despite being appropriately released from prison on a CTO, he

[28] Ts (Dr Verheggen), p.36
[29] Exhibit 1, Volume 1, Tab 13, SAC1 Clinical Incident Investigation Report dated 9 January 2023, p.30
[30] Level 3 observations are one hourly observations
[31] Exhibit 1, Volume 1, Tab 13, SAC1 Clinical Incident Investigation Report dated 9 January 2023, p.30
[32] Exhibit 1, Volume 2, Tab 1, Report of Dr Michael Verheggen dated 8 March 2024, p.2
[33] Exhibit 1, Volume 1, Tab 13, SAC1 Clinical Incident Investigation Report dated 9 January 2023, p.31
[34] Exhibit 1, Volume 2, Tab 1, Report of Dr Michael Verheggen dated 8 March 2024, p.2

was very quickly using illicit drugs. His mental state deteriorated, and he required an acute admission to the Mental Health Unit at SJOGMH in early January 2022.

66. During Mr Bolton's prolonged admission of more than ten months, I am satisfied that every attempt was made to rationalise his medications to improve his mental health and behaviour, and to assist him in being discharged into appropriate accommodation. Unfortunately, his behaviour did not substantially improve with treatment, and he remained a major risk of harm to himself and to others. As there was no appropriate safe place to house him in the community, the only option available was to keep him in the locked mental health ward at SJOGMH. As his treating psychiatrist said at the inquest:[35]

> We were always trying to move forward. We integrate, be less restrictive, look to community treatment. Yes, it would be fair to say that Mr Bolton was always two steps forward, one step back [which] was very much a kind of theme of his admission.

67. I was satisfied that the care Mr Bolton received was not only appropriate but of a high level. Given the complexity of his management and the known difficulties treating patients with personality disorders compounded by polysubstance abuse, his inpatient treatment was always going to be prolonged and intensive. I was also satisfied the resuscitation efforts after Mr Bolton was found unresponsive were appropriate.

68. Mr Bolton's case has highlighted the scarcity of appropriately staffed and resourced facilities for the long-term community care of people with complex behavioural and psychiatric needs. Too often these patients are left for months living in an acute psychiatric unit with no improvement in their presentation or behaviour, and no real prospect of meaningful rehabilitation. As the Chief Psychiatrist of Western Australia noted in 2020:[36]

> It has been estimated that around 25% of people with schizophrenia and related disorders have a severe and enduring illness with complex, long-term needs that impact on their personal, social and occupational functioning. A subset of this group present particular difficulty for services in their treatment and care because of what has been termed "challenging behaviour": essentially, significantly impaired executive function, severely disorganised behaviour, poor impulse control, and serious risk of self-harm and/or harm to others. Without appropriate

[35] Ts (Dr Stevens), p.17
[36] Chief Psychiatrist's Review: Building rehabilitation and recovery services for people with severe enduring mental illness and complex needs – including those with challenging behaviour, 2020, p.7

> treatment and care these individuals are at high risk of becoming homeless, facing criminal charges or ending up in prison. They are some of the most vulnerable people in our community.

69. I extend my condolences to the family and loved ones of Mr Bolton for their sad loss.

PJ Urquhart
Coroner
28 August 2024