JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	SARAH HELEN LINTON, DEPUTY STATE CORONER
DELIVERED	**:**	6 MAY 2024
FILE NO/S	**:**	CORC 138 of 2022
DECEASED	**:**	GINBEY, DEVAN BEAU

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:

Ms S Markham assisted the Coroner.
Mr M Olds (SSO) appeared for South Metropolitan Health Service and PLN Dinsdale.
Ms B Burke appeared for Ms Thomson (nee Benson) and Ms Gordon.
Mr M Williams (Dominion Legal) appeared for Ramsay Health Care Australia Pty Ltd, Dr Burbidge-King, Ms Norton, Ms Crilly and Dr Smith.

Case(s) referred to in decision(s):

Nil

Coroners Act 1996
(Section 26(1))

AMENDED RECORD OF INVESTIGATION INTO DEATH

I, Sarah Helen Linton, Deputy State Coroner, having investigated the death of ***Devan Beau GINBEY*** *with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, Perth, on 2 November 2023 - 3 November 2023, find that the identity of the deceased person was* ***Devan Beau GINBEY*** *and that death occurred on 17 January 2022 at Fiona Stanley Hospital, 102-118 Murdoch Drive, Murdoch, from hypoxic brain injury following ligature compression of the neck (hanging) in the following circumstances:*

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INTRODUCTION

1. Devan Ginbey was a troubled young man who went with his mother to the Peel Health Campus Emergency Department (Peel ED) on the morning of 12 January 2022 asking for help. Devan had been feeling stressed and suicidal for the past three weeks and had self-harmed that day. His physical injury was treated and he was then seen by a psychiatric liaison nurse. After reviewing Devan, the psychiatric liaison nurse considered Devan would benefit from a voluntary admission to clarify his psychiatric diagnosis and commence treatment. Unfortunately, as the mental health system was (and is) under severe pressure, no bed was immediately available for him. Accordingly, the plan was made for Devan to remain in the Peel ED until a mental health bed became available.

2. Devan indicated he was willing to wait in order to get the help he needed. Devan remained in the Peel ED all day and then overnight. His mother had stayed with him for the whole day, but she eventually went home to the rest of her family in the evening. Devan's mother assumed Devan would be safe overnight, given the presence of staff and their knowledge of why he had come to the hospital and was waiting to be admitted.

3. Unfortunately, the environment where Devan was waiting was noisy and uncomfortable. After his medical review, Devan was allocated a bed in an overflow section in the middle of the busy ED, next to the 'Flight Deck,' and adjacent to where the ambulance entrance doors opened regularly, described by one witness as a "thoroughfare."[1]. Mental health patients are often placed in this area, for various reasons, but it is acknowledged to be a particularly noisy area with a lot of foot traffic and no privacy. It appears the noise and activity eventually became too much for him, and Devan left the ED without informing staff. He left between 6.00 am and 6.30 am, around the time an agitated patient with small children was put in a bed near to his own.

4. Devan's mother returned to the Peel ED at around 8.00 am that morning. She found Devan was not in his bed. Enquiries established he had last been seen by a nurse at around 6.00 am. Devan couldn't be found, despite a quick search of the hospital. At around 9.00 am, there was a discussion between Devan's mother and the psychiatric liaison nurse staff about whether police should be informed. It was decided he didn't meet the criteria to be involuntarily detained under the *Mental Health Act 2014* (WA) and Devan's mother was concerned that involving the police might escalate the situation and make it harder for him to accept treatment. It was agreed the hospital staff would wait a little longer to give Devan time to return of his own accord before the authorities were notified.

5. Sadly, not long after, Devan's grandfather went to Devan's home in Wannanup and found Devan hanging in the garage. Devan was able to be resuscitated and he was taken by ambulance to Fiona Stanley Hospital, but he had suffered an irreversible hypoxic brain injury and he died four days later.

[1] T 129.

6. Devan's mother wrote to the Court requesting an inquest be held into Devan's death to explore how Devan was allowed to leave the hospital unnoticed, given his fragile mental state. Devan's mother queried how it could be that his absence was not noticed until she raised the alarm. In addition, Devan's mother referred to an earlier inquest involving Peel Health Campus that had discussed a need for an appropriate quiet area within the ED for mental health patients waiting for a bed, which she submitted might have benefitted Devan, given his disturbed mental state. Instead, the area he was kept in was hectic and had agitated patients creating a disturbance, which she believes caused him to leave the hospital without waiting for treatment.[2]

7. I made a determination under s 22(2) and s 24(1)(a) of the *Coroners Act 1996* (WA) that it was desirable to hold an inquest into Devan's death. I held an inquest on 2 and 3 November 2023.

8. The inquest explored the issues raised by Devan's mother, with a focus upon the adequacy of Devan's supervision and also whether access to a mental health bed or at least an appropriate mental health observation area might have altered the outcome for Devan.

GENERAL BACKGROUND

9. Devan was born via emergency caesarean section and he didn't breathe for several minutes after birth. In later life, his mother used to wonder if his learning and other difficulties could be traced back to this moment.[3] Devan was diagnosed with central auditory processing disorder (CAPD) when he was between four and six years old. He engaged with programs meant to help him retain and store information properly, but they didn't appear to be very effective. His concentration was described as being very poor and he struggled academically, particularly in his high school years. He was, however, a talented athlete at school and was a very fast runner and competitive in most sports.[4]

10. Devan's parents' marriage ended when he was very young. Devan didn't see his father for a number of years. His mother formed a new relationship with his stepfather and he had two younger half siblings from his mother's second relationship, so Devan was their big brother.[5]

11. Devan often lived with his maternal grandparents growing up, and had a very close bond with them throughout his life. Devan was his grandparents' first grandchild and he was very precious to them. Devan's grandmother recalled Devan was a "perfect loving and caring little boy."[6] They spent a lot of time together cooking, gardening and shopping and doing fun activities. His grandmother watched him struggle academically at school, although he excelled at sport and had many friends.[7]

[2] Exhibit 1, Tab 6.2.
[3] Exhibit 1, Tab 6.1.
[4] Exhibit 1, Tab 6.1.
[5] Exhibit 1, Tab 6.1 and Tab 8.
[6] Exhibit 1, Tab 15.
[7] Exhibit 1, Tab 6.1 and Tab 8.

12. There is evidence Devan became involved in substance use/misuse when he was 13 years old. From then he apparently used cannabis regularly.[8] Devan had reconnected with his father in late 2014 and he sometimes lived with his father over the following years. Devan's mother and grandmother noticed that Devan's drug use worsened when he was living with his father, who also had a substance abuse issue. Devan's drug and alcohol use often made it difficult for him to live with his mother and extended family, but she and her husband encouraged him to get better and clean, which he did manage for long periods.[9]

13. On 7 December 2015, Devan's mother rang a Coordinator at the Child and Adolescent Mental Health Service (CAMHS) to discuss her ongoing concerns about his drug use, low mood and some possible psychotic symptoms. She was advised to take him to his GP and discuss options, including mental health services and drug and alcohol services. It is unclear why he was not offered an assessment with CAMHS, given these identified issues.[10]

14. Sadly, on 12 December 2015, when Devan was 15 years' old and after he had just finished Year 9, his best friend died by way of suicide. Devan had initially planned to be with his friend on the day of his death but his family had decided he needed a break so he had gone away with his grandmother. Devan never forgave himself for not being there and was angry with his mother and grandmother. Devan's mental health severely declined after this time. Devan refused to get grief counselling, but eventually agreed to see a doctor, who gave him some mood stabilising medication.[11]

15. Devan left school in the early part of Year 10 in order to go to TAFE. He chose to study landscaping, as he loved gardening and the outdoors. He later completed a painting and decorating pre-apprenticeship and also tried to get work in plastering, but he struggled to settle into a work routine, partly due to having to rely on public transport.[12]

16. Tragically, it appears another of Devan's friends committed suicide in March 2016, which set Devan back even more.[13]

17. On 1 April 2016, Devan was brought to the Emergency Department of Peel Health Campus (Peel ED) by his mother as he was expressing suicidal thoughts. He had been taken to his GP, who had written a referral letter and sent him with the letter to the Peel ED. The GP's referral letter indicated Devan presented with significant suicidal risk. He was reviewed by a Psychiatric Liaison Nurse (PLN), who noted that Devan was a 15 year old boy with a vulnerable personality and a history of polysubstance abuse. He presented with low mood and recent likely drug induced psychotic phenomena, with possible THC withdrawal. He had ongoing fleeting suicidal ideation with no plan. It was noted that Devan's recent distress had been

[8] Exhibit 1, Tab 9.
[9] Exhibit 1, Tab 6.1 and Tab 15.
[10] Exhibit 1, Tab 11.
[11] Exhibit 1, Tab 6.1, Tab 14 and Tab 15.
[12] Exhibit 1, Tab 6.1 and Tab 16.2, Attachment 1.
[13] Exhibit 1, Tab 11.

triggered by the recent suicide of his friend, which had brought back memories of his best friend's suicide. An urgent referral was sent to the CAMHS triage.[14]

18. From 13 April 2016 to 19 May 2016 there was contact between Devan and the CAMHS Acute Community Intervention Team. It was documented that he did not engage. It noted he described preparatory acts for suicide in Year 9, but his best friend had talked him out of it. This was the same best friend that had subsequently suicided in December 2015. Devan was referred to the Peel CAMHS and choice service, even though it was felt he might not engage, as there was concern about his level of risk.[15]

19. On 17 April 2016, Devan presented again to the Peel ED. He was brought in by police as he was aggressive and appeared under the influence of alcohol, petrol and methamphetamine. He also had significant amounts of sedative medication and was threatening self harm and suicide. He was assessed as having a likely drug induced psychosis and there was discussion about both chemical and physical restraint. Devan had a comprehensive assessment performed by a PLN the following day. His past history was noted and lack of engagement with mental health and drug and alcohol services, along with his current low mood and fluctuating suicidal thoughts. His parents were noted to be feeling overwhelmed and all his relationships were deteriorating. Psychiatric review was scheduled.[16]

20. Devan was assessed by a psychiatrist on 18 April 2016, who concluded Devan was an adolescent with longstanding issues related to self-esteem, identity and relationships within the family. There was no clear evidence for depression or psychotic illness at that time, although it was noted he was already on an antidepressant and low dosage antipsychotic. He was considered to be at chronic risk of suicide but did not have active plans or intent at that time. Follow up was organised with his local mental health service and GP.[17]

21. He had a further presentation to Peel ED in July 2016 after punching a mirror and injuring his right hand.[18]

22. Devan sought help from his GP for depression on 6 and 7 August 2019 and was commenced on an antidepressant. Devan was also given a referral to see a psychiatrist, although the psychiatrist was too heavily booked so he was unable to follow through with the referral.[19]

23. Devan attended Peel ED with his mother on 29 August 2019. He had called her and asked her to bring him there. Devan presented with suicidal ideation related to increased life stressors. He stated that he had a plan but did not want to disclose it. His history of depression was noted. Devan was assessed by a PLN who noted that Devan's grandparents had found a suicide note in his bedroom drawer. The note was

[14] Exhibit 1, Tab 11.
[15] Exhibit 1, Tab 11.
[16] Exhibit 1, Tab 11.
[17] Exhibit 1, Tab 11.
[18] Exhibit 1, Tab 11.
[19] Exhibit 1, Tab 9.

not directed at anyone in particular and had themes of everyone being better off without him. He denied any acute risk that day and was agreeable to community follow up. It was felt he would benefit from follow up with a community mental health team for diagnostic clarity, risk monitoring and linking in with appropriate services, and also required follow up with his GP.[20]

24. Devan saw his GP the following week, who noted his recent ED presentation. Devan sought a new psychiatric referral, which was provided. He did not see a psychiatrist at that time. Devan eventually got another referral in March 2020 and then came under the care of Consultant Psychiatrist Dr Jonathon Williams. The referral was for assessment for possible ADHD.[21]

FIRST DOCUMENTED EPISODE OF PSYCHOSIS

25. Dr Williams first saw Devan on 11 May 2020. Devan described significant mood swings over the past few years since his best friend's death. He had been on antidepressants a few times, which he stated did little for him. His main ongoing problem seemed to revolve around anger and the fact he "did not know how to deal with it."[22] Devan had been in trouble with the law due to his anger and volatility. He also described his mood as still quite depressed at times. He had previously been very interested in music and sport but had dropped off a lot on these things. Devan had a family history of ADHD and showed significant features of ADHD when tested by Dr Williams. He was commenced on dexamphetamine after that first appointment for management of his ADHD with initial good results. However, his mother rang Dr Williams in early July to say that Devan seemed to be becoming paranoid, so Dr Williams advised he should stop the dexamphetamine.[23]

26. Dr Williams saw Devan for review the following week on 15 July 2020. Devan was still struggling with significant anxiety and described people coming to his grandmother's house and not feeling safe there, although he denied any auditory/visual hallucinations. Dr Williams thought Devan was probably suffering from stimulant induced paranoid psychosis, although Devan disagreed and was adamant someone was actually coming into the house. It seems Devan wasn't admitted to hospital on this occasion as no bed was available, although it seems he had eventually agreed to go.[24]

27. Dr Williams saw Devan again on 27 August 2020, at which time Devan reported his paranoia had largely settled. However, his mood was more depressed and described hearing auditory hallucinations of voices talking to him. He was somewhat stressed about an upcoming court appearance and described some ongoing self-harm thoughts. Devan was having ongoing counselling with Palmerston Centre, who had previously provided help with his substance use and were trying to link into the Billy Dower Youth Centre for support. Dr Williams commenced Devan on the

[20] Exhibit 1, Tab 11.
[21] Exhibit 1, Tab 9.
[22] Exhibit 1, Tab 8, p. 1.
[23] Exhibit 1, Tab 8.
[24] Exhibit 1, Tab 6.1, Tab 8 and Tab 14.

antipsychotic Quetiapine at night to help with the hallucinations and mood regulation.[25]

28. Dr Williams saw Devan again in September 2020 and he asked for a referral for a psychological assessment. He was still struggling with his insomnia. Dr Williams suggested increasing his quetiapine dose to help him sleep. He was having weekly counselling at Palmerston at this time and was future focussed, talking about plans to go back to study and perhaps to travel, although he still had another upcoming court appearance.[26]

29. When Dr Williams saw Devan again in January 2021, he was living in a rental, studying and working. His court issues were finished and he was on a conditional suspended sentence. He reported he was taking his quetiapine at night. Devan described ongoing anger issues and possibly some continued paranoid ideation about his grandmother. Devan and his family were expressing concern about the cost of ongoing private treatment and asked to be referred to a government service, so Dr Williams referred him to the Peel Community Mental Health Team, who agreed to take him on for ongoing treatment. Dr Williams had no further clinical contact with Devan, although he was kept informed about his progress.[27]

30. Devan's mother stated that Devan had stopped using drugs and alcohol in January 2021, with support from the Palmerston Association, and was doing extremely well. He was learning to ride a motorcycle as his grandparents had bought him one and were encouraging him to get his licence. However, he then fell back in with his previous friendship group and began using drugs again and drinking regularly.

31. Devan was apparently seen by the Peel CMHT on 16 March 2021, where he continued to display psychotic symptoms, in particular paranoid thoughts about his grandmother, but lacked insight into the possibility that he was unwell. He denied any thoughts to harm himself or others. It was recommended that he have a medical appointment through the Peel CMHT.[28]

32. From 17 March 2021 to 15 June 2021, Devan was a client of the Peel Acute Treatment Team. He continued to experience residual symptoms regarding his grandmother. He was living in his own rental house and had secured employment as a night fill worker, so he was reasonably stable in terms of living conditions. It was noted he was still using marijuana and lacked insight into his symptoms, although overall he was functioning well.

33. In May 2021, Dr Williams was informed of Devan's contact with the Peel CMHT on 28 April 2021 and 13 May 2021. The clinical impression was that he was settled while on his prescribed antipsychotic medication, which he was willing to accept along with psychological intervention. The ongoing plan was to refer Devan to the

[25] Exhibit 1, Tab 8.
[26] Exhibit 1, Tab 8.
[27] Exhibit 1, Tab 8.
[28] Exhibit 1, Tab 8 and Tab 9.

Peel Youth Mental Health Team for engagement with youth services and counselling.[29]

34. Devan's mother recalled that Devan had felt he had not benefitted from his treatment by Dr Williams and the costs of private treatment had been difficult to afford, so he had made the choice to move to the community health service. After transitioning to Peel CMHS, Devan's medication dose was increased and it would make him sleep excessively.[30]

35. Devan eventually indicated to the CMHT that he didn't want to engage with their services and he declined a referral to drug and alcohol services.[31]

36. On 2 September 2021, Devan presented to Peel ED with a soft tissue injury after punching a door with his right hand. Not long after, on 12 September 2021, he presented again with a self-inflicted laceration to his left arm. He did not wait for treatment. Devan doesn't appear to have had any specific mental health treatment around this time. The next, and last, time he was seen by a doctor was his final presentation in January 2022.[32]

FINAL PRESENTATION TO PEEL HEALTH CAMPUS

37. At the time of his death, Devan was single. He had been working as a ceiling repairer but had not been working for a few weeks leading up to his death. He was living independently from his family in a rental house in Wannanup near his grandparents but saw his family regularly. He had enjoyed creating a home for himself with second-hand items and his own sense of style, but his lease was about to end and Devan was worried he would be left with nowhere to live. He reportedly spent a lot of his time in the last few weeks of his life on his own, walking and fishing.[33]

38. Devan's grandmother was worried he had reconnected with some of his friends who were a negative influence on him and they had encouraged him to lapse back into alcohol and drug use. She had noticed a change in his personality and he was nasty at times. He would pop in for a meal, but never stayed long.[34]

39. In the early hours of Wednesday, 12 January 2022, Devan rang his grandmother's doorbell. She asked him what he was doing there and he said "this is my safe place"[35] and asked if he could stay. Devan's grandmother let him in and saw he had his left arm wrapped in a makeshift bandage fashioned out of a jumper. She asked Devan if she could have a look at his arm but he refused and denied hurting himself. She sent him down to his room to go to bed then followed him down and asked again to see his arm. Devan declined and said he was tired, so they both said "I love you" and she then left him to sleep. Devan's grandmother rang her daughter, Devan's

[29] Exhibit 1, Tab 8.
[30] Exhibit 1, Tab 6.1.
[31] Exhibit 1, Tab 11.
[32] Exhibit 1, Tab 11.
[33] Exhibit 1, Tab 16.2, Attachment 1; Exhibit 2.
[34] Exhibit 1, Tab 15, Tab 16.2, Attachment 1; Exhibit 2.
[35] Exhibit 1, Tab 15, p. 3.

mother, Erin Stanley, a little while later and told her that Devan appeared to have injured his arm and was bleeding. Devan's grandmother asked Erin to come over and have a good look at Devan's arm, as she believed he might need to go to hospital.[36]

40. Erin arrived at approximately 5.30 am and went downstairs to check on Devan. She woke him up and removed the bandage so she could check the extent of his wounds. She could see some of the wounds were extremely deep, so she told Devan to shower to wash off the blood and get changed and she was then going to take him to hospital. Erin couldn't recall if she asked Devan at that time what had happened, but she did recall that he later said that he had spoken to his ex-girlfriend the evening before, which had triggered him to self-harm. Erin drove Devan home, where he showered and changed and she put a clean dressing on his arm. She recalled Devan was extremely quiet and withdrawn during this time.[37]

41. After he had showered and changed, Devan's mother took Devan to Peel Health Campus for medical treatment. The records indicate they presented at 7.21 am. Erin is recorded as telling the staff she was very worried about her son as his lacerations were very deep. She said he had also been abusing alcohol and cannabis recently and she believed he was very low and not coping.[38] Devan told the triage nurse that he had become more stressed and suicidal over the past three weeks and wanted to see a psychiatrist.[39]

42. Erin recalled that after being triaged, they were seen by a nurse quite quickly. Devan was first reviewed by Registered Nurse Laura Thomson (formerly Benson). Nurse Thomson remembered seeing Devan as she had only just starting working in Peel ED and Devan was the first patient she saw there. Nurse Thomson was working with another nurse, Registered Nurse Sarah Fisher, and together they performed a nursing assessment of Devan, including taking a set of physical observations. Nurse Thomson recalled that Devan was quite teary and talking about the stresses in his life, including losing his job and being worried about losing his rental house. He reported feeling suicidal and admitted to previous self-harm. He was quite upset and wanted help with his drug and alcohol use as well as his mental health.[40]

43. Erin was aware Devan had been drinking heavily for some time in the lead up to this episode, and she noticed his hands were having tremors and he was sweating. He told her that he hadn't had a drink for 24 hours, which explained his symptoms. Devan also said to Erin that he "didn't want to be alive anymore"[41] and was "punishing himself."[42]

44. At the time of the nursing assessment, Devan was in a cubicle with curtains. Shortly after the nurses left the cubicle, Dr Thomas Burbidge-King arrived to review Devan.[43] Dr Burbidge-King is an Emergency Medicine Consultant. He performed a

[36] Exhibit 1, Tab 14.1.
[37] Exhibit 1, Tab 14.1.
[38] Exhibit 1, Tab 7.
[39] Exhibit 1, Tab 14.1.
[40] T 58 - 60; Exhibit 1, Tab 17.
[41] Exhibit 1, Tab 14.1, p. 1.
[42] Exhibit 1, Tab 14.1, p. 1.
[43] T 58 - 60; Exhibit 1, Tab 17.

medical assessment of Devan that morning. Devan's mother was present at the time. Dr Burbidge-King physically examined Devan as part of the assessment and reviewed the observations recorded by the nurses. He noted that Devan's blood pressure was a little high, which could have been related to the stress and anxiety of being in an ED, and his other observations were within normal limits. His only injuries were the cuts to his left forearm and they were not immediately life-threatening. Devan told Dr Burbidge-King that he had deliberately self-harmed by cutting his left forearm the night before with a clean razor blade, following a phone call from his ex-partner. He denied that he had been attempting to kill himself but did say he had increasing thoughts/wishes to die. In that context, Devan told Dr Burbidge-King he was planning to jump from the Dawesville Bridge onto the concrete. He mentioned his dog as a protective factor against following through with this plan. Devan also admitted daily alcohol use and intermittent cannabis and methylamphetamine use.[44]

45. Dr Burbidge-King's impression was that Devan required some immediate medical treatment to his cuts but they were not severe and he had no acute ongoing medical issues. Devan did not appear psychotic but Dr Burbidge-King was concerned about Devan's mental health and felt he required a more in-depth assessment of his mental state and his risk given his suicidal ideation. Devan received some treatment for the multiple superficial cuts to his arm and was put on alcohol withdrawal monitoring with diazepam as needed and thiamine. A referral was then made to the PLN and Dr Burbidge-King indicated to the ED team that Devan was not to leave the ED until the PLN had conducted their review.[45]

46. While they were inside the ED, Devan had apparently told Erin that he was "slowly poisoning/killing his body"[46] so she pulled Dr Burbidge-King aside and told him she believed Devan wanted to kill himself. Dr Burbidge-King advised her that Devan had told him similar information, so he was arranging for the PLN to come and review Devan. Erin also recalled that Dr Burbidge-King said Devan should not be left alone and was to stay at the hospital. Dr Burbidge-King did not recall saying this to Erin but it was consistent with his instructions to the ED staff and a note recorded in the emergency department electronic medical records in EDIS at 9.20 am that Devan was not to leave the hospital as he was awaiting psychiatric review.[47]

47. Dr Burbidge-King gave evidence he didn't consider it appropriate to start Devan on any medications for his mental health issues prior to his assessment by the PLN. He explained that often there is not an immediate response to antidepressants, so there are not something usually started immediately in the emergency department, and the other antipsychotic medications he might use would be sedating, which he didn't require as he was not agitated and sedation might also have inhibited a full psychiatric assessment being completed.[48]

[44] T 16 – 18; Exhibit 1, Tab 7; Exhibit 2.
[45] T 27; Exhibit 1, Tab 7; Exhibit 2.
[46] Exhibit 1, Tab 6.1, p. 4.
[47] Exhibit 1, Tab 6.1 and Tab 6.2 and Tab 7; Exhibit 2.
[48] T 31 - 32.

48. Dr Burbidge-King indicated that there was nothing about Devan's presentation that indicated he lacked capacity or otherwise met the criteria to be placed on forms under the *Mental Health Act* and detained as an involuntary patient. He had voluntarily presented to the hospital with his mother and indicated he was willing to remain there for assessment, so there was no reason to remove his autonomy. As a voluntary patient, he could not, therefore, be physically prevented from leaving the hospital. However, Dr Burbidge-King had intended to convey in his comments that staff should use all means available to encourage Devan to stay if it looked like he intended to discharge himself prior to being psychiatrically reviewed. If he could not be persuaded and still chose to leave, it would be usual practice to try to contact the next of kin, if they weren't present, to let them know he was leaving. [49]

49. After making giving these instructions, Dr Burbidge-King then left to attend to other duties in the ED.[50] It was understood that as a voluntary patient, Devan would be allowed to go in and out to have a cigarette or go to the toilet without supervision, but it was expected that staff would otherwise generally be keeping an eye on Devan until he was assessed by the PLN.[51]

50. Nurse Thomson recorded in the integrated progress notes at 8.20 am that although he admitted previous self-harm and had some superficial cuts to his arm, Devan had denied any specific suicidal plan. She also recorded that he appeared to have good insight and wanted to get help and he was waiting to be reviewed by the PLN.[52]

51. Enrolled Nurse Rebecca Norton took Devan's observations at 10.40 am and at that time his observations were within normal limits, and he indicated he was not in any pain. His mother was noted to be present with him at that time.[53]

52. At 11.30 am, Devan returned inside after having a cigarette with his mother. He was noted to be anxious with mild tremors, indicating mild alcohol withdrawal based on the alcohol withdrawal chart, so he was given some diazepam, as prescribed by Dr Burbidge-King, to calm him.[54]

53. When the PLN arrived to assess Devan at approximately 12.45 pm, Erin spoke to him briefly then left and went outside to make a phone call to her husband and to give Devan some privacy.[55]

PLN REVIEW

54. At the relevant time (and currently, although it is set to change), Peel Health Campus was operating as a private/public partnership under an agreement between Ramsay Health Care Australia Pty Ltd and the WA Department of Health. Public mental health services did not form part of the agreement, so mental health services at Peel

[49] T 35 – 37, 53; Exhibit 2.
[50] T 35 - 37; Exhibit 2.
[51] T 49, 53.
[52] Exhibit 1, Tab 12, Integrated Progress Notes, 12.1.22, 08.20 and Tab 17.
[53] T 68 – 69; Exhibit 3.
[54] Exhibit 1, Tab 7.
[55] Exhibit 1, Tab 6.1 and Tab 7.

Health Campus were provided by the South Metropolitan Health Service. There was an on-site community mental health service, as well as in-reach service available in the Peel ED through the form a PLN from 7.00 am to 11.00 pm, 7 days a week. The PLN provided a liaison service to assist ED staff, who may not have a lot of experience with mental health presentations, with assessing psychiatric patients, in conjunction with the consultations provided by the Psychiatric Registrar on weekdays.[56]

55. PLN Matthew Dinsdale was rostered to work in the Peel ED on 12 January 2022. He was informed at the start of his shift that Devan had presented and would require a mental health assessment, but he had not been medically cleared at that stage. Devan was eventually formally medically cleared and then referred to the Psychiatric Liaison Team at 11.00 am. Due to other earlier presentations, PLN Dinsdale was not able to assess Devan until about 12.45 pm.[57]

56. The notes indicate that Devan presented post an episode of self-harm and had suicidal thoughts. PLN Dinsdale had assessed Devan the previous year and he noted that this presentation was slightly different to the previous time. Devan's records showed he hadn't always engaged well with mental health services in the past, but on this occasion he was almost begging PLN Dinsdale to put him in hospital.[58]

57. Devan was taken to the consult room so they could speak more privately. Given PLN Dinsdale had seen Devan previously, he already had quite a good amount of his history, so the focus of this assessment was on why Devan had presented this time and what was going on for him? He recalled Devan was a really nice guy who very clearly wanted help.[59]

58. On assessment, Devan expressed paranoid themes and unusual beliefs, such as a belief men were poking their heads over his fence and looking in on him, which PLN Dinsdale identified as worrying symptoms of psychosis. He also recalled that Devan did not appear fully focussed on their conversation and whilst some of the time he engaged in quite intense eye contact, "on occasions he would pause and look to one side, as if someone was telling him something, before answering."[60] PLN Dinsdale felt Devan was experiencing perceptual disturbance, although he denied this was the case, and he thought it was possible that Devan was having command hallucinations. The impression was of a possible underlying psychotic process that might be substance induced, noting Devan had previously been treated for medication-induced psychosis. However, PLN Dinsdale also acknowledged that it can be difficult to determine whether a person is having auditory hallucinations or is just distracted or stressed, which is not uncommon in the ED environment.[61]

[56] T 152 – 153; Exhibit 13.
[57] Exhibit 1, Tab 16.1.
[58] T 157 – 158.
[59] T 158 - 159.
[60] Exhibit 1, Tab 16.2 [70].
[61] T 157, 164; Exhibit 1, Tab 16.1 and Tab 16.2.

59. Devan admitted some substance use, including alcohol daily, but it was felt he was not a reliable historian in relation to his substance use and he was underestimating his drinking.[62]

60. Devan was asking for an admission to hospital as he felt unwell and PLN Dinsdale agreed Devan would benefit from voluntary admission to clarify his diagnosis and commence treatment as he felt Devan was psychotic. As Devan appeared to have some insight into his situation and was asking to be admitted, he was not considered for involuntary admission as he did not meet one of the criteria for involuntary admission, namely 'that a patient must be refusing treatment'. Instead, a plan made was to arrange a voluntary admission in a mental health ward.[63]

61. PLN Dinsdale recalled that Devan had been settled and co-operative with the process of referral and admission and he thought the whole assessment process took a little less than an hour. A Risk Assessment and Management Plan (RAMP) was completed as part of the process, which noted that a protective factor was that he was seeking help. His overall assessment of risk was noted to be medium risk to self; however, he presented as paranoid. PLN Dinsdale explained that in his experience, a RAMP is not a particularly useful clinical tool for assessing risk, which is dynamic, but it is a requirement that he complete the form. His opinion echoed that of the psychiatric expert, Dr Brett, as noted below.[64] PLN Dinsdale noted that it is impossible to predict who is actually going to commit suicide, and statistically, "the people who actually complete suicide are usually the ones who don't tell you."[65]

62. When Devan's mother returned, PLN Dinsdale told Erin and Devan that he was going to try to get Devan a bed in a mental health ward that day or the next day. He asked Devan about which hospitals he was prepared to go to, and Devan said he would go anywhere as he just needed help. Erin also recalled that Devan said several times that if he left the ED, he would kill himself.[66]

63. Documentation was sent to Mimidi Park (Rockingham General Hospital's Psychiatric Unit), which was the nearest unit to Peel Health Campus, in order to try to get a bed allocated there, although it was also noted that he was happy to go out of the area. At the time of the referral, there were no available beds to admit Devan either in Mimidi Park or any other hospital, so Devan was to remain in the ED until a bed could be arranged. He was handed over by PLN Dinsdale to the ED staff and his notes indicated Devan was for 'regular review'[67] while he waited.[68] That review was to be performed by the PLN's, when on shift, but otherwise he would be generally monitored by the ED nursing and medical staff. PLN Dinsdale indicated in his statement that if he had been informed at any time during his shift that Devan's presentation had changed, such as Devan expressing that he no longer wanted to seek treatment, then his practice would be to reassess him and determine if he needed to

[62] Exhibit 1, Tab 16.2, Attachment 1.
[63] Exhibit 1, Tab 11, Tab 16.1 and Tab 16.2.
[64] T 166 – 167; Exhibit 1, Tab 11.
[65] T 177.
[66] Exhibit 1, Tab 6.1.
[67] Exhibit 1, Tab 16.2, Attachment 1.
[68] Exhibit 1, Tab 16.

take steps to involuntarily admit him under the *Mental Health Act* or not. However, when Mr Dinsdale had spoken to Devan, he had confirmed that he was willing to remain in the ED as a voluntary patient and Mr Dinsdale did not have any further contact with him.[69]

64. PLN Dinsdale finished his shift at 3.30 pm on 12 January 2022. He handed over to a colleague before he left, with the colleague due to finish their shift at 11.00 pm that evening. There is no evidence to suggest Mr Dinsdale's colleague was requested to see Devan at all that evening.[70]

65. At the inquest, PLN Dinsdale again confirmed that at the time he had seen Devan, it was clear to him that Devan had psychiatric issues but he also had insight and "knew there was something not quite right."[71] Devan wanted help and wanted to go to hospital to get treatment, so he was not a candidate for involuntary treatment under the *Mental Health Act*. Although he did not see Devan again, Mr Dinsdale felt certain that something had changed for Devan overnight that had led him to decide to leave and altered his level of risk to himself. It was possible that the agitated patient was part of that, although it was just a hypothesis.[72]

NURSING CARE PROVIDED OVERNIGHT

66. While Devan was waiting for a mental health bed to become available at another facility, he was allocated one of four beds in the 'Flight Deck' area. There was evidence that these beds were not part of the original design of the ED, but had been added in over time as overflow beds to accommodate additional patients. Flight Deck beds 1 and 2 beds were pushed up against one another on one side of the Flight Deck, opposite Bay 13, and then Flight Deck beds 3 and 4 were around the corner. The Flight Deck beds do not have curtains or a call bell, but are just beds placed in the open area.[73]

[69] T 152, 156, 179, 181; Exhibit 1, Tab 16; Exhibit 13.
[70] T 151; Exhibit 1, Tab 16; Exhibit 13.
[71] T 162.
[72] T 161 - 162.
[73] T 112.

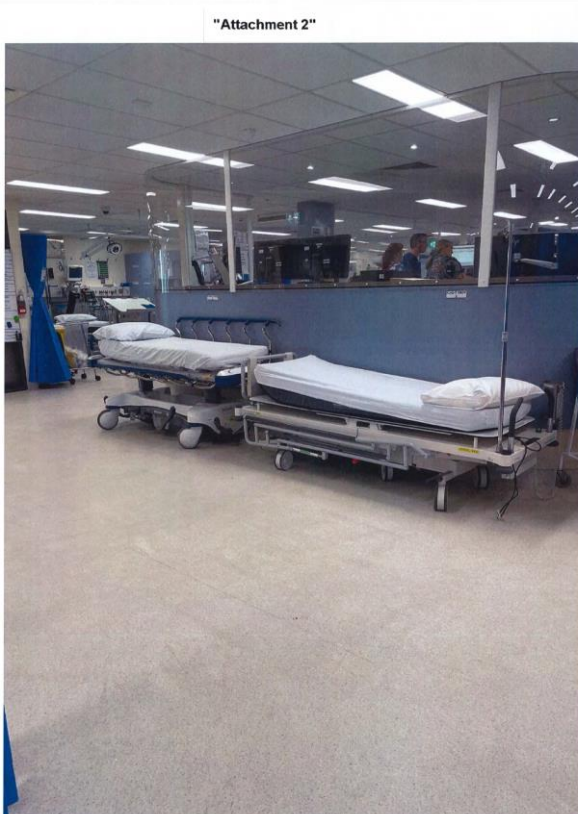

Exhibit 11, Statement of Nurse Vanessa Crilly, Attachment '2'

67. It was generally agreed in evidence that the beds were for patients who were clinically stable and did not require regular clinical monitoring by specific monitoring machines, which was often the mental health patients waiting for a mental health bed. It was said that the position of the beds close to the nurse's station and in a highly visible spot also had the advantage that the patients could be easily sighted by staff, although it was also generally accepted that they had the disadvantage that they had no privacy, were particularly noisy and exposed to foot traffic and there was no call bell for a patient to call for assistance, if required.

68. Nurse Norton gave evidence that she completed the alcohol withdrawal scale chart for Devan at 3.40 pm, which would have involved asking Devan some questions around how he was feeling in order to monitor his withdrawal symptoms. This would have included checking about his level of anxiety. Nurse Norton recorded Devan appeared calm at that time and the severity of his alcohol withdrawal overall at that time was mild, and slightly lower than earlier. She offered him diazepam, as per the chart, and he accepted the offer of the medication. She gave him the thiamine then went and got the diazepam.[74]

69. Erin went to Devan's house and packed him an overnight bag and toiletries, then went to the shops and bough him some snacks and drinks, along with some books and colouring in activities to keep him occupied. She then waited with him for a while in the ED until approximately 5.30 pm, before deciding that she needed to go

[74] T 69 – 70; Exhibit 1, Tab 3.

home to care for her other young children. Devan seemed in better spirits by that time. Erin told Devan that she would be back the next morning at 8.00 am to see him and then told his nurse that she was leaving and asked the nurse in front of Devan if they could keep an eye on him and to please make sure he took all his medications. The nurse assured her that Devan would be fine and they would take care of him. Erin then hugged Devan and told him she loved him before leaving. Erin understood from her discussions with various staff that Devan would be watched closely overnight.[75]

70. Nurse Norton thinks she may have completed Devan's observations again at around 5.30 pm. The observations that were recorded appeared normal. Nurse Norton gave evidence she would have been considering Devan's mental state as part of that process, and the fact that she did not record any concerns suggests to her that she had no concerns about Devan's mental state at the relevant time. Nurse Norton did not recall speaking to Devan's mother around this time.[76]

71. The integrated progress notes indicate that Devan was seen intermittently by nurses overnight, but the notes are brief and do not indicate any significant level of directed mental health risk assessment for Devan over the many hours he was waiting in the ED for a bed. It was suggested some assessment of Devan's mental health was done to some degree as part of the alcohol withdrawal monitoring, although there was expert psychiatric evidence that not a lot could be inferred from Devan's alcohol withdrawal scale scores given it is done for a very different medical purpose.[77]

72. Devan's last integrated progress note entry was at 6.04 am when there were no clinical concerns noted, based on the physical observations taken, but nothing specific to indicate what his mental state was like at that time other than the ticks recorded on the alcohol withdrawal scale. Those ticks suggested he was calm and had been able to rest, although there is no corresponding nursing note to provide any context or further information about his presentation at that time.[78]

73. The evidence in the brief was quite limited as to what more interaction was had with Devan overnight, but during the course of the inquest counsel for Ramsay Health were able to identify that the overnight shift coordinator, Clinical Nurse Vanessa Crilly, had a good recall of the events of the evening. Ms Crilly provided a statement[79] and also gave oral evidence at the inquest about her recollection of events on the last night Devan was alive.

74. Nurse Crilly was stationed in the Flight Deck in the ED overnight and was using a workstation facing into Bay 13 in the ED. Devan's Flight Deck bed was directly below Nurse Crilly's workstation. Nurse Crilly had received a handover from both the departing shift coordinator and the PLN, so she knew Devan had attended the Peel ED and been admitted with deliberate self-harm and suicidal ideation. Nurse Crilly recalled the PLN she spoke to was a woman and she clarified that Devan was a

[75] Exhibit 1, Tab 6.1 and Tab 6.2 and Tab 14.
[76] T 70 – 71; Exhibit 3.
[77] T 93.
[78] Exhibit 1, Tab 12.
[79] Exhibit 11.

voluntary patient and there were no grounds at that stage to consider requesting a medical review in order to consider changing his status and forming him or holding him if he indicated he wanted to leave.[80]

75. Nurse Crilly indicated in her statement that she was still concerned for Devan and his well-being, so although she was not allocated to care for Devan, she was mindful to keep any eye on him throughout the night. Nurse Crilly couldn't see Devan from her workstation if he was lying down, but could see him if he stood up at any point. In addition, as shift coordinator she was walking constantly around the ED, so she walked past the Flight Deck beds often. As a result, Nurse Crilly recalled she walked past Devan regularly during the overnight shift, which enabled her to conduct regular visual observations on him.[81]

76. Nurse Crilly remembered Devan was lying in his bed all night and he showed no obvious signs of distress or agitation. He did not require any medications or clinical interventions overnight. Devan had his last physical observations taken shortly after 6.00 am, and he was calm and compliant at the time.[82]

77. Nurse Crilly sent an escalation email at 6.21 am still seeking a mental health bed for Devan, prior to a bed prioritisation meeting.[83] This was done as Devan had been waiting for around 12 hours for a mental health bed, so it was required under the formal mental health escalation policies. In the email, Nurse Crilly advised that as at 6.21 am, Devan had been medically cleared and he was calm and co-operative. She recalled Devan was still in his bed at the time she sent the email.[84]

78. After sending the escalation email, Nurse Crilly began preparing for handover to the morning staff. She also spent some time assisting other staff to manage a loud and disruptive patient in Bay 13. The patient had been admitted to the ED just before 6.30 am and the patient and her two children were placed in Bay 13, around two metres from Devan's bed, so that they were highly visible to staff. The only thing separating this patient's cubicle from Devan's was a curtain and Devan would have been able to see and hear the patient causing the disruption. Nurse Crilly recalled that Devan woke up and sat up in bed when the woman began to cause a commotion, although he still appeared calm at that stage, despite the disruption. This was the first time he had not appeared to be sleeping that she could recall.[85]

79. Nurse Crilly explained that the patient in Bay 13 had become aggressive and was "screaming and yelling and swearing and flailing around,"[86] so a Code Black was called and security became involved. The patient eventually had to be sedated, which required the assistance of approximately three quarters of the staffing on the floor at that time, and the patient was then allocated a 'one to one nursing special' as she was an airway risk, which required extra staff to be found. Some efforts were also made

[80] T 133; Exhibit 11.
[81] Exhibit 11.
[82] Exhibit 11.
[83] Exhibit 1, Tab 7.
[84] T 138; Exhibit 11.
[85] T 134; Exhibit 11.
[86] T 137.

to find an alternative carer for the patient's children. Given Nurse Crilly's attention was occupied on these other tasks, Nurse Crilly did not see Devan leaving the ED, although he must have done so around this time.[87]

DISCOVERY THAT DEVAN WAS MISSING

80. Registered Nurse Claire Gordon was working in the Peel ED on the morning of 13 January and was in Team 2. She started her shift at 7.00 am and there were three nurses but no team leader allocated to Team 2 that shift. Team 2 manages bed spaces 11 to 20 and there would usually be a separate nurse allocated to the four 'Flight Deck' beds, but on this morning that position wasn't staffed, so two of the Flight Deck beds, Flight Deck 1 and 2, were absorbed into Team 2's nursing duties. Also, one of the three allocated nurses in Team 2 was required to perform a one to one nursing special with a patient, which left only Nurse Gordon and another nurse to take care of the remaining 11 patients allocated to Team 2 that morning, including the extra Flight Decks bed, one of which was the bed allocated to Devan.[88]

81. When Nurse Gordon started her shift, she received a handover for all of the patients. Nurse Gordon gave evidence that unlike for the other ED patients, the handover for the mental health patients is not normally done by their bedside for the sake of patient confidentiality. She recalled being told Devan had come in with his mother and there were concerns regarding self-harm and suicidal ideation. The next step was to go and speak to Devan and check his patient ID as part of the handover process, but Devan was not in his bed, although his backpack was there. Nurse Gordon recalled the night shift nurses who were handing over said that Devan had been settled and had slept relatively well overnight. They suggested he might have gone outside for a cigarette. Devan did not return to his bed, so Nurse Gordon did not meet him.[89]

82. Nurse Gordon gave evidence another patient who was very disruptive had been allocated to the bed next to Devan by the time she started her shift, which was also Erin's later recollection. However, there was other evidence the patient had actually been allocated to Bay 13, which was directly across from Devan's bed, and possible moved to the bed next to Devan's after he left. In any event, it is clear the female patient was causing a disturbance and "making her presence felt"[90] in the ED area very near to Devan while her two children made noise, prior to him leaving. The female patient's irritable behaviour was believed to be at least in part due to the effect of methylamphetamine and she was waiting to be reviewed by the PLN.[91]

83. While Nurse Gordon was still completing the shift handover with the nightshift nurses for the other patients, they were approached by PLN Dinsdale. Nurse Gordon gave evidence she took the opportunity to have a brief conversation with PLN Dinsdale about Devan. In particular, she wanted to clarify with him what she should

[87] T 134 – 137; Exhibit 7; Exhibit 11.
[88] T 111 - 115.
[89] T 117 - 119.
[90] T 116.
[91] T 115, 117, 120.

do if Devan indicted he didn't want to voluntarily remain in the ED anymore. Nurse Gordon could not recall if she told PLN Dinsdale at the time that Devan was not in his bed. PLN Dinsdale told her that they it wasn't likely they would use the *Mental Health Act* to prevent Devan from leaving if he could not be talked into staying voluntarily, but indicated Nurse Gordon should call him and he would come back and review Devan again.[92] PLN Dinsdale couldn't recall this conversation but agreed in his evidence that his general advice would have been that Devan would need to be reassessed before he left and encouraged to stay, although he wouldn't necessarily have put him on forms if he indicated he was determined to leave, as the restrictive powers under the *Mental Health Act* should only be used as a last resort.[93]

84. PLN Dinsdale also indicated that he or another PLN would have planned to conduct a periodic review of Devan sometime that day in any event, to get an update of his psychiatric state and determine if things have improved, remained stable or escalated.[94]

85. Erin returned to the Peel ED the next morning at 7.52 am. She found Devan's bed next to the Flight Deck was empty. His blanket was thrown back, as if he had just jumped out of bed. His bag was on the bed with his wallet and other personal items packed inside. Erin waited a few minutes and then stopped a nurse and asked if she could speak to Devan's allocated nurse.[95]

86. Nurse Gordon recalled that she received a message from the triage nurse at around 8.00 am and was told that Devan's mother, Erin, had arrived and was asking for an update on how Devan had been going. They then had a discussion.[96] Nurse Gordon advised that she had not seen Devan since her shift started almost an hour before. Erin recalled Nurse Gordon checked in Devan's notes and said that the notes indicated he was calm and seemed well throughout the night, despite how 'active' it was on the ward. Nurse Gordon went and spoke to the shift coordinator, who suggested that she should go with Devan's mother and look outside to see if they could find him. Erin and Nurse Gordon went through the ambulance doors and checked some inside and outside areas where people often smoke and also went for a walk to the café inside the hospital to see if Devan had gone to get a coffee, but there was no sign of Devan in any of these places. Nurse Gordon recalled Erin mentioned Devan had left the hospital grounds and gone to McDonald's the previous day for coffee and breakfast, which seemed to fit with other information Nurse Gordon had received, so this seemed a reasonable possibility. Given Devan had left his property on his bed, they were reassured that wherever he had gone, he was planning to return.[97]

87. Erin asked a staff member to leave Devan's breakfast tray, as she was expecting he would return and want a meal. She recalled she then told Nurse Gordon that Devan was supposed to have been supervised and asked if she could call her as soon as he

[92] T 119 - 120.
[93] T 169, 171, 179.
[94] T 179.
[95] Exhibit 1, Tab 6.1 and Tab 6.2.
[96] T 121.
[97] T 122 - 123; Exhibit 1, Tab 6.1 and Tab 6.2.

returned. Nurse Gordon then said she had alerted security to keep an eye out for him.[98] Nurse Gordon recalled that when they arrived back in the ED, the shift coordinator was on the phone talking to security and asking them to review the CCTV footage to look for Devan. Nurse Gordon recalled Erin wrote down her phone numbers and left to go to work sometime before 8.30 am, without being able to see Devan. Nurse Gordon said she would call Erin when Devan returned.[99]

88. An entry in the Integrated Progress Notes at 8.12 am recorded that Devan's mother had presented around 8.00 am requesting an update and Devan could not be located. His mother had indicated that Devan had gone to the local McDonald's the night before for coffee and space. Devan's belongings were still on his bed. The shift coordinator and security staff were aware that he was missing, and Devan's mother had advised he had no phone.[100]

89. Nurse Gordon recalled that a bit later in her shift, as she was leaving to go to tea, she spoke to the shift coordinator to say she would call Erin when she returned. The shift coordinator advised she had spoken to the PLN and "he was taking care of it."[101]

90. Clinical Nurse Leonie Wilson was working as a Clinical Nurse Manager (CNM) at the Peel Health Campus that morning and it was brought to her attention that Devan had left the ED while waiting for a voluntary mental health admission and searches by his mother, nursing staff and security staff had been unable to locate him. Security was asked to locate the available CCTV footage to try to determine when Devan had left the ED and in which direction he had gone. CNM Wilson viewed the relevant section of CCTV footage identified by security and observed Devan sitting on his bed at around 6.30 am. His bed was around 6 metres away from the ambulance airlock entry into the ED and the footage showed Devan got up off his bed and walked at a normal pace towards the airlock entry doors. The doors require a pin code or access swipe, but as Devan approached them, ambulance officers brought a patient into the ED through the doors. Devan could be seen on the CCTV footage walking out the doors behind the ambulance officers before the doors automatically closed. The CCTV footage then showed Devan going outside the hospital and walking off to the right of the exit. Not long after 6.30 am, he could be seen walking down to the end of the driveway, and then he disappeared out of the range of the CCTV camera. It was unclear where he had gone from there.[102]

91. It was recorded that the Psychiatric Team were informed and they were going to formulate a plan.[103] The Psychiatric Registrar informed PLN Dinsdale, that Devan was missing at about 9.00 am.[104]

92. PLN Dinsdale had come back on shift at 7.00 am that morning, He had been given a handover from the night shift doctors and they would usually mention if there had

[98] Exhibit 1, Tab 6.1 and Tab 6.2.
[99] T 123.
[100] Exhibit 1, Tab 7 and Tab 12.
[101] T 123.
[102] Exhibit 12.
[103] T 123; Exhibit 1, Tab 7 and Tab 12.
[104] T 172.

been any issues with the psychiatric patients overnight, but he was not informed at that time that Devan had left the ED. PLN Dinsdale had then reviewed the Emergency Department Information System (EDIS), which showed Devan was still waiting for voluntary admission to a bed. PLN Dinsdale did not see Devan at that time. He went to his office and commenced the routine tasks required at the start of the shift. At 9.00 am, Mr Dinsdale was going to the ED to assess another patient when he was informed by the Psychiatric Registrar that Devan had left the ED 6.30 am. Further enquiries established that Devan had left at about 6.30 am and had left his belongings behind. Devan's mother had been in at about 7.30 am and she had discussed with the nursing staff the possibility that Devan might have gone for a walk, but he had not returned.[105]

93. By the time PLN Dinsdale was informed, Devan had been absent from the ED for two and a half hours. He stated he was immediately concerned for Devan as he believed that Devan "was experiencing psychotic phenomena."[106] In evidence, PLN Dinsdale said he thought Devan had been gone "way too long" by that time and he was concerned. He called Devan's mother to discuss what should happen next, noting that under new provisions of the *Mental Health Act*, family considerations should be taken into account when making decisions under the Act.[107]

94. At around 9.00 am, Erin received a call from PLN Dinsdale. He told her that Devan still had not returned to the ED. In his statement, he indicated he had told Devan's mother that Devan had been missing for a while and he was planning on placing Devan under the *Mental Health Act* and requesting police assistance to return him to the ED.[108]

95. Erin recalled PLN Dinsdale asked her if he should call the police. Erin said she was wary of the police becoming involved as she knew it would distress Devan even more if he was confronted by the police and he might lash out in a state of agitation and make things worse. Erin stated she told PLN Dinsdale, "maybe not yet as he is anxious and maybe just needed a break."[109] Erin said she had noticed that a woman who appeared to be coming off drugs or alcohol had been in the bed next to Devan's, along with two small children, and the ED was generally noisy, so she thought he might have wanted to go outside for some respite. Erin had been reassured by the fact Devan had left his bag, and he hadn't discharged himself, so she thought at the time he couldn't be far away. She recalled that PLN Dinsdale agreed and told Erin he would call her back if Devan turned up.[110]

96. PLN Dinsdale stated that after discussing the matter, he told Devan's mother that he would give it a bit more time before he contacted the police, to give her time to find him, with a plan to call her back in about an hour. She was concerned that involving

[105] Exhibit 1, Tab 16.1 and Tab 16.2.
[106] Exhibit 1, Tab 16.1 [19].
[107] T 172 - 173; Exhibit 1, Tab 16.1.
[108] Exhibit 1, Tab 16.1 and 16.2.
[109] Exhibit 1, Tab 6.1, p. 5.
[110] Exhibit 1, Tab 6.1 and Tab 6.2.

the police might cause Devan additional distress and she was hopeful he could be found before that became necessary.[111]

97. After speaking to Devan's mother, PLN Dinsdale worked on an action plan, that included speaking to the Psychiatric Registrar and with the ED team to try to figure out exactly when Devan had left the ED, which was established to be 6.30 am.

98. Consistent with his recollection of the plan, PLN Dinsdale rang Devan's mother back an hour later, at 10.00 am. Sadly, by that time Devan had already been found hanging and she communicated that information to him before the call ended.[112]

FINDING OF DEVAN BY HIS GRANDFATHER

99. Devan's grandfather went to Devan's house in Wannanup to put out his rubbish bins and to check the house was secure. He had no idea at that time that Devan had left the hospital and made his way home. I do not have a lot of information about what happened next, but at 9.25 am, an emergency call was received by police advising that Devan's grandfather had found Devan hanging in the garage. He said he had cut him down but Devan wasn't breathing. He asked police to attend. Police were on the scene by 9.29 am and they immediately took over resuscitation efforts from Devan's grandfather. Four police officers took turns continuing CPR on a rotating basis until an ambulance arrived.[113]

100. St John Ambulance received the call for an ambulance to attend at 9.26 am. An ambulance arrived at Devan's home in Wannanup at 9.48 am. Police officers were still performing CPR when the SJA officers arrived. After further resuscitation efforts by the ambulance officers, including administering intravenous adrenaline, a return of spontaneous circulation was achieved at 9.55 am. However, Devan's down time at that stage had been in excess of 30 minutes, so his prognosis was not good. The SJA officers decided to bypass Peel Health Campus and go straight to a tertiary hospital as it was apparent Devan would require intensive medical care. They took Devan directly to Fiona Stanley Hospital.[114]

101. In the meantime, at around 11.00 am, the PLN rang Devan's mother again and was informed by Erin that Devan's grandfather had found him hanging in his garage and he was being taken by ambulance to hospital. She was understandably distressed and asked why Devan had been allowed to leave the hospital. The call ended soon after and the PLN started notifying relevant people at the hospital.[115]

102. Devan was admitted to the ICU for full active management. He was kept sedated while neuroprotective measures were put in place. Over the following days, his heart was able to beat unsupported, but he could not breathe spontaneously and showed no neurological activity. On 16 January 2022, following a full neurological assessment,

[111] Exhibit 1, Tab 16.1 and Tab 16.2.
[112] Exhibit 1, Tab 16.1 and Tab 16.2.
[113] Exhibit 1, Tab 2.
[114] Exhibit 1, Tab 5.
[115] Exhibit 1, Tab 7.

doctors met with Devan's mother and father separately and explained to them both that Devan had lost all brain function that morning. The doctors performed secondary brain death testing that afternoon that confirmed brain death. Devan's death was confirmed by a doctor at Fiona Stanley Hospital at 6.24 pm on 16 January 2022. His death was reported to the coroner and a coronial investigation commenced.[116]

CAUSE AND MANNER OF DEATH

103. A Forensic Pathologist and a Forensic Pathology Registrar, Dr Cooke and Dr Patton, performed an external post mortem examination and CT scan. The external examination showed changes of recent medical are, healing superficial cuts to the left forearm and a healing ligature-type mark to the neck. The CT scan showed no internal neck injury and possible swelling of the brain.[117]

104. Toxicology analysis showed the presence of a small amount of cannabis and a number of medications consistent with Devan's recent medical care.[118]

105. At the conclusion of the limited investigations performed, Dr Cooke and Dr Patton formed the opinion the cause of death was hypoxic brain injury following ligature compression of the neck (hanging). I accept and adopt this cause of death.

CLINICAL INCIDENT INVESTIGATION

106. Immediately after Devan's death, on 16 March 2022, Dr Simon Smith, Medical Practitioner, did a quick review of Devan's medical notes and then spoke to Devan's mother, Erin. Dr Smith formed the impression form the notes that Devan was a "very high risk individual"[119] who presented seeking help for substance abuse. Dr Smith spoke to Erin, who expressed the opinion that if Devan had been watched, he would not be dead. Dr Smith explained that as Devan was a voluntary patient, he was free to leave the ED, and although a 1:1 nursing special was possible, it did not always occur, especially if the patient was compliant like Devan. Erin queried why no one had noticed until 7.00 am, and Dr Smith explained that if a patient has been in and out regularly, they are usually trusted to return. Also, at that around 6.00 am, staff are fatigued, especially if the night has been busy, and it is approaching handover, so there are a lot of nursing chores to be done at that time. They discussed why police were not called, as would usually occur, and Dr Smith recorded that Erin felt guilty as she had asked for police not to be called. Dr Smith reassured her that it is a common request as sometimes it will make the situation worse, and he assured Erin that she was not to blame herself.[120]

107. Dr Smith also noted that he explained to Erin that the mental health system in ED's on a national level is experiencing a lack of access and the system must carry the burden of poor outcomes. Dr Smith acknowledged that Devan was in a high-risk

[116] Exhibit 1, Tab 10.
[117] Exhibit 1, Tab 3.1.
[118] Exhibit 1, Tab 3.1 and Tab 4.
[119] Exhibit 1, Tab 12, IPN 16.3.22.
[120] Exhibit 1, Tab 12, IPN 16.3.22.

category as a male with substance abuse issues and as a department (rather than any individual) they should have, or at least could have, kept a closer watch on Devan. However, he noted that this category of mental health patient is often difficult to stop once they make a plan.

108. Also, following Devan's death, the South Metropolitan Health Service initiated its own Clinical Incident Investigation as it fell into the category of a sentinel event or Severity Assessment Code 1 (SAC1) clinical incident, noting it involved a patient missing or absent without leave with an adverse outcome. The investigation was completed on 1 March 2022 and a copy of the Final report was voluntarily provided to the Coroners Court.[121]

109. The panel, which included the Nursing Director of Clinical Services, Emergency Head of Department, and Emergency Consultant and a Psychiatric Liaison Nurse amongst others, reviewed Devan's mental health history and the history of his presentation at Peel Health Campus on the relevant day. The panel agreed with the assessment at the time that Devan did not require re-prioritisation for a more urgent bed request. It was acknowledged that it had been a noisy night in the ED, with an elderly dementia patient shouting for most of the night and at the time Devan had left the hospital at around 6.30 am, another mental health patient and her children had arrived at the ED, which had been a distraction. Therefore, Devan was not seen leaving the department. It was discussed that there were issues with bed placement for mental health patients in the ED, as some beds were too close to the ambulance access door and others were in noisy positions. The design of the Flight Deck at that time did not have an ideal location for mental health patients, although that was the best location for allowing constant visual observations of mental health patients.[122]

110. The panel noted that there had been no delay in escalation to the psychiatric team and Devan's mother had been insistent that the police should not be contacted when it had been discussed. As a voluntary patient, Devan had been encouraged to communicate with staff when they left the department, but he was not required to do so and was allowed to go outside unsupervised. The panel agreed a process needed to be introduced for management of voluntary patients in the ED while waiting for a bed, with a documented management plan covering whether supervision was required and who must be detained if they tried to leave.[123]

111. The panel also discussed the increased demand for mental health beds and the continued challenges of managing mental health patients within a busy ED. Devan had been waiting for a bed for more than 12 hours post assessment due to state-wide bed access difficulties. It was also noted that there was no psychiatric cover in the ED between 10.00 pm and 8.00 am so identification of mental health deterioration was expected to be recognised by non-mental health staff. It was suggested a 24/7 PLN was required.[124]

[121] Exhibit 1, Tab 7.
[122] Exhibit 1, Tab 7.
[123] Exhibit 1, Tab 7.
[124] Exhibit 1, Tab 7.

112. Two recommendations were made by the panel. The first was for the PLN or a medical officer to establish a management plan for voluntary patients in order to identify those voluntary patients who should be supervised and restrained if they attempt to leave. The second was in relation to reporting of delayed transfers of a mental health patient to a bed.

113. In conclusion, the panel noted that:[125]

> *The increase and demand on mental health beds is having a direct impact on patient's length of stay in the emergency department. The constant demand for mental health beds is increasing. The investigation noted that the patient was awaiting a bed for more than 12 hours post assessment due to state-wide bed access difficulties. It is acknowledged that state-wide bed access issues is not within the control of the site but this remains a systemic risk of relevance to WA Health.*

EXPERT REVIEW BY DR BRETT

114. Dr Adam Brett is a very experienced Forensic Consultant Psychiatrist who has provided expert opinion in many coronial cases, as well as working in the Magistrates' Mental Health Court and providing expert reports for other courts in Western Australia. Dr Brett was asked by this Court to review Devan's case and provide an opinion on Devan's mental health management leading up to his death. Dr Brett provided a report and also gave evidence at the inquest.[126]

115. Dr Brett gave close consideration to Devan's history, as well as the documented events on 12 to 13 January 2022. Dr Brett commented that it appeared that Devan had mental health issues since his adolescence. He had experienced significant trauma, including the death by suicide of two friends, and had a history of suicidal ideation. He also had a history of substance abuse from the age of 13 years. Devan had been diagnosed with ADHD and commenced on stimulant medication. He later developed psychosis and depression.[127]

116. At the inquest, Dr Brett observed that the death of Devan's close friend when he was so young was significant as was "an extremely traumatic event and trauma can impact on young people's mental health severely."[128] It was apparent Devan suffered some feelings of guilt about the friend's death, which would have continued to have a significant impact on all aspects of his mental health.[129]

117. Dr Brett observed that Devan had been offered follow up by mental health services in April 2016, some six years before his death. He commented that it is important to review Devan's care during this time, as prevention of mental disorders and morbidity should occur early. Dr Brett noted that Devan did not engage in services at

[125] Exhibit 1, Tab 7, p. 8.
[126] Exhibit 1, Tab 11.
[127] Exhibit 1, Tab 11, p. 9.
[128] T 78.
[129] T 78.

that time, when he was 16 years old, which was unfortunate. However, Dr Brett indicated that he was aware from personal experience that this does not just reflect on Devan, but also possibly on the services offered as it is difficult to access appropriate mental health services for young people and usually the help that is needed is from more than one service. Ideally, in Devan's case he should have been offered conventional services such as a psychiatrist and case manager, but also a peer support worker and carer support worker for his mother, which might have helped engage him and would have assisted his mother on how and when to access services. Substance abuse services should also have been part of this team. This kind of holistic approach to recovery, which would include medications where appropriate but also psychosocial assistance such as therapy, counselling, vocational and recreational assistance, would have been Devan's best chance for recovery.[130] As it is, there is limited information about what Devan was offered and the reasons why he chose not to engage.

118. Dr Brett had been provided with Dr Williams' summary of his dealing with Devan in 2020 to 2021 and noted that this diagnosis of ADHD provided some context to the struggles that Devan had experienced previously at school. Dr Brett observed that it has been shown that people with undiagnosed and unmanaged ADHD have a higher rate of substance use, as well as general issues of impulsivity and acting out, which may have been one reason for Devan's early drug and alcohol use.[131]

119. Noting Devan's history of trauma as a young man with a suicide attempt, the suicide of his friend, his history of substance use and his ADHD and central auditory processing disorder, it was clear he required holistic care to try to manage these problems together. Dr Brett observed that ADHD is, for some reason, generally only diagnosed and treated in the private health system in WA rather than the public system, which meant Devan was forced to go to see a private psychiatrist rather than being able to engage in wrap around mental health services in the public system.[132]

120. It seemed that Devan experienced psychosis while being prescribed dexamphetamine by Dr Williams, and Dr Brett commented that it was appropriate that Dr Williams then stopped Devan's dexamphetamine prescription. It was, however, possible that when Devan then used methylamphetamine (which is much stronger than dexamphetamine), he would have been susceptible to psychosis again.[133]

121. Dr Brett noted that at the time of his death, Devan was not still engaged in mental health care. He believes this was a "significant omission."[134] It is clear that in the weeks leading up to his death, Devan was experiencing a number of situational crises that were exacerbating his already fragile mental health. He had lost his job and was worried about becoming homeless. This resulted in Devan experiencing suicidal thoughts and seeking help at Peel ED as he had no regular community mental health service where he could seek help. Dr Brett commented in his evidence that in his

[130] T 78 – 79; Exhibit 1, Tab 11, pp. 9 - 10.
[131] T 80 – 81.
[132] T 81 – 82.
[133] T 82 – 83.
[134] Exhibit 1, Tab 11, p. 10.

view, it is always preferable to try and do the work in the community outside of the emergency department, but in Devan's case, this unfortunately didn't occur.[135]

122. As to the quality of Devan's mental health care when he presented to Peel ED on 12 January 2022, Dr Brett noted Devan's physical health issues were appropriately managed. Dr Brett agreed with Dr Burbidge-King's decision not to prescribe any psychiatric-type medications for Devan at that time. The diazepam was a sedative medication that would have helped with any agitation and no other medication was indicated at that time. Dr Brett also expressed the opinion Devan had an appropriate mental health assessment performed by PLN Dinsdale, noting that it was apparent PLN Dinsdale had seen Devan previously and had some background knowledge of him. The recommendations and risk assessment made were appropriate and there was a good treatment plan developed.[136]

123. Devan was not made an involuntary patient as he agreed to the plan to be admitted voluntarily to a mental health unit. Dr Brett expressed the opinion that on the evidence available, this decision was appropriate. Dr Brett noted that the ethos of the *Mental Health Act* is to impose the least restrictive method wherever possible, and in Devan's place there was nothing to suggest a more restrictive step was required. Dr Brett also commented that even if Devan had been made an involuntary patient, it would not have been likely to result in him getting a bed any quicker or changed his management at that time.[137]

124. The problem arose after PLN Dinsdale had completed his assessment and the plan was formulated. Dr Brett commented that this problem that arose was "a system issue and not an individual clinician problem."[138] The problem was that there was no mental health bed available. Therefore, the only option was for Devan to wait in the noisy ED. In his report, Dr Brett observed that an emergency department is not an appropriate venue to manage people like Devan for any length of time, given the noise, bright lights and number of people. This opinion appeared to be shared by the health practitioners who dealt with Devan at the Peel ED, but they had no alternative place for Devan to wait in the Peel ED.[139]

125. Dr Brett was shown an image of the particular location where Devan's bed had been placed, next to the central Flight Deck where the nurses' station was situated. Dr Brett's impression was that the beds are small and uncomfortable, the location of the bed was not private and in an area that would have been particularly busy and noisy and, in his view, it "would have been very unpleasant to be there."[140] In Dr Brett's expert opinion, it is "inappropriate for people who are in mental health crisis to be housed in areas like that"[141] as it would be likely to exacerbate their mental health issues. In particular, it would be very difficult for someone to sleep in an area like that, and sleep is extremely important for the brain.

[135] T 100.
[136] T 83; Exhibit 1, Tab 11.
[137] T 83, 88; Exhibit 1, Tab 11.
[138] Exhibit 1, Tab 11, p. 10.
[139] T 83; Exhibit 1, Tab 11.
[140] T 84.
[141] T 84.

126. Dr Brett noted that Mental Health Observation Areas (MHOAs) have been developed in the major metropolitan hospitals to manage people with these problems. He is personally familiar with the one at Sir Charles Gairdner Hospital. Dr Brett described a MHOA as a safe place, staffed with trained mental health staff as part of a full multi-disciplinary team. It does not have the noise of an ED and the patients can be assessed and observed in a safe space. Dr Brett suggested that, given Peel ED does not have a MHOA, it would have been useful if Devan could have been transferred to a hospital that did have a MHOA whilst he was waiting for a mental health bed to become available. However, Dr Brett acknowledged in his evidence that it does not appear this is generally possible. Therefore, for the future, Dr Brett suggested the proper solution would be to build a MHOA at Peel Health Campus.[142]

127. Dr Brett observed that an advantage of caring for ED mental health patients in a MHOA is that many of those patients ultimately do not require a bed and are able to be discharged back into the community. After being assessed by a psychiatrist and given some time in a safe, therapeutic environment where they are cared for by specialist mental health staff, the patients are often sufficiently rested and recovered from their crisis to be able to be discharged back into the community with a plan in place for follow up. In fact, Dr Brett gave evidence his understanding is that the vast majority of people who are held in a MHOA are sufficiently recovered after a period of time in that space to not require admission to a mental health unit. In Dr Brett's opinion, it is very likely Devan would have received a similar benefit.[143]

128. Given there was no MHOA to place Devan while he was waiting for a bed, Dr Brett expressed the opinion Devan should have been kept under more intense supervision and his whereabouts should have been known at all times. Dr Brett noted that Devan had presented with suicidal ideas and it is good practice to then monitor such patients as their state of mind can change rapidly. Dr Brett acknowledged that this would probably still mean that Devan might leave the ED and go outside to smoke a cigarette or for other reasons, but he believes it was incumbent on staff to talk to him regularly and check on how he was managing in the difficult environment to ensure his level of risk hadn't changed.[144]

129. Dr Brett also suggested an alternative would have been to allocate an enrolled nurse or even an assistant in nursing to sit with Devan and monitor him. Although such a person would not have the skills to make risk assessments like a PLN, Dr Brett noted that PLN's are busy and are limited in how long they can spend with a patient like Devan, but if someone was given the task to monitor Devan closely, they could have raised any concerns. However, Dr Brett noted there is a cost issue involved in allocating a staff member as a companion for that purpose and given Devan was compliant and not causing any security concerns, he thought it unlikely Devan would have qualified for one-to-one nursing based on ordinary practices. I note that Dr Burbidge-King gave evidence in his experience such a practice would be rare in any ED when the patient was voluntary, which also supported that conclusion.[145]

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[142][142] T 83; Exhibit 1, Tab 11.
[143] T 85.
[144] T 87 – 88, 90; Exhibit 1, Tab 11.
[145] T 87.

130. In one sense then, the difference for Devan of being made an involuntary patient might have been more close supervision with a one-to-one nursing special allocated. However, Dr Brett agreed with the assessments by Dr Burbidge-King and PLN Dinsdale that Devan did not fit the criteria for an involuntary patient during the time he was at the Peel ED. Dr Brett noted that this position might have altered if someone had spoken to Devan prior to him leaving the ED that final time, as his mental state may have altered and he may have fulfilled the criteria of the *Mental Health Act* to be made an involuntary patient. However, as no one spoke to him before he left, it is unknown whether it would have been identified that his level of risk had changed.[146]

131. In terms of the actions taken when it became apparent Devan was missing, Dr Brett expressed the opinion it was appropriate for the staff to take his mother's advice and not immediately call the police. Devan was a voluntary patient, his risk was not assessed as being high and he had agreed to the plan of being admitted into a mental health unit for treatment, so his death could not have been easily predicted at that time.[147] If someone had noticed Devan trying to leave and spoken to him before he left, more might have been known about Devan's mental state, which could have better informed the risk assessment, but there was no such information available at that time.

132. Dr Brett also commented that the current risk assessment process in mental health is poor and not contemporary, with staff required to use a form that is unvalidated and poorly designed. Therefore, if a more formal risk assessment had been completed before Devan left, it still may not have identified his elevated risk.[148] Dr Brett noted that risk assessment is very difficult, even in the best circumstances, and it is very difficult to predict who is going to suicide, so risk management is also important.[149] Dr Brett made reference to a text written by Tony Maden, who comments that "risk assessment will never be an alternative to looking after the patient properly,"[150] which appears apt in Devan's case.[151]

133. Dr Brett concluded his report with an observation that,[152]

> *[m]ental health professionals working in emergency departments have extremely difficult jobs and risk assessment and management of acutely distressed people is very difficult. This is harder when they do not have access to resources that they need, including safe mental health beds. It is analogous to surgeons being asked to operate without scalpels or operating theatres. Mental health presentations to the emergency department are common. The clinicians and consumers deserve to be able to access appropriate resources.*

[146] T 88 – 89.
[147] T 85 – 86; Exhibit 1, Tab 11.
[148] T 94.
[149] T 100.
[150] T 90.
[151] Exhibit 1, Tab 11.
[152] Exhibit 1, Tab 11, p. 12.

134. In evidence, Dr Brett observed that when he first finished his training as a psychiatrist, generally a patient who required a bed in a mental health unit would go there directly after being assessed. That is very different to what happens now, where they generally wait for days in an emergency department pending a hospital bed becoming available. There is a clear need for more thought to be given for ways to improve the access to mental health beds, but in the meantime, it seems that alternatives such as MHOA, are at least an improvement for patients like Devan.[153]

FAMILY COMMENTS

135. Devan's mother, Erin Stanley, provided a letter to the Court, describing her memories of Devan on those last days and her grief and anger surrounding his death. Erin noted that when she brought Devan to hospital, he was transparent about his poor mental health and disclosed he was suicidal and had a plan in place and had deliberately self-harmed. He also asked for help. Erin sat with him all day in the ED to keep him calm and when she left him that night, she believed that she had left him in "the best place for him to be safe from harming himself further"[154] until a bed could be found for him. Devan wanted to go and wait at what he considered to be his 'safe place', with his grandparents, but in Erin's own words,[155]

> *I convinced my son that he was safer at the hospital and they would take care of him. Oh, how wrong I was.*

136. Erin described Devan as a quiet and shy person and recognised it must have taken great courage for him to open up to staff who were strangers on how fragile he was feeling, and she feels distressed now to think about how frightened and scared he must have been to overcome his shyness and seek help and try to save himself. Erin and her parents were genuinely hopeful that his presentation to hospital was a positive step towards Devan getting better and making a new life for himself.[156] However, in hindsight, Erin will now forever regret leaving her son at the emergency department as he did not get the help he needed.[157]

137. Erin expressed her anger that Devan may be the person that has to be bring about necessary change, but also her hope that his death does lead to positive change for other people like Devan who are suffering mentally and seek help and save their families from losing their loved one like she has lost Devan. Erin has identified a number of changes she would like to see at Peel Health Campus, including more comprehensive mental health nurse training for all staff in the ED setting, companions for patients who need supervision, early notification of security staff and police when a patient goes missing, greater consideration of making a patient involuntary when they present in a similar way to Devan and the introduction of some kind of MHOA, where mental health patients can be cared for in a quieter, calm environment while they are waiting for admission to a psychiatric facility.[158]

[153] T 97.
[154] T 203.
[155] T 203.
[156] Exhibit 1, Tab 14.1 and Tab 15.
[157] T 203.
[158] T 205 – 206.

138. Just briefly, in relation to some of these concerns, I note that the Peel Health Campus Nurse Special/Companions Policy allows for any staff and family or carers to identify an at-risk patient requiring such a measure, although it will only be considered if there is a clinical need, and there was evidence it will be rare in the case of a voluntary patient. However, Dr Smith gave evidence that it is his understanding since Devan's death more consideration is given to one to one supervision of voluntary patients, when required, and doctors will support those requests, although ultimately it is a decision for nursing staff and management.[159]

139. Other changes, such as introducing a 24/7 PLN presence will hopefully go some way to providing more training for ED staff, as there was evidence that the PLN's provide a consultation and liaison service to assist the ED staff to manage the patients, rather than taking all responsibility for the care and management of these patients.[160]

140. Dr Smith also gave evidence that it is his understanding that security staff and police would ordinarily be notified at an early stage when a patient cannot be found, although as a voluntary patient there are limits to what the police can do if they find the patient and they do not appear to be at risk.[161] In addition, in this case the wishes of the family were consulted as part of the decision making process, which is appropriate under the *Mental Health Act*, and there were valid reasons given for not involving the police immediately.

COMMENTS ON CARE AT PEEL HEALTH CAMPUS

141. The ED Consultant who first assessed Devan, Dr Burbidge-King, gave evidence that in his experience, due to the limited availability of mental health beds in Western Australia, mental health patients are sometimes required to remain admitted to an ED for long periods of time while they are awaiting a bed. He acknowledged that lengthy periods of time spent awaiting a bed can be very challenging for mental patients and staff alike. Dr Burbidge-King noted that the beds used for mental health patients like Devan in the Peel ED are generally located near the 'Flight Deck', where the ED doctors and nurses have their work stations. This ensures the mental health patients are within a highly visible area of the ED and within the sight of the ED staff working on the Flight Deck. However, while it means they can be seen by staff, the level of activity, noise, foot traffic and lighting in that area is not conducive to mental health patient care. The same can really be said of the whole of the Peel ED, as "the intensity of the activity in an ED can exacerbate a mental health patient's feelings of anxiety, or disturb their ability to rest."[162]

142. Dr Burbidge-King described in further detail at the inquest the busy nature of the Emergency Department. He explained it is noisy with alarms going off a lot of the time, and there can be children screaming as well as people shouting and a lot of people moving quickly back and forth. The lights are on 24 hours a day and it can be

[159] Exhibit 9.
[160] T 192 – 194.
[161] T 192 – 194; Exhibit 4.
[162] Exhibit 2 [75].

quite disorientating remaining in that environment for a long period. Dr Burbidge-King gave evidence that in his experience a lot of mental health patients in emergency departments across the State are progressively spending longer times waiting for a bed, often for periods of two or three days, and many of them will eventually say that they do not want to remain in that hectic environment anymore.[163]

143. Dr Burbidge-King noted that unfortunately Peel ED does not have a specialised mental health observation area (MHOA) where these patients can wait. He agreed with Dr Brett that a MHOA is a more appropriate setting for mental health patients because it provides a quieter environment, with specialised mental health staff, separate from the main ED and its hectic activity. In Dr Burbidge-King's experience, it is not possible to transfer a patient from Peel ED to another hospital that has a MHOA in its ED. Therefore, the only solution is to keep the patient in the main Peel ED until a mental health bed becomes available.[164] Dr Burbidge-King commented that it is "very sad for our care of our patients,"[165] but there is usually no other option available.

144. Dr Burbidge-King noted that some involuntary patients will actually be seen in the emergency department by a consultant psychiatrist, have treatment initiated and be discharged with a community plan without ever actually getting a mental health bed as the wait is so long. He agreed that this was not great for the patients and meant that in the meantime, they are sitting in an uncomfortable environment feeling more and more disturbed. Dr Burbidge-King noted that there is usually no medical reason for them to be held in the ED, but there is nowhere else for them to go, so it is the best, safe option available, but certainly not the best option.[166]

145. In Devan's case, for example, Dr Burbidge-King indicated that there was no real reason for Devan to have physical observations as he had no acute medical issues. However, he agreed in questioning that as a person who had been expressing suicidal ideation and who was likely to be feeling more anxious in such an environment, it might have been appropriate for the ED staff to make observations of his mental state more regularly. He noted that the fact that a patient like Devan is being held in an environment that is not really the right place to treat him, and he was supportive of introducing a MHOA at Peel ED for that purpose. However, Dr Burbidge-King agreed that in the interim, without a more appropriate place for someone like Devan to wait, it might be a good idea to monitor his mental health systems in the way that physical observations are regularly monitored while a patient is waiting for a bed.[167]

146. Nurse Gordon, who would have been caring for Devan that morning if he had remained in the ED, acknowledged that at the relevant time, the mental health patients in the Flight Deck beds were often forgotten as they were supposed to get their own nurse but the position was often not staffed and they didn't require any particular tasks to be done for them. Accordingly, "patients on the Flight Deck

[163] T 40 - 41.
[164] T 40.
[165] T 41.
[166] T 41 – 42.
[167] T 43 - 48.

typically would go shifts were nobody interacted with them."[168] Nurse Gordon gave evidence that the patients on the Flight Deck are now officially allocated, which stops them being forgotten, "but because they don't have medical needs as such, they still don't get comprehensive nursing care."[169] Nurse Gordon explained that the nurses in the ED are often very busy and they tended to be "very medically focussed."[170] She explained that this makes it harder for the nurses to have the time to create a relationship with the patients in the Flight Deck beds, who are often "extremely vulnerable, and …complex patients."[171]

147. Dr Brett discussed the practice of conducting a mental state examination with a patient, having a chat with them and asking how they are going and how they are coping, which can then be documented on the file and any concerns can be escalated.[172] This is not so much a form, as a process that can be documented in the integrated progress notes, but it is an example of what is required for a patient like Devan, who is waiting for a long period for a mental health bed to become available. However, noting the evidence of Nurse Gordon, it is clear that there would need to be time to do so.

148. It was generally agreed that there are "definitely better places"[173] for a patient like Devan to be kept while waiting, given how chaotic and stressful the ED can be at times.[174] Nurse Gordon described the ED as being "the best and the worst place"[175] for patients like Devan, as it is the best place to keep them physically safe but the worst place because the Flight Deck beds are "not conducive to healing."[176] Nurse Gordon candidly expressed her feeling that "we really let Devan down"[177] and it is clear that even though she never got the chance to meet Devan, his death had had an impact upon her.

149. Nurse Crilly was working in the shift coordinator role at the time Devan left the ED, although she did not see him go. She was frank in her evidence about the pressures she was facing in managing the busy ED with limited nursing staff and patient beds, as well as complex patients, many of whom were critically unwell physically. Nurse Crilly expressed her view that there were not enough staff to look after the patients and she felt they should not be using the flight deck beds at all. Nurse Crilly said that she felt terrible about what happened to Devan and acknowledged that "things like this shouldn't happen to anybody,"[178] but they simply don't have the resources in the ED for nurses to be able to sit down and spend time with a patient like Devan while they are dealing with acute medical emergencies. Nurse Crilly expressed her view that "we fail as primary nurses because we just don't have the time."[179]

[168] T 125.
[169] T 126.
[170] T 126.
[171] T 129.
[172] T 99.
[173] T 75.
[174] T 63 -64, 75 - 76.
[175] T 127.
[176] T 127.
[177] T 127.
[178] T 141.
[179] T 142.

150. The nurses and doctors who work in the Peel ED all gave supportive evidence that they believe a MHOA would be a significant improvement for mental health patients waiting for a bed, given they are often waiting days for a bed to become available. In such an environment, there would be a greater chance they could be kept calm and designated staff with appropriate mental health training would be able to focus on these patients and conduct ongoing risk assessments. I will address this further under the topic of Future Planning below.[180]

151. As to the care provided to Devan prior to his death, I accept the expert evidence that Devan did not meet the criteria to be 'placed on forms' under the *Mental Health Act* and referred for assessment as an involuntary patient, which would likely have triggered a one-to-one nursing special being allocated until a bed was found for him in Mental Health Unit. He showed insight and was willing to seek help voluntarily and wait in the ED, so under the Act, which requires the least restrictive option to be selected, there was no basis for considering referring Devan for assessment under s 25(1) of the Act. His mental health risk assessment was appropriate at the time and the plan to try and find him a bed for admission as a voluntary mental health patient was appropriate. There was no MHOA at Peel ED, and also no option to transfer Devan to another hospital with a MHOA to wait, so the only option was to keep him in the Peel ED until a bed was found.[181]

152. The problem was that the longer that Devan was left to wait in the ED, generally agreed to be a noisy and non-therapeutic environment, the greater the risk that he would change his mind about voluntarily waiting for a bed to become available.

153. I accept from the evidence of the witnesses, and based upon the expert evidence of Dr Brett, that the staff working in Peel ED at the relevant time were doing their best to care for Devan. They all appeared to be caring and appropriately trained staff who wanted only the best for their patients. However, the staff who worked in the ED all seemed to accept that the design of the Peel ED was not conducive to caring safely for mental health patients like Devan. The nursing staff were also generally too busy to be able to spend much time with Devan checking how he was coping in that environment as they were dealing with clinically acute patients and there was no formal requirement for them to note his mental state, other than what was on the alcohol withdrawal chart.

154. Despite the noisy environment, Devan does appear to have managed to sleep overnight and he was generally left alone when sleeping, which was appropriate. Devan was last seen by a nurse at 6.04 am for assessment on the alcohol withdrawal scale, but there was no evidence from the nurse who did that assessment as that nurse could not be identified. While I accept the nurse recorded Devan was not demonstrating any anxiety, agitation or hallucinations at that time, the assessment was made in the context of alcohol withdrawal and not a psychiatric assessment, which Dr Brett and Dr Smith agreed was a different assessment.[182] I accept Devan must not have been obviously agitated or anxious at that time, as I am sure any

[180] T 71.
[181] Submissions filed on behalf of Ramsay Health Care Australia Pty Ltd, dated 1 December 2023.
[182] T 92, 188.

trained nurse would have been able to recognise those signs. There is no evidence either way as to whether the nurse discussed his mental state further, but I note the area where Devan was placed and would have been speaking to the nurse was quite public and not conducive to encouraging an exchange of personal information in any event.

155. I do have the evidence of Nurse Crilly, the shift coordinator, who recalled Devan seemed calm when she sent a follow up email escalating his bed allocation request at 6.21 am.[183] I accept that the evidence supports the conclusion the significant change in Devan's mindset most likely occurred after this time, when the agitated patient near him began to cause a disruption. We know Devan left the ED about 10 minutes later. He left without speaking to any of the staff, although I note most of them seem to have been preoccupied with the agitated patient at that stage, who required sedation. It is unclear whether Devan initially intended to return, given he left his belongings there and appeared calm immediately before, or if he had already formed the intention that he was going to go and harm himself. All I can be certain of is that he did form that intention at some stage.

156. From the nursing staff's perspective, Devan's absence wasn't noted until around 7.00 am, when things had calmed down in the ED and handover was occurring. It wasn't immediately apparent that he had left without intending to return, given he had been in and out a number of times and voluntarily returned and the presence of his possessions reassured them he intended to return again. Devan's mother, who knew him very well, also formed this impression when she arrived. By that time, security staff had been notified, and Nurse Gordon began to search for Devan with his mother's assistance. Given Devan didn't have a working phone, they couldn't call him. Over the next hour or so, it became clear Devan had left the hospital on foot at 6.30 am, but no one knew where he had gone.[184]

157. I accept that the police were not notified at that stage with the agreement of Devan's mother as she understood that police involvement could make Devan more reluctant to accept treatment. In any event, in my experience from other coronial matters, even if the police had been notified, given Devan was a voluntary patient and there was no acute risk identified, it would not have been given a high priority by police at that stage. Therefore, given the timing of events, I accept it is very unlikely that earlier notification to police would have altered the sad outcome in this case.

158. The key opportunity to intervene and potentially prevent Devan's death was while he was still in the ED and willing to wait. Unfortunately, due to the length of time he was there and the different demands upon the nursing staff's time over that period, there was little opportunity for anyone to speak to Devan and ascertain that his risk has changed. Whilst I accept the expert evidence to the effect that risk is dynamic and it is notoriously difficult to predict which suicidal patients will actually follow through with their intent, the fact that no one noticed Devan leaving was a missed opportunity to speak to him and conduct some kind of risk assessment. He may or may not have disclosed what he was intending to do, but we will never know now.

[183] Exhibit 11.
[184] Exhibit 6.2.

FUTURE PLANNING

159. The evidence before me, particularly from Dr Brett, was clear that larger hospitals based in the Perth metropolitan area have moved towards implementing mental health observation areas due to the increasing number of mental health presentations to hospital emergency departments and the ongoing problems with access to mental health beds resulting in these patients spending longer periods waiting in the ED's. It seems very obvious that moving these patients to a designated observations area, designed to be a calming space with appropriately trained staff, is of benefit not only to the mental health patients, but also to other patients presenting to an ED who can access the beds that become free and to the staff in the ED who have less experience managing patients with mental health issues and who are also working in a pressured environment dealing with life threatening medical emergencies that makes proper supervision of mental health patients effectively impossible.[185]

160. The additional benefit of moving mental health presentations to a MHOA is that the patient's crisis will sometimes resolve after a relatively short period of time in this more therapeutic environment, meaning they can be discharged on a robust mental health plan without the need for admission to a mental health unit. This then reduces some of the pressure on the few mental health beds, leaving them available for more acutely unwell patients.[186]

161. Nurse Gordon suggested that more nursing staff in the Peel ED would help them have time to do risk assessments with mental health patients and create a therapeutic relationship with them so that they can feel comfortable telling nursing staff when they are not feeling well and need someone to talk to or medication to help keep them calm.[187]

162. Nurse Crilly, as an experienced shift coordinator, expressed a similar view, noting that if a MHOA was created for mental health patients, but not properly staffed, then the ED nurses "would have to absorb them into an already impossible workload."[188] Nurse Crilly gave the example of the plan to employ 24/7 PLN's in the ED, which had resulted in a room being cleared for their use as an office, but these roles had not yet been filled.[189]

163. Nurse Crilly suggested that actually employing more nurses to fill the 24/7 PLN role would have a beneficial effect for patients like Devan, as they would be available in the ED to check on mental health patients waiting for a bed when they were not performing assessments and hopefully speak to them in the private office, rather than in the very public flight deck bed area.[190]

164. Dr Smith, who was involved in the initial internal hospital review and works in the Peel ED, gave evidence that in an ideal world he would like to see more mental

[185] T 97.
[186] T 97.
[187] T 128.
[188] T 143.
[189] T 145.
[190] T 145 – 146.

health beds statewide so that all mental health patients can go straight to a bed in an appropriate mental health facility when required. However, he was realistic that mental health beds, and mental health staff, are a limited resource, so the ED is often the only available place for them while they wait for a bed to become available and, in particular, the flight deck beds are all they have left. Dr Smith conceded that these beds are "definitely not ideal for anybody, the caring clinicians, nor the patients, not their families, nor the community,"[191] but there is no other practical alternative available.

165. Dr Smith has no personal experience of working with a MHOA, but agreed that "having a dedicated area that's off the main floor of a chaotic emergency department for people having quite possibly … the worst day of their lives"[192] would be an improvement on the sleep deprivation and constant observation by everyone walking past that is the current situation in the Peel ED for mental health patients, which Dr Smith described as a "difficult place for mental health patients to be, especially once they're clinically stable.[193] and certainly not an environment designed to help them get better.[194]

166. PLN Matthew Dinsdale, who has worked as an authorised mental health practitioner since 2010, working regularly in ED departments, expressed his opinion that "ED Departments are not for mental health. The reality is … in an ideal world mental health clients would not get anywhere near an ED."[195] PLN Dinsdale commented that if there were beds available, it would be ideal to send a patient straight to a bed in a "therapeutic, treatment-orientated environment,"[196] but unfortunately that is not the current reality in Western Australia, so the "unfortunate thing is that at this stage ED is the best we've got to keep somebody safe."[197]

167. PLN Dinsdale acknowledged that the ED is full of things that people can hurt themselves, or other people, with, and it is glaringly in the public eye. The environment makes private conversations with patients difficult and that is particularly so in the flight deck beds, where there is not even a curtain. He indicated that at the time of the inquest hearing in November 2023, the average wait time for a mental health bed was around three days.[198]

168. At the time of the inquest, he still worked in the Peel ED and indicated the recruitment more psychiatric liaison nurses to provide the 24/7 cover was progressing. PLN Dinsdale commented that one benefit of the additional shift cover would be to hopefully allow the PLN's to "go back periodically to see if anything has changed"[199] while the patient is waiting, which could mean that the patient is feeling better and no longer requiring a bed, as well as the reverse. It would also mean that

[191] T 201.
[192] T 191.
[193] T 200.
[194] T 200 - 201.
[195] T 154.
[196] T 154.
[197] T 154.
[198] T 154 – 155.
[199] T 173.

the PLN returning for the morning shift faces less chaos, as someone has been managing the workload overnight, rather than assessments simply piling up.[200]

169. In terms of the creation of an office for the PLN's within the ED, PLN Dinsdale indicated that in the past the office had existed in the ED, and then they had later moved to an office in the community clinic. For safety reasons when moving to the 24-hour roster, it was planned to bring the nightshift PLN's back into the ED. PLN Dinsdale gave evidence he hoped this would mean the dayshift would also work from that office.[201]

170. In terms of a MHOA, PLN Dinsdale agreed with the other witnesses that such a unit would be beneficial as it would provide a therapeutic environment for assessments as well as for the period that patients are waiting. PLN Dinsdale also agreed with the evidence of Dr Brett that a MHOA might mean that some patients no longer require an admission as their level of distress might sufficiently reduce after a period in that environment, with appropriate support. PLN Dinsdale gave evidence he understood that the building of MHOA and a 10 bed unit has been mentioned as part of plans for a redevelopment of the Peel Health Campus by the South Metropolitan Health Service (SMHS).[202]

171. I am informed that Peel Health Campus (PHC) will soon come under the operation of the SMHS and Ramsay Health will no longer be involved in operating the campus. This transition is currently planned to occur in August 2024. That is why any plans to implement a MHOA at PHC are being considered by the SMHS and not Ramsay Health.

172. Counsel for the SMHS very helpfully provided comprehensive submissions following the inquest provided information in relation to:[203]

- the possibility of installing a MHOA at PHC after the operation of the campus is taken over at the end of the year, given I had foreshadowed making a recommendation in those terms;
- what interim measures could be taken before the development of a MHOA; and
- some additional relevant information.

I address those matters below.

MHOA

173. I am advised that SMHS will present a business case to Government this year as to the redevelopment of PHC. Consistent with PLN Dinsdale's understanding, I am informed the business case includes a proposal to establish a 10 bed MHOA and 20 bed inpatient mental health unit. It is ultimately a decision that rests with government

[200] T 174.
[201] T 180.
[202] T 174 – 175.
[203] Submissions filed on behalf of SMHS dated 30 November 2023.

as to whether the plans will be approved and funded, but it is a very positive step that the proposal is intended to be put forward. I am informed the model of care being proposed is likely to be similar to that which is currently being proposed at the Rockingham General Hospital in the form of the Mental Health Emergency Care Centre (MHECC), so there is a good understanding of what is required.[204]

174. I am very pleased to hear of the proactive steps being taken by SMHS to create this necessary low stimulus environment to provide timely care and treatment timely for mental health patients at PHC, noting the MHOA would form part of a pathway of care to inpatient and outpatient settings. The intention to also seek funding for an inpatient mental health unit in that context is entirely appropriate, particularly given the compelling evidence heard at this inquest about the current regular long wait times for mental health patients presenting at Peel ED. I am satisfied that the proposal is well considered and accordingly, I simply intend to make a recommendation supportive of the project, in the hope it might assist in persuading Government to approve and fund the project. I firmly believe if a MHOA, or indeed a mental health bed, had been available for Devan when he presented to Peel ED, it might very well have changed the trajectory for him, and this inquest might never have needed to be held.

Recommendation 1

I recommend that the Minister for Health commit to funding SMHS to build a 10 bed Mental Health Observation Area and 20 bed Inpatient Mental Health Unit when SMHS take over the operation of Peel Health Campus at the end of 2024.

Interim Measures

175. As to procedures that could be implemented prior to a MHOA being approved and developed, I am informed there is no other suitable location currently at PHC to hold mental health patients than the ED, but consideration has been given to whether additional nurse 1:1 specials for voluntary patients could be provided. It was indicated that it can be done, even if the patient is voluntary and not involuntary, but it will require clinical assessment and may require additional nursing resources within the ED. The 24/7 PLN roster was planned to be operational by the start of this year, while Ramsay Health is still operating PHC, so I assume that is now implemented and will remain so once SMHS takes over the health campus operations.

Other Information

176. Additional information was provided about how the MHOA currently operates at Sir Charles Gairdner Hospital and I was advised that by 2025, Fremantle Hospital (which also falls under the governance of SMHS) will have 40 additional mental

[204] Submissions filed on behalf of SMHS dated 30 November 2023.

health beds available for urgent care as part of a 24-hour urgence care service, with mental health staff employed 24 hours a day. Ten of those beds will be reserved for older adults, but that will leave 30 beds still available for younger patients like Devan.

177. I am also aware from media reports and evidence in another recent inquest, which was heard after the submissions from counsel for SMHS for this inquest were filed, that the State Government has very recently announced that it will take on a three year lease contract for the former Bethesda Clinic mental health facility in Cockburn, to be run by SMHS. A significant number of the beds will be set aside for female patients, including those requiring specialist eating disorder services, and there will also be beds set aside for other types of specialist patients, as well as a mental health wellness and recovery centre. In addition, these new beds will hopefully free up other mental health beds in other hospitals.[205]

178. The dire shortage of mental health beds in this State is unlikely to be resolved entirely by these new projects, but they will certainly go a long way to improving the timeliness of care, and the options available, for people like Devan in the future, who are experiencing an acute mental health crisis and require a safe and therapeutic place where they can receive the support, care and treatment they need to get better.

CONCLUSION

179. All of the witnesses who gave evidence agreed that Devan "deserved to get some treatment and get well,"[206] but that given the stretched resources and lack of beds, that help was difficult to provide in a timely manner. It was felt by everyone that the ED was not the ideal place to care for Devan once he had been medically cleared, but there were no other options.

180. It seems that Devan did manage to get some sleep and stay calm for a long period of time, with the help of his mother's presence for the early part, but early on the morning of 13 January, the activity in the ED escalated and it seems that Devan's mindset changed. Due to the need to deal with the agitated patient, no one noticed Devan leaving and when they did, the fact that he had been outside before and returned, and that he had left his belongings behind, led them to believe he would come back. It's possible that is what Devan originally intended to do, but once he was outside the ED, he very quickly left the hospital premises and never returned. It seems he most likely then walked home, where he followed through on the suicidal thoughts that he had been having in the lead up to first presenting to the hospital and hanged himself. Although he was discovered and all efforts were made to revive him, he had already suffered a permanent brain injury that led to his death.

181. It is possible Devan was in a psychotic state at the relevant time, but there is nothing to suggest he didn't have the mental capacity to intend to take his life. Accordingly, I am satisfied Devan died by way of suicide.

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[205] https://www.wa.gov.au/government/media-statements/Cook-Labor-Government/Cockburn-clinic-to-become-public-mental-health-service-20240325.
[206] T 178.

182. Devan's death is a tragedy, and it is important that we remember him and try to learn from his death to create positive changes. Devan's mother, Erin, wrote at the conclusion of her letter,

Please remember his face; remember the name Devan Beau Ginbey.

183. I have no doubt that the nurses and doctors involved in Devan's case will remember him. Devan's family, the staff involved, and I all hope that this inquest leads to changes to at Peel Health Campus that will honour Devan's memory. The cost to the community of not providing a comprehensive and caring mental health service is too great when it involves preventable deaths like Devan's.

S H Linton
Deputy State Coroner
6 May 2024