JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	MICHAEL ANDREW GLIDDON JENKIN, CORONER
HEARD	**:**	26 MARCH 2024
DELIVERED	**:**	8 APRIL 2024
FILE NO/S	**:**	CORC 191 of 2022
DECEASED	**:**	MCLOUGHLIN, PAUL

Catchwords:

Nil

Legislation:

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

Counsel Appearing:

Mr W. Stops appeared to assist the coroner.

Ms M. Watson (State Solicitor's Office) appeared for the North Metropolitan Health Service and Dr C Hodgson.

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Michael Andrew Gliddon Jenkin, Coroner, having investigated the death of ***Paul MCLOUGHLIN*** *with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, Perth, on 26 March 2024, find that the identity of the deceased person was* ***Paul MCLOUGHLIN*** *and that death occurred on 21 January 2022 at 206 French Street, Tuart Hill, from incised injuries to the neck in the following circumstances:*

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INTRODUCTION

1. Paul McLoughlin (Paul)[1] died on 21 January 2022 at his family home in Tuart Hill, from incised injuries to the neck. He was 59-years of age.[2,3,4,5]

2. At the time of his death, Paul was the subject of an inpatient treatment order[6] made under the *Mental Health Act 2014* (WA) (the MHA),[7] and was therefore an "*involuntary patient*" and a "*person held in care*".[8] Paul's death was therefore a "*reportable death*"[9] and in such circumstances, a coronial inquest is mandatory.[10]

3. Where, as here, the death is of a person held in care, I am also required to comment on the quality of the supervision, treatment and care the person received while in that care.[11]

4. I held an inquest into Paul's death in Perth, on 26 March 2024, which was attended by his wife. The Brief of evidence tendered at the inquest consisted of one volume, and included a report of the police investigation into Paul's death,[12] expert reports and medical notes.

5. Dr Chris Hodgson, who is a consultant Psychiatrist at Graylands Hospital and was Paul's treating psychiatrist provided a report and gave evidence at the inquest.

6. The inquest focused on the standard of supervision, treatment and care Paul received while he was an involuntary patient, as well as the circumstances of his death.

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[1] At the request of his wife, the deceased was referred to as "Paul" at the inquest and in this finding, no disrespect is intended
[2] Exhibit 1, Vol. 1, Tab 1, P100 - Report of Death (13.02.23)
[3] Exhibit 1, Vol. 1, Tab 2.1, Life Extinct Form (21.01.22)
[4] Exhibit 1, Vol. 1, Tab 3, P92 - Identification of Deceased Person (21.01.22)
[5] Exhibit 1, Vol. 1, Tab 4, P98 - Mortuary Admission Form (21.01.22)
[6] An order made under the MHA that a person receive treatment on an involuntary basis in an approved hospital
[7] Section 22, *Mental Health Act 2014* (WA)
[8] Section 3, *Coroners Act 1996* (WA)
[9] Section 3, *Coroners Act 1996* (WA)
[10] Section 22(1)(a), *Coroners Act 1996* (WA)
[11] Section 25(3) *Coroners Act 1996* (WA)
[12] Exhibit 1, Vol. 1, Tab 8.1, Report - Det. Sen. Const. C Duke (02.04.23)

PAUL

Background[13,14,15,16]

7. Paul was born in England and came to Australia with his family when he was six years of age. He had two younger siblings (a sister, and a brother) and after leaving school in Year 11, he completed an apprenticeship as a blacksmith. Paul was also employed in other roles during his working life including as a cleaner, and as a gardener.

8. Paul and his wife lived in Tuart Hill and had three children, one of who was stillborn. Paul was described as an artistic and creative person, and he had an art studio at his home. He was in receipt of the disability pension and there was reported to have been "*longstanding conflict*" between Paul and his brother.

Medical and mental health issues[17,18,19]

9. Paul's medical history included type-2 diabetes, high blood pressure, high cholesterol, and fatty liver. Paul had also been a patient of a community mental health service (the Service) since 1998, and he had a long-standing history of heavy, daily cannabis use.

10. Paul was variously diagnosed with bipolar affective disorder, schizoaffective disorder, drug-induced psychosis, cannabis amotivational syndrome, generalised anxiety disorder with depressive features, dysthymia,[20] and dependent personality disorder.

11. Paul was admitted to Sir Charles Gairdner Hospital (SCGH) on a number of occasions, and received electro-convulsive therapy on eight occasions. He had also been admitted to Graylands Hospital (Graylands) on five occasions since 2018, and he had attempted to take his life in 2003, 2008, 2018, and 2020 by medication overdoses of "*high lethality*".[21]

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[13] Exhibit 1, Vol. 1, Tab 9, Statement - Ms S McLoughlin (21.01.22), paras 3-6
[14] Exhibit 1, Vol. 1, Tab 8.1, Report - Det. Sen. Const. C Duke (02.04.23), p2
[15] Exhibit 1, Vol. 1, Tab 18, Report - Dr C Hodgson (11.03.24), paras 15-18
[16] Exhibit 1, Vol. 1, Tab 8.2, Memorandum - Sen. Const. D Stankevicius (22.01.22)
[17] Exhibit 1, Vol. 1, Tab 18, Report - Dr C Hodgson (11.03.24), paras 19-26
[18] Exhibit 1, Vol. 1, Tab 13, Discharge summary - Graylands Hospital (21.01.22)
[19] Exhibit 1, Vol. 1, Tab 14, Medical records - Stirling Lakes Medical Centre
[20] Dysthymia has been described as a milder, but long lasting form of depression
[21] ts 26.03.24 (Hodgson), p8

12. Following a 43-day admission to Sir Charles Gairdner Hospital (SCGH) from 7 September to 19 October 2020, Paul was regularly followed up by the Service, and on 1 November 2021, his bipolar affective disorder and schizoaffective disorder were assessed by a psychiatric registrar as "*being in remission*".[22]

Admission to Graylands[23]

13. On 4 January 2022, Paul presented to SCGH in the company of his family. He had expressed suicidal ideation, and was reviewed by a psychiatrist in the mental health observation area. Paul disclosed an "*on and off*" fight with his brother, and said he had been using "*a lot of cannabis over a long period of time*". Paul also said he had been feeling suicidal "*a lot lately*" although he denied having a plan to end his life.

14. Paul told the psychiatrist that whilst he would prefer to be at home and felt uncomfortable in hospital, he also felt hospital was "*a safer environment for him*". The psychiatrist noted Paul's mental health history and placed him on a Form 1A under the Mental Health Act 2014 (MHA), on the basis that Paul was considered: "*to pose a risk of suicide and lack of capacity to make decisions regarding his mental health management*".

15. The purpose of the Form 1A was to detain Paul at SCGH until he could be reviewed by a consultant psychiatrist at an authorised hospital. For that purpose, Paul was transferred to Graylands.

Management at Graylands[24,25]

16. On admission to Graylands, Paul was initially assessed by a mental health triage nurse. He disclosed a decline in his mood over the previous few weeks and that he had been using increasing amounts of cannabis. As Paul was expressing suicidal ideation and appeared anxious, he was admitted to Pinch Ward, a locked ward which was "*smaller and quieter*".

[22] Exhibit 1, Vol. 1, Tab 18, Report - Dr C Hodgson (11.03.24), paras 23-24
[23] Exhibit 1, Vol. 1, Tab 18, Report - Dr C Hodgson (11.03.24), paras 11-14
[24] Exhibit 1, Vol. 1, Tab 13, Discharge summary - Graylands Hospital (21.01.22)
[25] Exhibit 1, Vol. 1, Tab 18, Report - Dr C Hodgson (11.03.24), paras 27-62 and ts 26.03.24 (Hodgson), pp7-19

17. Paul's treating psychiatrist at Graylands was Dr Chris Hodgson (Dr Hodgson), who provided a report and gave evidence at the inquest. In his report, Dr Hodgson explained that at Graylands:

> The hospital treats patients in accordance with the principles of least restrictive practice, to promote recovery while mitigating the risks of harm. For example, when a patient can safely be granted ground access, it will be allowed. Or when a patient can safely move from a locked/secure ward to an open ward, efforts will be made to facilitate the move if there is a bed available. The goal for involuntary patients is to discharge them to a voluntary status, when it is safe to do so. From there, the goal is to discharge the patient to a 'Hospital in the Home' service or other outreach service where home visits and follow-ups are conducted.[26,27]

18. When Paul was reviewed by a psychiatric registrar shortly after his admission to Graylands, he described his mood as "*not the best*" and his affect was assessed as "*anxious and restricted*". No formal thought disorder or psychotic symptoms were identified, but Paul disclosed suicidal ideation, but "*did not disclose a plan*".[28]

19. Paul was diagnosed with generalised anxiety disorder with depressive symptoms/dysthymia, and he was also considered to have "*cluster C personality disorder with dependent and anxious avoidant features*". A two to three week admission was planned to allow "*cannabis detoxification, monitoring of mental state and to provide his wife with some respite*".[29]

20. During Paul's admission at Graylands, key aspects of his management included:[30]

> a. *5 January 2022*: Paul was reviewed by Dr Hodgson for the first time and although he said he did not "*feel good*" he denied any suicidal intent or plan;

[26] Exhibit 1, Vol. 1, Tab 18, Report - Dr C Hodgson (11.03.24), paras 32-33
[27] See also: ts 26.03.24 (Hodgson), p18
[28] Exhibit 1, Vol. 1, Tab 18, Report - Dr C Hodgson (11.03.24), paras 34-35
[29] Exhibit 1, Vol. 1, Tab 18, Report - Dr C Hodgson (11.03.24), paras 36-37 and ts 26.03.24 (Hodgson), pp7-8
[30] Exhibit 1, Vol. 1, Tab 18, Report - Dr C Hodgson (11.03.24), paras 38-59 and ts 26.03.24 (Hodgson), pp8-19

a. *5 January 2022*: (continued) Paul was also reviewed by the Alcohol and Drug Team in relation to his cannabis use and symptoms of withdrawal. Paul appeared to settle quickly onto the ward and spent a lot of time in his room reading, although he also attended occupational therapy groups "*which he appeared to enjoy*". After Dr Hodgson's review, Paul was granted escorted grounds access with a nurse or family member, but was required to "*check in*" every 60 minutes;

b. *7 January 2022*: Paul was granted unescorted grounds access as well as periods of day leave of up to four hours with his family;

c. *10 January 2022*: Paul appeared "*more relaxed*" and was reported to be enjoying visits with his family;

d. *14-16 January 2022*: on each of these days, Paul left Graylands on day leave with his wife and returned on each occasion "*without incident*";

e. *17 January 2022*: after a review by Dr Hodgson, Paul was granted unaccompanied day leave for two hours so he could "*go to the shops by himself*", and he was also granted extended day leave of up to eight hours with his family;

f. *19 January 2022*: when reviewed by Dr Hodgson, Paul's mood had improved, and he was "*far less anxious*". No psychotic symptoms were observed and Paul did not express any suicidal ideation. Dr Hodgson also approved Paul's transfer to a less acute ward when a bed became free. However at the inquest, Dr Hodgson said the proposed transfer to a less acute ward had caused Paul to feel anxious, and it was therefore decided to allow him to remain on Pinch Ward.[31];

g. *19-20 January 2022*: on each of these days, Paul left Graylands on day leave with his wife and returned on each occasion "*without incident*";

h. *21 January 2022*: Paul was reviewed by a psychiatric registrar at about 10.30 am, and reported feeling anxious. He was given some lorazepam with good effect and he remained in his room for the rest of the day, which was usual for him.

[31] ts 26.03.24 (Hodgson), p13

EVENTS LEADING TO PAUL'S DEATH[32,33,34,35,36,37]

21. At about 3.00 pm, Paul's wife collected him from Graylands for a period of leave. The plan had been that Paul would have dinner with the family before returning to Graylands by 8.00 pm. After leaving Graylands, Paul and his wife did some grocery shopping, and they arrived at the family home at about 5.15 pm.

22. Paul and his wife sat in the backyard chatting until about 6.00 pm when she went inside to prepare dinner. She told Paul about an unpleasant text message she had received from Paul's brother, but when she asked Paul how he was "*everything seemed fine*". Although Paul seemed somewhat anxious this was not unusual, and nothing about their conversation, or his presentation gave Paul's wife any cause for concern.

23. While Paul's wife was cooking dinner, Paul came inside briefly for an iced coffee and said hello to his daughter's partner (who was visiting) before going back outside. Dinner was ready at about 6.40 pm, and Paul's wife went into the backyard to let him know. Paul was nowhere to be seen but there was an iced coffee on the steps leading down to the shed.

24. There was no reply when Paul's wife called out his name, and she went back inside and asked her daughter if she knew where Paul was. When the daughter said she didn't, Paul's wife went back outside and walked towards the shed and looked through the window. She saw Paul lying face down with a pool of blood to his left, and called out for help.

25. The daughter's partner called emergency services. Police and ambulance officers (including a clinical support paramedic) arrived and started CPR, but Paul could not be revived and he was declared deceased at 7.05 pm on 21 January 2022.[38]

[32] Exhibit 1, Vol. 1, Tab 9, Statement - Ms S McLoughlin (21.01.22), paras 8-41
[33] Exhibit 1, Vol. 1, Tab 8.1, Report - Det. Sen. Const. C Duke (02.04.23), pp1-4
[34] Exhibit 1, Vol. 1, Tab 10, Police Running sheet, 210122 2040 14412
[35] Exhibit 1, Vol. 1, Tabs 12.1 & 12.2, Incident Reports 210122 2040 14412 & LWP22012100053223
[36] Exhibit 1, Vol. 1, Tabs 15.1-15.3, SJA Patient Care Records: CSE01DD, MOR22N2 & OPK23N2 (21.01.22)
[37] Exhibit 1, Vol. 1, Tab 18, Report - Dr C Hodgson (11.03.24), para 58 and ts 26.03.24 (Hodgson), pp14-15
[38] Exhibit 1, Vol. 1, Tab 2.1, Life Extinct Form (21.01.22)

CAUSE AND MANNER OF DEATH

Post mortem examination[39]

26. On 2 February 2022, a forensic pathologist (Dr Clive Cooke) conducted a post mortem examination and noted deep cuts (incised injuries) to both sides of the front of Paul's neck. The jugular veins were cut, and there were minor cuts to the front of both wrists.

27. Minor abrasions and bruising was noted on the right side of Paul's forehead and right cheek, and early atherosclerotic hardening of the arteries, and gallstones were also noted. Microscopic examination of major body tissues, and specialist examination of Paul's brain, identified no significant findings.[40]

28. Toxicological analysis also detected therapeutic levels of a metabolite of venlafaxine, and quetiapine. A sub-therapeutic level of salicylic acid was also detected, along with risperidone, and sitagliptin. Alcohol and other common drugs were not detected.[41]

Cause and manner of death[42]

29. At the conclusion of the post mortem examination, Dr Cooke expressed the opinion that the cause of Paul's death was incised injuries to the neck.

30. I accept and adopt the conclusion of Dr Cooke as to the cause of Paul's death. Further, in view of the available evidence, I find that Paul's death occurred by way of suicide.

[39] Exhibit 1, Vol. 1, Tab 5.1, Supplementary Post Mortem Report (13.05.22)
[40] Exhibit 1, Vol. 1, Tab 7, Neuropathology Report (23.02.22)
[41] Exhibit 1, Vol. 1, Tab 6, Toxicology report (06.05.22)
[42] Exhibit 1, Vol. 1, Tab 5.1, Supplementary Post Mortem Report (13.05.22)

QUALITY OF SUPERVISION, TREATMENT AND CARE

31. A police investigation determined that Paul had not left any notes indicating his intentions, either in his room at Graylands or at home. In terms of managing Paul at Graylands, in his report Dr Hodgson noted that Paul had a tendency to be impulsive and "*had to be carefully managed*". Dr Hodgson also said that the manner in which Paul had taken his life (incised wounds to the neck) was "*impulsive and inconsistent with his previous attempts*".[43]

32. Dr Hodgson also noted that Paul's management was complicated by his refusal to engage with any outpatient recovery programs, and this reluctance appeared to be due to "*his anxious, avoidant, and dependent personality style plus his ongoing heavy use of cannabis*". Paul also declined alcohol and drug counselling, which he was offered during his admission.[44] Dr Hodgson said he had reviewed him on five occasions and that Paul "*appeared to be making good progress in hospital*".[45]

33. However, Dr Hodgson also noted that:

> [Paul] was socially isolated and dysthymic, his history of mental illness, vulnerability to stress (such as the conflict with his brother) and prior impulsive suicide attempts meant that he was at chronic high risk of completed suicide.[46]

34. At the inquest, Dr Hodgson confirmed that suicide is impossible to predict. Death by suicide is a rare event and it is impossible to predict rare events with any certainty. Instead, clinicians conduct risk assessments where they consider historical and dynamic risk factors. Dr Hodgson also confirmed that a person's suicidality can fluctuate, sometimes on relatively small time frames, and that often even those closest to the deceased do not notice anything different about their behaviour immediately before the person takes their life.[47]

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[43] Exhibit 1, Vol. 1, Tab 18, Report - Dr C Hodgson (11.03.24), paras 60 & 62
[44] ts 26.03.24 (Hodgson), p15
[45] Exhibit 1, Vol. 1, Tab 18, Report - Dr C Hodgson (11.03.24), paras 59 & 61
[46] Exhibit 1, Vol. 1, Tab 18, Report - Dr C Hodgson (11.03.24), paras 59 & 61 and see also: ts 26.03.24 (Hodgson), p8
[47] ts 26.03.24, (Hodgson), pp17 & 19

35. In 2017, the Department of Health published a document entitled: *Principles and Best Practice for the Care of People Who May Be Suicidal* (the Document). As to the widespread community belief that suicide can be accurately predicted, the Document stated that this belief:

> [H]as led to the assumption that suicide represents a failure of clinical care and that every death is potentially preventable if risk assessment and risk management were more rigorously applied. However the evidence is clear that, even with the best risk-assessment practices and care, it is not possible to foresee and prevent all deaths by suicide.[48]

36. Having carefully considered the available evidence, I am satisfied that it was appropriate for Paul to be placed on a treatment order and managed as an involuntary patient, given his initial suicidal ideation, and his inability to guarantee his safety.

37. I am also satisfied that Paul's actions in taking his life could not have been anticipated, and that it was appropriate for him to have been granted day leave with his family on 21 January 2022. By that stage, Paul's mental health seemed to be improving, and he had successfully managed several previous periods of day leave with his family.[49]

38. Neither Paul's treating team nor his family identified any significant change in his behaviour in the period leading up to his death. Further, as noted, Paul's symptoms appeared to be improving. This leaves Paul's family to grapple not only with the tragedy of his death, but also with its inexplicability.

39. Finally, having regard to all of the evidence I have reviewed, I am satisfied that the supervision, treatment and care that Paul received while he was an inpatient at Graylands was of a good standard.

[48] Principles and Best Practice for the Care of People Who May Be Suicidal, Dept. of Health (2017), pp2-3
[49] ts 26.03.24 (Hodgson), pp15-16

CONCLUSION

40. Paul was a much-loved husband, father, family member, and friend who had long-standing mental health conditions, and who was regarded as being at chronic risk of self-harm.[50]

41. Paul was 59-years of age when he inexplicably took his life at his family home whilst on a period of day leave from Graylands. Paul's death is both tragic and impossible to fathom.

42. As I did at the conclusion of the inquest, I wish to convey to Paul's family and loved ones, my very sincere condolences for their terrible loss.

MAG Jenkin
Coroner
8 April 2024

[50] ts 26.03.24 (Hodgson), p8