JURISDICTION	:	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	:	CORONERS ACT 1996
CORONER	:	PHILIP JOHN URQUHART, CORONER
HEARD	:	23-26 June 2025
DELIVERED	:	23 DECEMBER 2025
FILE NO/S	:	CORC 652 of 2023
DECEASED	:	STEINHAUSER, KARL ALBERT

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:

Mr W Stops assisted the Coroner
Ms K. M. Niclair and Ms T.J. Richards appeared on behalf of the WA Country Health Service, the South Metropolitan Health Service and the Department of Health
Ms B.J.H. Kendall and Mr E.A. Panetta appeared on behalf of Dr Ugwu
Mr S.M. Denman and Ms S.A. Harper appeared on behalf of Dr R. Kathirgamanathan and Dr A. Roney
Ms C.A. Elphick appeared on behalf of Dr M. Saw
Mr J.R. Johnson (instructed by Blumers Lawyers) appeared on behalf of Chloe Johnston and the family of Mr Steinhauser

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

Nil

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Philip John Urquhart, Coroner, having investigated the death of ***Karl Albert STEINHAUSER*** *with an inquest held at Perth Coroners Court, Central Law Courts, Court 51, 501 Hay Street, PERTH, on 23 - 26 June 2025, find that the identity of the deceased person was* ***Karl Albert STEINHAUSER*** *and that death occurred on 12 March 2023 at Fiona Stanley Hospital, 11 Robin Warren Drive, Murdoch, from pulmonary thromboembolism in an overweight man with comorbidities (including recent hospital-acquired pneumonia) in the setting of receiving treatment for acute exacerbation of a psychotic disorder in the following circumstances:*

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LIST OF ABBREVIATIONS & ACRONYMS

Abbreviation/Acronym	Meaning
the ***Briginshaw*** principle	the principle to be applied by the Court when deciding if a matter adverse in nature has been proven on the balance of probabilities
the Court	the Coroners Court
CPR	cardiopulmonary resuscitation
the desktop review	the review in May 2025 conducted by Dr Marshall, other medical clinicians and the Head of Security into the care provided to Karl at FSH
DVT	deep vein thrombosis
ECG	electrocardiogram
ECT	electroconvulsive therapy
ED	emergency department
FSH	Fiona Stanley Hospital
HDU	High Dependency Unit at KHC
ICU	intensive care unit
KCMHS	Kalgoorlie Community Mental Health Service
KHC	Kalgoorlie Health Service
mg	milligrams
MHAU	Mental Health Assessment Unit at FSH
MHIU	Mental Health Inpatient Unit at KHC
PE	pulmonary embolism
the panel	the panel that undertook the SAC1 investigation by WACHS
the pool	the pool of extra casual security staff that can be called on when there is a shortage of security staff at FSH
RFDS	Royal Flying Doctor Service
SMHS	South Metropolitan Health Service
SSO	State Solicitor's Office
TTO	Sedation Team Time Out
VTE	venous thromboembolism
WACHS	WA Country Health Service

INTRODUCTION

"As long as we live, they too will live; for they are now a part of us, as we remember them."
Eliezer Wiesel – author and Holocaust survivor

1 Karl Albert Steinhauser (Karl[1]) died in the ICU at Fiona Stanley Hospital (FSH) from pulmonary thromboembolism on 12 March 2023. He was 30 years old.

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

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

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

5 From 23 - 26 June 2025, I held a four day inquest into Karl's death at Perth. Twelve witnesses gave oral evidence at the inquest:[5]

i. Dr Izuchukwu Ugwu: (consultant psychiatrist at Kalgoorlie Health Campus (KHC));
ii. Elizabeth Caulker: (clinical nurse specialist at FSH);
iii. Dr Bolanle Ayeni (resident medical officer at KHC);
iv. Dr Rajasutharsan Kathirgamanathan (emergency physician at KHC);
v. Dr Melanie Saw (ICU consultant at FSH);
vi. Dr Andrew Roney (consultant psychiatrist at FSH);
vii. Dr Justin Yeung (WA Country Health Service (WACHS) Medical Director, Command Centre);

[1] As the family had requested their relative be referred to as "Karl" during the inquest, I will identify him in the same manner in my finding.
[2] *Mental Health Act 2014* (WA) ss 4 and 21
[3] *Coroners Act 1996* (WA) s 3
[4] *Coroners Act 1996* (WA) s 22(1)(c)
[5] The listed positions of the witnesses who were involved in Karl's care are the positions they held at the relevant time.

viii. Dr Samir Heble (Area Director of Clinical Psychiatry at WACHS);

ix. Dr Andrew Marshall (acting Director, Clinical Services, South Metropolitan Health Services (SMHS))

x. Dr Roberto Radici (Head of Medical, Royal Flying Doctor Service (RFDS));

xi. Dr Tim Paterson (independent ICU consultant); and

xii. Dr Adam Brett (independent consultant psychiatrist)

6 At the conclusion of the inquest's oral evidence, Karl's mother, Lynda Duncan, read out a prepared statement.[6] At the completion of the closing submissions from counsel for interested parties, Chloe Johnston (Chloe), the partner of Karl, also read out a statement she had written.[7]

7 The documentary evidence comprised of two volumes of material which were tendered by counsel assisting at the commencement of the inquest and became exhibit 1. Various other documents were tendered during the inquest and these became exhibits 2-8.

8 At the completion of the inquest, I requested the following additional information: (i) from WACHS, SMHS, the Department of Health and the Mental Health Commission concerning the wording of recommendations I was considering making and (ii) from SMHS, concerning information regarding security escorts at FSH.

9 This additional information was provided by the State Solicitor's Office (SSO) in a letter dated 4 September 2025 that was attached to an email of the same date. The letter also provided some clarification regarding exhibit 8 which was a table prepared by Mr Johnson's instructing solicitors that listed selected observations from Karl's hospital records at KHC and FSH. As counsel for the other interested parties had also received the letter, it became exhibit 9.

10 At the inquest, I granted Mr Johnson, counsel for the family, leave to provide short written submissions in response to the further information from the SMHS regarding security escorts at FSH. The Court subsequently received those submissions from Mr Johnson's instructing solicitors on 19 December 2025.

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[6] Exhibit 6.1
[7] Exhibit 2

11 My primary function at the inquest was to investigate the quality of the supervision, treatment and care that was provided to Karl when at KHC from 21 February to 9 March 2023, and then when he was transferred by RFDS to the ICU at FSH on 9 March 2023 until his death three days later.

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

13 I am also mindful not to insert hindsight bias into my assessment of the actions taken by Karl's health service providers in their treatment of him in KHC and FSH. Hindsight bias is the tendency, after an event, to assume the event was more predictable or foreseeable than it was at the time.[8]

KARL

Background [9]

14 Karl was born in Kalgoorlie on 15 February 1993. He had two brothers.

15 Karl worked as a mechanic, and lived in a suburb of Kalgoorlie with Chloe and their two young daughters. At the time of Karl's death, he was engaged to Chloe. The statements provided to the Court by Karl's family and loved ones described a friendly man with a big heart who would help anyone. It is very clear to me that Karl deeply loved his fiancée and two daughters.

16 Sadly, however, Karl was burdened with major mental health issues.

Karl's mental health [10]

17 Karl was known to the Kalgoorlie Community Mental Health Service (KCMHS) since 2016. He was treated for significant mental health issues and his previous diagnoses included adjustment disorder, bipolar affective disorder, drug-induced psychosis and schizoaffective disorder. Karl's mental health issues and aggressive behaviour when unwell were complicated by ongoing substance misuse that included alcohol, cannabis and methylamphetamine.

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[8] Dillon H and Hadley M, *The Australasian Coroner's Manual* (2015) 10
[9] Exhibit 1, Volume 1, Tab 2; Exhibit 2; Exhibits 6.1-6.4
[10] Exhibit 1, Volume 1, Tabs 2 and 11

18 Karl had three previous admissions to psychiatric units. An admission to Graylands Hospital from 5 December 2017 to 4 January 2018 for drug-induced psychosis, a three week admission to Fremantle Hospital in April and May 2019, and another admission in 2019 to St John of God Midland Hospital following a manic episode.

19 The prescribed medications to treat Karl's schizoaffective disorder had resulted in some health issues. The anti-psychotic medication, paliperidone, had caused erectile dysfunction and elevated prolactin in 2019; and the medication, valproate, had cause bilateral tremor and metabolic syndrome.

Karl's mental health deteriorates [11]

20 In early 2023, Karl's family and work colleagues noted he was displaying early warning signs of a decline in his mental health. This included aggression, grandiose views about his employment prospects, gambling, increased mobile phone use, excessive spending on items and keeping company with suspicious men who he referred to as "the bros".

21 At this time, Karl's regular medications included a depot injection of aripiprazole (an anti-psychotic medication) of 400 mg every four weeks.

22 On 6 February 2023, Karl was reviewed by his treating consultant psychiatrist at KCMHS. It was noted that Karl had pressured speech and an elevated mood with psychotic symptoms. Nevertheless, he agreed to continue with his four-weekly depot injection and the oral anti-psychotic medication, quetiapine, of 200 mg every night was added by the consultant psychiatrist.

23 On 20 February 2023, Karl did not attend the KCMHS for his aripiprazole depot injection. Attempts by KCMHS staff and police to locate him that day were unsuccessful.

24 On 21 February 2023, Karl voluntarily attended the KCMHS and accepted the aripiprazole injection but complained the quetiapine had been too sedating. It was recorded that Chloe had concerns regarding her own safety, and she had left the family home with her two daughters to stay with her parents in Perth.

[11] Exhibit 1, Volume 1, Tabs 2 and 13

25 The consultant psychiatrist at the KCMHS noted that Karl was paranoid, irritable, elevated and had poor judgement. It was suspected he had used methylamphetamine recently. The consultant psychiatrist diagnosed Karl with an exacerbation of schizoaffective disorder and as Karl could not be safely treated as an outpatient, the consultant psychiatrist completed a "*Form 1A - Referral for Examination by Psychiatrist*" pursuant to section 26(1) of the *Mental Health Act 2014* (WA). Karl agreed to be taken to KHC for this examination.

Admission to KHC [12]

26 On the morning of 21 February 2023, Karl was initially assessed in the ED at KHC where routine blood investigations were found to be within normal range. Other observations were normal apart from a mildly raised heart rate, which was attributed to Karl being very agitated and highly driven. Although he admitted taking illicit substances, Karl refused a urine drug screen or disclose exactly what illicit drugs he had been taking. Later that same day, Karl was admitted to the Mental Health Inpatient Unit (MHIU) at KHC.

27 Karl refused an initial assessment by the registrar at the MHIU and also refused a routine physical examination. He became verbally abusive and physically threatening by punching and kicking doors. A security guard had to be placed with him to protect Karl and other patients from harm.

An Inpatient Treatment Order is made

28 Dr Izuchukwu Ugwu, a consultant psychiatrist at the MHIU, assessed Karl on the morning of 22 February 2023. Dr Ugwu found Karl to be mentally unstable, with predominantly manic symptoms. His mood was highly elevated and irritable, he was paranoid and verbally aggressive, had racing thoughts, and behaved in an aggressive way towards Dr Ugwu. It was readily apparent to Dr Ugwu that Karl lacked insight into his mental health condition, and he was demanding to be discharged from KHC. Karl admitted using methylamphetamine and cannabis.

29 After his initial assessment of Karl, Dr Ugwu spoke to Chloe who outlined Karl's recent behaviour.

[12] Exhibit 1, Volume 1, Tabs 14 and 15; Exhibit 1, Volume 2, Tabs 6-10

30 Dr Ugwu's mental health diagnosis for Karl was schizoaffective disorder and polysubstance use disorder. Shortly before midday on 22 February 2023, Dr Ugwu completed a "*Form 6A - Inpatient Treatment Order*" which meant that Karl was to be detained as an involuntary patient in an authorised hospital for mental health treatment.[13] Dr Ugwu also restricted Karl's use of his mobile phone as he had been sending threatening messages to Chloe.

Karl's mental health does not improve

31 Unfortunately, Karl remained uncooperative with his treatment plans and remained irritable. He refused to be psychically examined or have his vital signs such as blood pressure, heart rate and respiratory rate monitored.

32 Dr Ugwu increased Karl's quetiapine medication and also prescribed oral lorazepam and droperidol[14] injections to manage Karl's behaviour on an as need basis. Karl's sleep was poor and he was disrupting the sleep of other patients on the ward. As Dr Ugwu said in his written statement to the Court, Karl's "*management was extremely challenging considering the limitations of managing acutely aggressive and agitated patients on MHIU Kalgoorlie.*"[15]

33 On 24 February 2023, Karl was given accompanied leave on hospital grounds as his inability to smoke cigarettes was causing him more agitation. However, on 25 February 2023, he attempted to break into a car in the carpark in search of cigarettes and his leave was suspended after this incident.

34 On 26 February 2023, Karl continued to display threatening behaviour and required extra medications throughout the day. Dr Ugwu made the decision to have all of Karl's electronic devices removed.

35 On 27 February 2023, Karl was given an initial dose of Acuphase[16] (zuclopenthixol acetate) and had to be restrained by security for that to take place.[17] He was given further doses of Acuphase on 28 February and 1 March 2023 due to his ongoing agitation and aggression towards

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[13] KHC is an authorised hospital.
[14] A rapid-acting anti-psychotic medication used for sedation.
[15] Exhibit 1, Volume 2, Tab 9, p.15
[16] A short-acting anti-psychotic medication to treat acute psychosis when the patient is agitated, hostile or aggressive.
[17] Ts p.37

staff. Guidelines only permit three injections of Acuphase in a single course of treatment.[18]

36 On 2 March 2023, Karl's quetiapine medication was increased to 600 mg at night and 200 mg in the morning. His heart rate was noted to be elevated and concerns were raised regarding possible neuroleptic malignant syndrome (a reaction to anti-psychotic medication that can cause fever, muscle stiffness and altered mental state). An ECG showed sinus tachycardia and he was placed on hourly observations.

37 After sleeping through the night for the first time on 2 March 2023, Karl appeared to be improving and his escorted leave on hospital grounds access was reinstated on 3 March 2023. This was successful and he was subsequently allowed the use of his electronic devices on 5 March 2023. However, Karl did not sleep well that night and was irritable the next day.

38 On 7 March 2023, Karl's mental state deteriorated and Dr Ugwu noted he had "*gone back to square one*" and that within the space of 48 hours, his treating team was "*dealing with the issue we had dealt with from the time he was admitted.*"[19] Karl was found smoking in his room, was elevated and he was demanding a discharge to attend his daughter's birthday (which was 12 March). Karl's laptop use was restricted at night as he was using it and his mobile phone late at night and was not sleeping. His mood stabiliser medication (sodium valproate) dose was increased.

39 At this time, Dr Ugwu arranged for the registrar to contact Chloe to update her on Karl's mental state and treatment progress. Despite Karl having been admitted for nearly two weeks, this was only the second time Chloe had been contacted by Karl's treating team at the MHIU. The explanation from Dr Ugwu for this lack of contact was that there had been a focus on stabilising Karl's mental state during this time. And additionally: [20]

> Moreover, after speaking with her [Chloe] initially the day after his admission, I felt that she was too distressed to be inundated with calls on how unwell and aggressive he had been most of the time.

[18] Exhibit 3
[19] Ts p.48
[20] Exhibit 1, Volume 2, Tab 9, p.26

40 By 8 March 2023, Karl had had a full manic relapse. He refused to take his oral medication and threatened to leave the ward. Multiple Code Blacks were called and despite extra doses of medication, Karl's behaviour did not settle. As the MHIU did not have a seclusion room and Karl's behaviour was placing staff and other patients at risk, a decision was made to transfer his care to a more appropriate facility in Perth. FSH was the designated hospital for KHC.

41 At the inquest, Dr Ugwu said that all treatment options available at the MHIU had been exhausted by this stage. He explained that once the initial course of Acuphase was completed, it could not be repeated.[21] The only other option was ECT; however, KHC did not have an ECT suite.[22] Dr Ugwu also said that Karl was never stable enough to undergo psychotherapy and in any event, there was no psychologist in the MHIU at the time.[23] Consequently, Dr Ugwu stated: "*So there was no other thing that was left for me to do there [at the MHIU] that I could do to get Karl well. And I was left with the only option of transferring him to the metropolitan area, which we did.*"[24]

42 On the afternoon of 8 March 2023, a "*Form 4A - Transport Order*" and a "*Form 4C - Transfer Order*" were completed and the WACHS Command Centre arranged an urgent transfer for Karl via the RFDS to FSH.

Karl is moved to the High Dependency Unit (HDU) at KHC

43 At about 6.10 pm on 8 March 2023, Karl was moved to the HDU at KHC to be monitored overnight. He continued to be uncooperative and due to his aggressive behaviour, he required the presence of two security staff and a nurse.

44 On the morning of 9 March 2023, Dr Ugwu contacted Dr Rajasutharsan Kathirgamanathan, the ED consultant at KHC, regarding Karl's transfer. Dr Ugwu advised Dr Kathirgamanathan that Karl had already had a significant amount of sedation with minimal effect and asked that he be intubated for safe transport by RFDS to FSH. When Dr Kathirgamanathan subsequently assessed Karl he was still displaying significant agitation, was uncooperative and refusing to be monitored. After completing his assessment and noting the

[21] Ts p.58
[22] Ts pp.47-48
[23] Ts p.50
[24] Ts p.58

sedative medication Karl had had in the preceding 24 hours, Dr Kathirgamanathan determined:[25]

> After careful consideration of the clinical risks and severity of his agitation, risk of harm to staff (and self), and likelihood of unpredictable behaviour, as well as the anticipated changes associated with aerodynamical transfer, I agreed that intubation was the safest course of action for transfer.

45 Later that morning Dr Kathirgamanathan intubated Karl. A chest x-ray confirmed correct placement of the ETT (a breathing tube inserted into the windpipe for ventilation) and the NGT (a nasogastric tube for delivering nutrition and medications). The transfer via RFDS was planned to take place that day with police assistance.

EVENTS LEADING TO KARL'S DEATH [26]

46 Karl remained stable during the RFDS flight from Kalgoorlie to Perth. He was transferred to the care of St John Ambulance at Jandakot Airport at 2.50 pm on 9 March 2023.

Karl is admitted to the ICU at FSH

47 Karl was admitted to the ICU at FSH at 3.28 pm. On arrival, a chest x-ray revealed aspiration pneumonia/ventilation associated pneumonia, and Karl was commenced on intravenous antibiotics. Karl remained intubated and sedated in the ICU with his upper limbs restrained.

48 On 10 March 2023, Karl was reviewed by FSH consultant psychiatrist, Dr Andrew Roney. Dr Roney noted that Karl's blood tests and QTc (corrected QT interval) were normal. Although a bed in the Mental Health Assessment Unit (MHAU) at FSH was available that afternoon, due to the unavailability of security required to be present for the extubation, Karl's transfer to the MHAU could not occur on that day.

49 On 11 March 2023, staff at the ICU were again ready to extubate Karl and transfer him to the MHAU. Although a bed was available in the MHAU and was being kept for Karl, security staff were unavailable until 6.00 am on 12 March 2023. Consequently, Karl remained sedated and intubated in the ICU on 11 March 2023.

[25] Exhibit 1, Volume 2, Tab 10, p.2
[26] Exhibit 1, Volume 1, Tabs 18 and 22; Exhibit 1, Volume 2, Tabs 4 and 5

50 On 12 March 2023, it was noted Karl's temperature had spiked overnight, his oxygen saturations had dropped, and he had developed a new wheeze. He was commenced on an intravenous antibiotic to treat worsening aspiration pneumonia.

51 On the morning of 12 March 2023, Karl appeared mildly hypotensive, cold and clammy. There were signs suggesting inflammation. A chest x-ray showed left lower lobe collapse and a build-up of fluid in the space between the lungs and the chest wall.

Karl is eventually extubated

52 At about 9.30 am on 12 March 2023, Karl was extubated. He initially appeared to be doing well after the extubation. His vital signs were adequate and although he was observed to be drowsy, he was able to obey commands. However, minutes later, Karl developed a sudden onset of tachycardia (increased heart rate). He then lost consciousness and became unresponsive.

53 The emergency buzzer was immediately activated, and CPR was commenced. Karl was re-intubated and a prolonged period of resuscitation commenced with multiple intravenous medications given, which included adrenaline, amiodarone, lignocaine, magnesium and atropine. An ECG showed a dilated right ventricle but no blood clot.

54 However, repeat imaging showed a large amount of clotting in the right atrium and right ventricle, consistent with a massive pulmonary embolus. Karl was administered medication to break up this clotting and a mechanical chest compression (LUCAS) machine was attached.

55 Sadly, further extensive CPR failed to establish circulation and Karl was certified life extinct at 12.00 pm on 12 March 2023.[27]

CAUSE AND MANNER OF DEATH [28]

56 Two forensic pathologists, Dr Nina Vagaja and Dr Jagbir Grewal, conducted a post mortem examination on Karl's body on 23 March 2023. The examination found Karl was of a large build with an increased body mass index (BMI) of 36.9. Karl's heart was enlarged and he had bilaterally congested and heavy lungs. There was evidence of medical intervention, including CPR.

[27] Exhibit 1, Volume 1, Tab 3
[28] Exhibit 1, Volume 1, Tabs 6 and 6.1, Tab 7, Tab 9

57 Findings from tissue microscopy included a thromboembolus visible in one moderately sized artery within the lungs. There was also fatty change to the liver.

58 Toxicology testing detected multiple medications in Karl's blood consistent with the hospital treatment he had received. All these medications were detected at low and therapeutic concentrations. Alcohol and illicit drugs were not detected.

59 A macroscopic examination of Karl's brain by a specialist neuropathologist detected no significant abnormalities.

60 Although Karl had a family history of Factor V Leiden (a condition that increases the risk of blood clots), post mortem haematology testing did not detect Factor V Leiden mutations.[29]

61 Dr Vagaja noted:[30]

> In this case the deceased's cardiac arrest was most likely due to pulmonary thromboembolism, with convincing signs having been noted on ultrasound of the heart (echocardiogram) at the time of cardiopulmonary resuscitation at Fiona Stanley Hospital. With consideration to this finding, a medication was given during resuscitation in order to break down clots in the body (thrombolysis), which was then followed by 30 minutes of vigorous resuscitation. At this time, the clots would have been largely dissolved, although residual pulmonary thromboembolism was demonstrated on postmortem microscopy of the lungs. The deceased had risk factors for deep vein thrombosis and thromboembolism: at baseline, he was of a large build, with a history of smoking/possibly current smoker, with enlarged heart and a fatty liver.
>
> ...
>
> Inflammation in the body is associated with increased risk of abnormal clotting. The deceased's risk of venous thrombosis and thromboembolism may have been increased by the use of anti-psychotic medications for management of exacerbation of psychosis, with reduced mobility associated with sedation and requirement for intubation, and recent clinically diagnosed hospital-acquired pneumonia (aspiration or ventilator associated).

62 At the conclusion of the post mortem investigations, Dr Vagaja expressed the opinion that the cause of death was: "*Pulmonary thromboembolism in an overweight man with comorbidities (including*

[29] Exhibit 1, Volume 1, Tab 6.1, p.3
[30] Exhibit 1, Volume 1, Tab 6.1, pp.3-4

recent hospital-acquired pneumonia) in the settings of receiving treatment for acute exacerbation of a psychotic disorder".[31]

63 I accept and adopt the conclusion expressed by Dr Vagaja as to the cause of Karl's death, and I find that death occurred by way of natural causes.

THE CLINICAL INCIDENT INVESTIGATION BY WACHS [32]

64 A clinical incident in a hospital which has caused serious harm or death to a patient that may be attributable to a patient's healthcare (rather than their underlying condition or illness) is known as a SAC1 Clinical Incident. Such an incident should always become the subject of an investigation (known as a SAC1 investigation) by the Health Service with oversight of the hospital in question.

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

66 A SAC1 investigation is undertaken by a panel which comprises of medical experts in the areas subject to the investigation.

67 WACHS formed a panel which undertook a SAC1 investigation with respect to Karl's admission to KHC (the panel), which noted the following:[33]

1. On a review of the ECGs performed on Karl there was evidence of a potential right heart strain on the seventh day of his admission to the MHIU. The initial changes subsequently resolved and then returned prior to Karl's extubation at FSH. The panel noted that the right heart strain plus sinus tachycardia may be indicative of pulmonary artery pressure changes and that a pulmonary embolism should be considered. However, the panel noted the ECG changes were subtle; and although hindsight raised the possibility Karl may have had existing thrombi, an alternative explanation may have been that he had a chest infection and that the inflammatory process may have led to a pulmonary emboli. The panel accepted that Karl's treating

[31] Exhibit 1, Volume 1, Tab 6.1, p.1
[32] Exhibit 1, Volume 1, Tab 16
[33] Exhibit 1, Volume 1, Tab 16, pp.8-9

psychiatric team may not have noted the subtle changes and that the ECGs were performed with the intent of monitoring the QT interval relating to the Acuphase that Karl was receiving. In addition, the panel shared the ECGs with five general physicians and only two identified the changes.

2. As to the prevention of venous thromboembolism (VTE), the panel noted that the risk for VTE in mental health inpatients is generally considered to be low, unless there are known high risk factors for VTE. It was noted that in this instance Karl was mobile, agitated, and moving around the ward; and based on information available to staff at that time, he did not meet the criteria for VTE prophylaxis.

3. As to the clinical risk of VTE, the panel concluded that decision making is challenging, particularly in the diagnosis of suspected pulmonary embolism where patients have non-specific signs of symptoms or atypical presentations. The panel found that Karl's case illustrated the complexity of diagnosing pulmonary embolism where there is a presentation of atypical signs and symptoms.

68 I have accepted these findings from the panel.

69 The panel made the following recommendations:[34]

1. As the MHIU was not appropriately designed to manage highly aggressive or agitated patients, a project working group be established to identify an interim infrastructure solution.

2. The MHIU is to proactively engage with the carers of patients as further engagement with Karl's partner had the potential to identify triggers in his behaviour.

3. There was a verbal conversation rather than a formal medical consult which resulted in a lack of information that could have been transferred to the HDU and the admitting ICU team at FSH. A review of site-based referrals should be undertaken to determine the level of formal consult processes.

4. Undertake a policy review of the coordination of care and decision-making involving intubation prior to transfer.

[34] Exhibit 1, Volume 1, Tab 16, pp.14-18

5. Implementing a Sedation Team Time Out (TTO) in the setting of escalating sedation requirements for behavioural agitation.

6. Findings from the SAC1 investigation to be considered as part of the VTE prophylaxis working group.

ISSUES RAISED BY THE EVIDENCE

Was the medication provided to Karl in the MHIU appropriate?

70 From the information available to me, it was clear that Karl presented as a very challenging patient for his treating team in the MHIU. He was uncooperative, very irritable, physically aggressive and threatening which exacerbated the difficulties facing Dr Ugwu and his team to effectively treat Karl.

71 Notwithstanding those difficulties, I am satisfied that the various medications provided to Karl whilst he was in the MHIU were appropriate. In making that finding, I note that counsel for Chloe and Karl's family submitted: "*It's accepted that there can be no conclusion other than the medication that was administered was appropriate. ... The conclusion should be that the use of medication to try and manage Karl's illness was appropriate and justified.*"[35]

72 I also note the opinion of Dr Adam Brett, the independent consultant psychiatrist, regarding this matter:[36]

> A number of the medications that Mr Steinhauser was prescribed have a risk of pulmonary embolism, these include Acuphase, quetiapine, olanzapine, droperidol and midazolam. The risk is rare, very rare or unknown. I do not believe that the medications prescribed at the time were contra-indicated or inappropriate. It would have been impossible for the treating team to predict the issues that ensued.

73 The independent ICU consultant, Dr Timothy Paterson, expressed the same view, noting that the "*escalating medication administration was justified and handled well.*"[37]

74 I am satisfied the medications administered to Karl during his admission to the MHIU were appropriate.

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[35] Ts p.473 (closing submissions by Mr Johnson)
[36] Exhibit 1, Volume 1, Tab 11, p.12
[37] Exhibit 1, Volume 1, Tab 10.1, p.6

Communications by the MHIU with Karl's family

75 As outlined above, Dr Ugwu and his team only spoke to Chloe on two occasions whilst Karl was in their care. The first conversation was by Dr Ugwu on 22 February 2023 (shortly after Karl had been admitted to the MHIU), and the second took place on 7 March 2023 by the registrar at the MHIU (at Dr Ugwu's direction). This was two days before Karl was transferred to FSH.

76 Dr Samir Heble, the Area Director of Clinical Psychiatry at WACHS, gave evidence at the inquest. He was also a member of the panel. At the inquest, he outlined the opportunities for Karl's carers and family to have been more involved. He continued:[38]

> So no matter how challenging the complexities in the person's life are, I think there's always an opportunity to talk more with the carer … In hindsight, I think it would have been better or more useful to have Choe's and mum and dad's involvement all through the process, as they would have identified triggers and things we could have done differently with him, things that might trigger him, things that might help in de-escalation.

77 Dr Heble agreed that this was a missed opportunity with respect to Karl's care at the MHIU.[39]

78 Dr Brett also agreed with Dr Heble when he gave evidence at the inquest, stating: "*I think ongoing liaison with the family is essential. They know him better than anyone else.*"[40]

79 Dr Ugwu told the inquest that when he spoke to Chloe on 22 February 2023, she was very upset and crying.[41]

80 Dr Ugwu gave the following explanation as to why he had not communicated more with Chloe:[42]

> So we didn't have much prolonged periods of stability, so there wasn't much good news to give. We were struggling to get things under control. Maybe in hindsight I should have spoken to her more than I did, but I was trying to protect her. She had two young children and there wasn't much information to give her. I knew that other family members were also coming into the ward, but she was the next of kin. So when I look

[38] Ts p.254
[39] Ts p.255
[40] Ts p.416
[41] Ts pp. 24-25
[42] Ts p.49

> back, maybe I should have communicated better. Maybe I should have communicated, but it wasn't in any way to neglect anybody. It was more or less to protect her from this lack of good news, per se. So when things deteriorated further, I said, look, it's time for us to get her to know.
> ...
> Everything, in hindsight, looks - I could have changed that if I were to communicate now. But at the time, there was a reason why I did that. And it's purely because of what I perceived as her distressed state when I spoke with her the first time.

81 In her written statement to the Court, Chloe expressed her frustration regarding the lack of communication the MHIU had with her:[43]

> I took notes of the fluctuations of Karl's mental state, and the triggers. I had dated and detailed notes providing information, as well as Karl's own handwritten timeline he kept. These notes provided an insight into what could upset Karl. It's a shame I wasn't consulted regularly to help diffuse Karl rather than staff sedating him each time. I was always frustrated that no one would communicate Karl's treatment plan with me, and whenever I did call, I could never get hold of the person in charge.

82 Although it was unfortunate that no feedback and participation from Karl's family was sought to assist with de-escalating Karl's behaviour, I accept Dr Ugwu's explanation that his motivation in not having more to do with Chloe was a desire to give her a break from being provided with further negative updates.

83 However, I am satisfied that there was a missed opportunity by Dr Ugwu and/or his treating team to have further communications with Karl's family regarding their assistance to de-escalate Karl's behaviour which the MHIU (for the most part) was finding very difficult to manage. As I stressed to counsel or Dr Ugwu at the inquest, this is not an adverse finding made against Dr Ugwu. It simply means there was an oversight to take an advantage of a situation that existed.

84 I agree with Mr Johnson's observation that Dr Ugwu's motivation was "*misconceived but well-intentioned.*"[44]

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[43] Exhibit 2, p.2
[44] Ts p. 475 (closing submissions by Mr Johnson)

Was it appropriate to intubate Karl?

85 I am satisfied it was appropriate to intubate Karl. In so finding, I note the opinion of Dr Paterson:[45]

> Transportation options for acutely escalated psychiatry patients have inherent significant risk to the patient, medical staff and transportation staff. This includes not only aggression/physical risk in an unpredictable and closed environment, but also the risks to the patient of restraint or over-sedation (e.g. impaired airway reflexes, impaired ventilatory drive, hypoxia, aspiration pneumonia, hypertension, arrythmia, cardiac arrest).
>
> One way of mitigating risk is semi-elective induction of anaesthesia and intubation, in the otherwise healthy patient, for reason of psychiatric transfer. This procedure is not without risks of its own. This practice is accepted in Western Australia as necessary for some patients. Mr Steinhauser himself had previously been intubated for transfer from KHC to Rockingham General Hospital in May 2019.
>
> The decision to intubate came from a discussion between the treating consultant psychiatrist and the ED consultant on 9 March 2023. I note that the decision to intubate Mr Steinhauser was made in the absence of RFDS request or review. I also note the risk factors for behavioural disturbances detailed in Section 1.7 of the RFDS Western Operations Clinical Guidelines, (V13), many of which were evident here. In particular, "History of violent behaviour" and "Alcohol or drug use" highlighted as the biggest risk factors for recurrent violent behaviours. Given the circumstances, I am of the opinion that the decision to intubate for transfer was reasonable.
>
> There did not appear to be any major complications during the intubation, or in the immediate post-intubation period.

86 This opinion from Dr Paterson was not challenged at the inquest.

87 I also note Dr Kathirgamanathan's evidence at the inquest that he still would have intubated Karl if he knew he would remain intubated for 72 hours:[46]

> That would not have impacted my decision to support intubation. It would have mattered to do appropriate steps to provide prophylaxis treatment to minimise the risk of deep vein thrombosis.

88 I am satisfied that on the information available to me that Karl was provided with appropriate prophylaxis at the ICU. This was

[45] Exhibit 1, Volume 1, Tab 10.1, p.7
[46] Ts p.150

done via the administration of heparin[47] and the placement of thrombo-embolic deterrent (TED) stockings.[48]

Was security required for Karl's extubation?

89 Based on the information outlined below, I am satisfied it was appropriate for security to be present during Karl's extubation.

90 In her written statement to the Court, Dr Melanie Saw, the ICU consultant at FSH, provided the following:[49]

> The decision not to attempt extubation without the security team would have been influenced by different factors. The main issue would have been risk of harm - to the patient himself and then risk to staff and other patients. Of note, Mr Steinhauser had already had a two-week long admission in the Kalgoorlie Hospital Acute Psychiatric Unit and was displaying escalating aggression despite large doses of sedating and anti-psychotic medications. His behaviour had become so extreme that it was felt by the Kalgoorlie Hospital mental health team and the RFDS transferring doctor that a general anaesthetic and intubation was the only way to transfer him safely and manage his aggression.
>
> The psychiatry notes from Kalgoorlie Hospital also describe incidents pre-admission where family members felt unsafe and police were called. The downside of keeping Mr Steinhauser intubated included various risks, including ventilator associated pneumonia, pressure injuries, damage to vocal cords and trachea, deep venous thrombosis, pulmonary embolism, impaired cough, muscle wasting and side effects of the sedation (lowering of blood pressure and heart rate, constipation, delirium, and propofol infusion syndrome).
>
> ...
>
> Given the concerns regarding Mr Steinhauser's recent behaviour and the risks this posed, the advice from the psychiatry team was that it was necessary to have security staff present during the extubation in order to ensure his safety and the safety of other patients, visitors and staff within the ICU.

91 This evidence from Dr Saw was not challenged.

Mental health bed availability for Karl

92 The lack of beds for acutely unwell mental health patients is often a major issue at inquests. However, in this instance, the information

[47] Exhibit 1, Volume 2, p.1 of 7
[48] Exhibit 1, Volume 2, Tab 1.1, p.114
[49] Exhibit 1, Volume 1, Tab 22, pp.3-4

before the Court indicated that a bed was available for Karl from the afternoon of 10 March 2023.

93 It would not have mattered if there had been a bed available for Karl on 9 March 2023. That is because a transfer of a patient from the ICU to a mental health unit must take place between 8.00 am and 6.00 pm, "*as this is considered safer for patients due to availability of staff during working hours.*"[50]

94 Although Karl was admitted to the ICU just before 3.30 pm on 9 March 2023, a patient who is extubated must remain in the ICU for four hours post extubation. As Dr Marshall explained:[51]

> The requirement to remain in the ICU for four hours post extubation is to ensure airway and breathing are adequate, that sedation has fully worn off and that the patient can pass urine post Indwelling Urinary Catheter (IDC) removal. During this time, ICU staff need to be readily available in case any of these medical issues need attending to, or in the case of a potential ongoing agitation or violence from a patient, that there are enough staff to attend for emergency sedation.

95 These timelines would have prevented Karl's transfer to a mental health bed even if he had been extubated immediately upon admission to the ICU.

96 Given the regular shortage of mental health beds, I am satisfied that the availability of a bed for Karl within 24 hours of his admission to the ICU was very reasonable.

Lack of security available for an extubation on 10 and 11 March 2023

97 As I have already outlined above, although a bed was available at the MHAU on 10 and 11 March 2023, security was not available to be present for the extubation on either of those days.

98 The information provided to the Court regarding this matter was outlined by Dr Marshall:[52]

> Unfortunately, the Security Office was unable to source enough staff to provide the several security specials occurring at the hospital at the time. This was due to staff sick leave, the number of Security Specials required and the resources available to them. Security staff do not

[50] Exhibit 1, Volume 2, Tab 8, pp.5-6
[51] Exhibit 1, Volume 2, Tab 8, p.7
[52] Exhibit 1, Volume 2, Tab 8, p.7

> determine which patient they should provide officers for, that is a manner for the clinical staff and hospital coordinators to determine.

99 Dr Marshall was part of a desktop review of the care provided to Karl at FSH that was conducted by a panel that included medical clinicians and the Head of Security (the desktop review).[53] As to the unavailability of security to be present during Karl's extubation on 10 and 11 March 2023, the desktop review concluded:[54]

> It is not unusual for involuntary mental health patients in a resuscitation area of the Emergency Department (ED) to require security and there can be a significant fluctuation in the need for security, which at times can be an extraordinary demand. During Mr Steinhauser's admission to ICU the security team had limited resources due to illness and other high-risk patients in the hospital requiring 1:1 security. The panel were informed that during the period 10-11 March 2023 there was security special required in the Mental Health Youth Ward, the ED and then on a medical ward once the ED patient was transferred. The panel considered that the decision not to relocate the available security resources from their duties to the ICU to expedite the transfer of Mr Steinhauser was, in all the circumstances, a reasonable decision.

100 As to the number of security personnel at FSH at the time of Karl's ICU admission, there was a control room officer, a lead patrol officer, and four patrol officers. This meant there was a total of five security officers who could respond to the needs of the hospital.[55]

101 At the inquest, Dr Marshall provided further evidence regarding the unavailability of security on 10 and 11 March 2023. Although there was a pool of 18 casual staff that security had access to (the pool), a number of staff from the pool had already come in to meet extra demand during that period.[56] On 9 March 2023, three additional security officers from the pool were called in, on 10 March 2023 three were also called in, and on 11 March 2023 one was called in from the pool.[57] However, if the pool was exhausted, there was no other plan in place to address a further demand for security.[58]

102 Unfortunately, Dr Marshall was unable to answer my question as to whether there were any efforts by security to acquire an additional officer to deal with the request regarding security for Karl on either

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[53] Exhibit 1, Volume 2, Tab 8, p.3
[54] Exhibit 1, Volume 2, Tab 8, p.9
[55] Ts p.315
[56] Ts pp.296-297
[57] Ts p.317
[58] Ts p.298

10 or 11 March 2023.[59] Nor was Dr Marshall able to answer the question whether other requests for security between 9 - 11 March 2023 had not been fulfilled.[60]

103 At the inquest, Dr Marshall was asked by Mr Johnson why the panel concluded that the decision not to reallocate available security to Karl on 10 and 11 March 2023 was a reasonable one. Dr Marshall answered:[61]

> I think, on the basis that there was demand elsewhere in the hospital, that was deemed more a potential risk.
>
> But how did you do that? How did you assess that the demand for the other security staff meant that there wasn't somebody available to reallocate? --- So, looking at the demand that was on the hospital from those patients, as I said, there's a balance of risk to be judged, and that was the conclusion we came to, that that judgment had been - was reasonable.

104 I am satisfied that the delay in extubating Karl due to no security being available was a rare occurrence. Ms Caulker had never encountered another situation where that had arisen in her three years working for the Mental Health Consultation Liaison Service at FHS.[62] Similarly, Dr Saw said that such a scenario was "*not often*", and had previously occurred "*a long time*" before Karl's incident.[63]

105 As it transpired, on 12 March 2023 no security personnel ended up being physically present during Karl's extubation. As Dr Saw explained:[64]

> The security team had been informed of our plan to extubate Mr Steinhauser but only arrived shortly before the event. They were not in the room at the time of extubation. As he was calm and cooperative, the security team left soon after.

106 The subject matter of procedures and policies regarding security presence for involuntary patients was the subject matter of some discussion during closing submissions at the inquest. Subsequently, I sought additional information from SMHS regarding this matter. As mentioned earlier, the SSO provided a response from SMHS in a letter

[59] Ts p.318
[60] Ts p.319
[61] Ts p.319
[62] Ts pp.110-111
[63] Ts p.199
[64] Exhibit 1, Volume 1, Tab 22, p.6

to the Court that is exhibit 9. That letter provided the following information:[65]

> The South Metropolitan Health Service was asked to confirm whether at the time of Karl's death, as a matter of course/general rule, was a security escort required for an involuntary mental health patient being transferred from the Emergency Department (ED) or the Intensive Care Unit (ICU) to the Mental Health Assessment Unit (MHAU) and if so, whether one or two security guards were required.
>
> [I]n practice, it is understood a security officer is always present when psychiatric patients are being extubated in the ICU.
>
> The South Metropolitan Health Service confirms there is no policy that stipulates that patients being transferred from the ICU or the ED to a mental health ward, including MHAU, must be accompanied by security officers. Rather, it is considered a matter of common sense and clinical judgement.
>
> ...
>
> Whilst no policy requires security presence, it is understood a security officer is always present when psychiatric patients are being extubated in the ICU of the Fiona Stanley Hospital (FSH).
>
> In relation to Karl, FSH had information from the Kalgoorlie Hospital regarding Karl's mental state, prior to intubation. In Karl's case, it is understood that to mitigate potential risks to staff and other patients, the MHAU recommended to the ICU that security be present for extubation in the ICU. This recommendation was based on the history that was provided from Kalgoorlie Hospital and also taking into consideration the patient himself. Karl was a well-built man, who if became aggressive, would be very challenging to manage in the ICU environment. The MHAU also required security staff to be present on the ward for him to be admitted which would include having security staff accompanying him from ICU to the MHAU.
>
> It appears the ICU accepted the recommendation. As indicated in the oral evidence of Dr Saw, if Karl's clinical presentation had deteriorated, the ICU could have decided to extubate Karl without security.
>
> Whether one or two security officers is required is considered a matter for security to decide, based on the information available to them.

107 As pointed out on behalf of the family by counsel in his closing submissions at the inquest and by his instructing solicitors in their written submissions to the Court dated 19 December 2023, a number of questions remain unanswered as to the precise efforts made to have security available for an extubation on either 10 or 11 March 2023.

[65] Exhibit 9, p.4

However, the ability of the Court to find answers to these questions has been hamstrung by the passage of time and the absence of a SAC1 investigation regarding the care provided to Karl at FSH. This second matter is dealt with later in this finding.

108 It was regrettable that even though there was a bed available for Karl on 10 and 11 March 2023, his extubation could not take place on either of those days due to the unavailability of security to be present during his extubation. As I have already found, I am satisfied it was appropriate for security to be present during the extubation process. Given Karl's previous behaviour, there was a level of risk his aggressive behaviour might return once he regained consciousness.

109 It is troubling that no security was available on either of these two days. However, based on the information available to me, I accept that this event was a rare one. Furthermore, and notwithstanding its limited investigation, there was no information before me to contradict the conclusion by the desktop review that reasonable steps were taken to find security personnel who could be present during the extubation process. In those circumstances, and applying the ***Briginshaw*** principle, no finding can be made against SMHS that inadequate efforts were made to find security for an extubation on either 10 or 11 March 2023.

Was Karl's death preventable?

110 Dr Paterson was asked whether there were any signs of "red flags" that meant Karl should have been extubated before 12 March 2023. Dr Paterson answered: "*No*".[66] Nor did he think there were any "red flags" for those clinicians who treated Karl at KHC that indicated he might have pulmonary embolism or that a blood clot was forming.[67] Dr Paterson agreed that the pulmonary embolism was "*unexpected*"[68] and with respect to whether it was not predictable, he answered: "*We would expect a certain percentage of intensive care unit patients to have deep vein thrombosis and pulmonary embolus, but for any one individual, it is an unpredictable event, yes.*"[69]

111 The desktop review noted:[70]

> With the benefit of hindsight, the panel did not identify any alternative steps that could have been taken with respect to treatment of the

[66] Exhibit 1, Volume 1, Tab 10.1, p.10
[67] Ts p.365
[68] Ts p.382
[69] Ts p.382
[70] Exhibit 1, Volume 2, Tab 8, p.4

> Deep Vein Thrombosis (DVT) or Pulmonary Embolism (PE) whilst he was in the care of FSH, based upon the information that was known to treating medical staff at the time.

112 The desktop review also conferred with the consultant haematologist who was part of the panel that undertook the SAC1 investigation. Dr Marchall's written statement to the Court outlined what this haematologist had noted:[71]

> ... it was possible that the DVT formed in the initial part of Mr Steinhauser's presentation to hospital elsewhere, including the initial sedation and transfer by RFDS and noted that the speed of which a DVT forms and embolises is very variable. The median time for a DVT to present with symptoms is one week post immobilisation, and the approximate median time for a PE is two weeks or longer, following immobilisation. However, DVT and PE can become evident in hospital, even during or shortly after surgery. The haematologist expressed the opinion that it is impossible to say when the DVT formed, whether it embolised immediately or whether DVT was present and worsening for a few days beforehand.

113 In those circumstances, I accept the desktop review panel's observation that: "*It was considered highly unusual that a PE developed in the circumstances.*"[72]

114 The consultant haematologist had also indicated to the desktop review that, "*earlier extubation could have reduced the risk of a DVT or PE, however it may not have prevented it.*"[73] Dr Marshall's written statement to the Court said that the desktop review "*did not form the same view*".[74]

115 As there was no explanation why it had not formed that view, I asked Dr Marshall what was the contrary view held by the desktop review. He explained that the Head of Service of the ICU (a member of the desktop review) expressed the opinion that it was an exceptionally rare event for a patient who did not have an underlying blood disorder, to experience a thromboembolic event such as the one Karl had after a short period of immobilisation and intubation.[75] The desktop review agreed with this opinion and that was why Dr Marshall had made the comment cited above in his written statement.

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[71] Exhibit 1, Volume 2, Tab 8, p.4
[72] Exhibit 1, Volume 2, Tab 8, p.3
[73] Exhibit 1, Volume 2, Tab 8, p.5
[74] Exhibit 1, Volume 2, Tab 8, p.5
[75] Ts p.303

116 It is therefore evident that given this explanation from Dr Marshall, the desktop review did not actually have a differing view, and I accept Dr Marshall's explanation at the inquest that he may have been "*clumsy*" in how he tried to describe it in his written statement.[76]

117 Given the specific expertise of the consultant haematologist, I accept his opinion that an earlier extubation could have reduced the risk of deep vein thrombosis or pulmonary embolism. I also note that Dr Paterson's view was similar; namely, that a shortening of Karl's duration of ventilation would have likely reduced his risk of venous thromboembolism.[77]

118 Nevertheless, I am unable to make a finding that an extubation on 10 or 11 March 2023 would have prevented Karl's death. Neither the consultant haematologist nor Dr Paterson were able to say that.

The lack of a SAC1 investigation by SMHS

119 Although WACHS conducted a SAC1 investigation regarding the care provided to Karl at KHC, no such investigation was undertaken by SMHS regarding Karl's care at FSH.

120 Dr Brett was critical of this failure:[78]

> I do not understand why a SAC1 [investigation] was not undertaken at FSH. This was not a natural or expected death, it was extremely unnatural and unexpected. I believe that a SAC1 should have been undertaken by Fiona Stanley Hospital. The benefits would be to review the process of transferring intubated mental health patients from the regions, having access to mental health beds and ensuring there are sufficient security staff to appropriately manage clients like this.
>
> SAC1 investigations should be root cause analyses to address the key issues as to why tragic events occur. It should then make recommendations to learn from them to ensure they do not occur again. This would highlight the issues to senior management to ensure changes are made. This is Anthony Maden 101 risk management.[79]

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[76] Ts p.302
[77] Exhibit 1, Volume 1, Tab 10.1, p.11
[78] Exhibit 1, Volume 1, Tab 11.1, p.13
[79] This is a reference to the publication by Anthony Maden: *Treating Violence: A Guide to Risk Management in Mental Health* (2007)

121 At the inquest, Dr Marshall agreed that a SAC1 investigation by SMHS should have taken place.[80] At the inquest, he also agreed that this was not because of hindsight, it was what should have been the assessment made at the relevant time.[81] That concession from Dr Marshall was appropriate.

122 Dr Marshall was of the view that the delays incurred for Karl's extubation required a SAC1 investigation.[82] In addition, he agreed that the best description of what happened with the SAC1 investigation not taking place was "*an oversight of some significance*".[83]

123 I also agree that this is the best description for what occurred. The magnitude of the oversight only increases when it is noted that the WACHS SAC1 investigation had actually referred its review to FSH and noted: "*The care provided during the patient ICU admission at the Tertiary site has been referred for consideration of site-based review and action (recommendations) if required.*"[84]

124 The desktop review did not take place until mid-May 2025, and only after Dr Marshall became aware of the coronial investigation.[85] Consequently, it occurred approximately two years after the SAC1 investigation would have been expected to take place.

125 The problems with that delay are obvious. At the inquest, Dr Marshall said that a SAC1 investigation "*would have been more robust*" than the desktop review.[86]

126 Furthermore, as Mr Johnson pointed out in his closing submissions at the inquest, although three security officers from the casual pool of 18 officers were called in during the 10 and 11 March 2023 to attend to other matters at FSH, "*we don't know how many of the 15 were contacted to see whether they were available*" to attend Karl's planned extubation on either of those days.[87]

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[80] Ts p.324
[81] Ts p.324
[82] Ts pp.324-325
[83] Ts p.325
[84] Exhibit 1, Volume 1, Tab 16, p.10
[85] Ts pp.325-326
[86] Ts p.84
[87] Ts p.482 (closing submissions of Mr Johnson)

127 As I later noted at the inquest: "*The moment has passed for a thorough investigation of this to take place*".[88] The time for this thorough investigation was when the SAC1 investigation by SMHS should have taken place.

128 I am therefore satisfied that the failure to undertake a SAC1 investigation by SMHS was a significant one. As a result of this oversight, it was very difficult for the Court to examine, in any great detail, the efforts made to have a security officer present for Karl's extubation on 10 or 11 March 2023.

129 The sad irony for Karl's family is that the extubation on 12 March 2023 went ahead without security being present (although they were close by).

QUALITY OF KARL'S SUPERVISION, TREATMENT AND CARE

At KHC

130 Although I am satisfied that the supervision, treatment and care of Karl whilst he was at the MHIU at KHC was adequate, this finding is made with one important qualification. It was adequate given the significant impediments that existed in the MHIU. As Dr Ugwu pointed out in his written statement to the Court:[89]

> The MHIU in Kalgoorlie is an open authorised ward with restricted access.
>
> It has no Snoezelen room (the relaxing space that helps reduce agitation and anxiety) or seclusion room.
>
> ...
>
> His [Karl's] management was extremely challenging considering the limitations of managing acutely aggressive and agitated patients in MHIU Kalgoorlie.
>
> ...
>
> We did not have the adequate facilities to manage him in the Kalgoorlie mental health ward.
>
> ...
>
> The only place to transfer patients we could not manage in Kalgoorlie due to agitation and aggression was to Perth.

[88] Ts p.485
[89] Exhibit 1, Volume 2, Tab 9, pp.14-15, 30-31

131 Dr Brett was particularly scathing of the MHIU in his report for the Court: "*I do not believe that the facility is fit for purpose. I do not understand how it is gazetted as an authorised facility.*"[90]

132 When asked by his counsel what a fit-for-purpose mental health facility at KHC would look like, Dr Ugwu replied:[91]

> Well, it would be a proper unit that is, in some places, you have different wings for males, females. So when patients are agitated, they don't mix up, and some can be sexually disinhibited and things like that don't happen on the unit. A proper unit would have a proper ward with rooms, individual rooms, where patients would be looked after … have a proper common area with open courtyard, where patients can easily go and ventilate when they are very agitated. And it should also have a Snoezelen room - as I said earlier on - a seclusion room to make sure patients are isolated from the unit, from the rest of the patients. In a properly built psychiatric unit there should also be an ECT suite where the patients get ECT treatment if they need it.
>
> And of course it would be staffed by different specialties, occupational therapists, social workers, psychologists, the nursing staff and doctor, and even - yes, with access to dietitians and different non-allied, different allied health professionals that would help us manage patients on the unit. So in Kalgoorlie, … most times, it was … doctors that worked with me, myself, nurse manager on the unit and a social worker. I think the social worker was just there for three months, and that was it.

133 I am also satisfied that the treatment and care Karl received at the ED and the HDU at KHC was appropriate.

At FSH

134 I am satisfied that the supervision, treatment and care provided to Karl by health service providers in the ICU at FSH was appropriate. This included the extensive efforts to resuscitate Karl following his extubation. In so finding, I note that Dr Paterson expressed the view that Karl's treatment and care in the ICU was appropriate in his report to the Court and his evidence at the inquest. I also note that no submission was made to the contrary by counsel for Karl's family.

135 The only issue of an otherwise appropriate level of care provided to Karl was the unavailability of a security officer to be present during an extubation on either 10 or 11 March 2023. On the information (albeit

[90] Exhibit 1, volume 1, Tab 11.1, pp.11-12
[91] Ts pp.102-103

limited) available to me, I am satisfied there was a reasonable explanation for this not taking place.

136 Although the evidence fell short of establishing that an earlier extubation would have prevented Karl's death, I appreciate the concerns expressed by Karl's family that the extubation could not take place once a mental health bed was available. It was regrettable that the timely availability of a bed (which is so often not the experience of the Court) could not be utilised for Karl.

IMPROVEMENTS SINCE KARL'S DEATH

137 As would be expected of all government entities, SMHS and WACHS are always on the pathway of continual improvement with respect to the treatment and care of patients requiring their services. Given there is ordinarily a gap of some duration between the date of the death requiring a mandatory inquest and the date of the inquest, the entities connected to the death will often implement changes that are designed to improve practices and procedures before the inquest is heard.

138 In addition, when the death occurs in a hospital setting, a SAC1 investigation is usually completed well before the inquest has commenced. As was the case with the WACHS SAC1 investigation after Karl's death, they will frequently make recommendations designed to implement improvements.

Improvements by WACHS

139 At the inquest, Dr Kathirgamanathan said that he had not been provided with any guidelines as part of his locum placement in the ED at KHC. Although Dr Heble indicated guidelines would have been available, they were not easy to navigate at that time. He advised the Court that WACHS had recently implemented an intranet page for ED doctors, including locums, to address that issue to make the relevant guidelines easily identifiable.[92]

140 Dr Heble also acknowledged that Karl's case highlighted the importance of consistently involving a patient's next of kin in care planning. Following the recommendation from the WACHS SAC1 investigation, the mental health arm of WACHS has initiated a

[92] Ts p.435

structured project to enhance care, and an audit completed in mid-2024 has shaped a service-wide action plan to enhance carer involvement.[93]

141 Since Karl's death and noting the relevant recommendations from their SAC1 investigation, WACHS identified several sedation-related policies were due for review and have used this as an opportunity to undertake a system-wide review.[94]

142 With respect to sedation during transfers, in May 2024, WACHS published the *Acute Behavioural Disturbance in Emergency Department's Guideline.* This guideline standardises sedation practices, de-escalation approaches, and legal considerations across all sites. Complimenting this, the recently created TTO was introduced to ensure structured communication and risk mitigation during high-risk transfers. Following a successful trial across three regional sites, TTO has now been endorsed for system-wide implementation.[95]

143 Karl's death has also led to a strengthening of the VTE assessment and documentation processes, particularly within nursing care plans during inter-ward transfers at WACHS. The improvements that have been introduced has now meant there are better communications between department leads (including the security department).[96]

144 There is no doubt that the facilities available in the MHIU at time of Karl's admission were substandard. At the inquest, Dr Heble outlined the resources that were not available to Karl at that time, which are now present at the MHIU. They include lived experience persons, in-reach peer support workers, social workers, occupational therapists and an art therapist.[97] However, the inadequate infrastructure housing the MHIU remains.

Improvements regarding security staffing at FSH

145 Dr Marshall outlined the improvements that have been made at FSH regarding the number of security personnel available. The causal pool has been expanded from 18 staff to 24 and there are now two security officers in the control room instead of one, and one extra patrol officer, making a total of six patrol officers on the floor.[98]

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[93] Exhibit 1, Volume 2, Tab 11, p.5
[94] Exhibit 1, Volume 2, Tab 11, p.6
[95] Exhibit 1, Volume 2, Tab 11, p.6; Exhibit 1, Volume 2, Tab 12
[96] Exhibit 1, Volume 2, Tab 11, pp.6-7
[97] Ts p.436
[98] Ts pp.436-437

RECOMMENDATIONS

The MHIU at KHC

146 It is not in issue that the MHIU was a suboptimal environment to treat acutely unwell mental health patients at the time of Karl's admission. I have already outlined the views expressed by Dr Ugwu and Dr Brett regarding its inadequacies.

147 In his report for the Court, Dr Heble noted that the MHIU is not a purpose-built mental health unit and therefore is not appropriately designed to manage highly agitated or aggressive patients.[99]

148 Planning is already underway for a purpose-built mental health unit at KHC. As Dr Heble noted:[100]

> WACHS fully acknowledges the limitations of the current non-purpose built ward and the impact this has on patient care. Having the purpose built MHIU will reduce the need for patients to be transferred to metropolitan secure beds and all the challenges related to their transfer.

149 It is almost trite to say that the existence of such a facility in March 2023 may have reduced the risk of Karl's death.

150 The shortcomings of the MHIU were highlighted in an inquest before Coroner Michael Jenkin in January 2022.[101] This inquest concerned the suicide of an involuntary patient who had absconded from the MHIU in August 2018. In his concluding remarks in the Court's finding, Coroner Jenkin stated:[102]

> Mr Williams' death highlights systemic issues faced by clinicians tasked with delivering mental health services in regional areas of Western Australia, including staff shortages and the standard of mental health facilities. It is patently obvious that the current mental health impatient facilities at KHC are not fit for purpose. As I have explained, the evidence before me is overwhelmingly in support of a purpose-built mental health facility and it is my sincere hope that the Government will urgently fund this desperately needed resource.

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[99] Exhibit 1, Volume 2, Tab 11, p.5
[100] Exhibit 1, Volume 2, Tab 11, p.5
[101] ***Inquest into the death of Jordan James Williams*** [2022] WACOR 16
[102] ***Inquest into the death of Jordan James Williams*** [2022] WACOR 16 [210]

151 One of the three recommendations from this finding was:[103]

> **The Western Australian Country Health Services (WACHS) should urge the Department of Finance to fast-track the WACHS proposal to construct a purpose-built mental health facility at the Kalgoorlie Health Campus so that construction of the facility can start as soon as possible. WACHS should also undertake detailed planning to ensure that when opened, the new facility is appropriate staffed by mental health and allied health professionals.**

152 Unsurprisingly, I fully endorse this recommendation from Coroner Jenkin (which I note was made nearly four years ago). As to a recommendation regarding this purpose-built facility, I invited WACHS to propose how that recommendation should be drafted. The SSO provided the following response on behalf of WACHS:[104]

> The WA Country Health Service respectively declines this invitation, as it considers that given the progress of the planning process to date, a proposed recommendation would require the WA Country Health Service to propose a recommendation with respect to a funding decision. As funding decisions are decisions for the executive arm of government, the WA Country Health Service does not consider it appropriate to suggest the working of a recommendation in these circumstances.

153 Taking note of that response, I am satisfied the following recommendation is appropriate:

Recommendation No.1

In order to provide appropriate treatment to acutely unwell mental health patients in the Goldfields region without the need to transfer them to Perth for their treatment, the Court remains committed in its support for the construction of a purpose-built mental health facility at the Kalgoorlie Health Campus and recommends it be undertaken as soon as possible.

[103] ***Inquest into the death of Jordan James Williams*** [2022] WACOR 16 [206]
[104] Exhibit 9, p.3

Improving the referral and transfer process of rural and regional mental health patients to metropolitan hospitals

154 In his opening address at the inquest, counsel assisting raised the question whether a joint-targeted review was required regarding the referral and transfer practices of regional mental health patients to metropolitan hospitals.[105]

155 The wording of a recommendation or recommendations in this area was considered during the course of the inquest. After taking further instructions, the SSO provided further information regarding these matters on behalf of WACHS, SMHS, the Department of Health and the Mental Health Commission. I express my appreciation to these entities for the helpful information they provided in exhibit 9.

156 I have agreed with those submissions and have adopted the suggested wording of the two proposed recommendation put forward, with some minor changes.

> ***Recommendation No.2***
>
> **To improve the transfer of rural mental health patients to metropolitan hospitals and for the reasons outlined in Appendix 7 of the *Statewide Mental Health Bed Access, Capacity and Escalation Policy 2025* (Version 1.2, released in July 2025) (the Policy), a working group be established that is co-led by WACHS and the Department of Health State Health Operations Centre, with input from the Mental Health Commission and the Office of the Chief Psychiatrist and other relevant stakeholders. The purpose of the working group is to ensure processes are in place to support the implementation of the Policy, particularly the referral and transfer practices, including a fast-track trial prioritisation process, of rural and regional mental health patients to metropolitan hospitals.**

157 In order to monitor the outcomes of polices, investment in infrastructure and the working group referred to in the above recommendation, I also make the following recommendation:

[105] Ts p.11

Recommendation No.3

The Department of Health, in collaboration with relevant stakeholders across the State's health system, develops a system level process that provides oversight for the quality of care of interhospital transfers of mental health patients from rural and regional areas who are under the *Mental Health Act 2014* (WA). This should include regularly reporting the numbers and modality of transfer by site (whether intubated or sedated), any morbidity or mortality related to transfer (inclusive of effects of intubation/ sedation) subsequently detected, and whether the underlying reason for transfer relates to considerations such as a lack of specialised mental health infrastructure at the referring site.

CONCLUSION

158 Karl was a dearly loved partner, father and family member who was only 30 years old when he died from a pulmonary thromboembolism.

159 All too frequently the Court encounters caring, compassionate and thoughtful people who have died from complications of the terrible scourge of a major mental illness. When these people suffer a relapse of their mental illness, they can behave as completely different people, and are frequently held in mental health wards for extended periods of time on an involuntary basis. Sadly, because of these relapses and the strain it places on their bodies, and in combination with treatment-resistance to medications, these people may die when in hospital care. Sadly, Karl has become another person to be added to this lengthy list.

160 Although I was satisfied of the supervision, treatment and care provided to Karl when he was in the MHIU at KHC, that finding was made with a not insignificant qualification. Namely, it was appropriate given the inadequate resources available to the MHIU to treat patients with an acute mental illness who are displaying aggressive behaviour.

161 I was satisfied that the medical treatment and care provided to Karl at the ICU in FSH was appropriate. Unfortunately, Karl's supervision at FSH was blighted by the fact that security was not available when the ICU was ready to extubate him on 10 and 11 March 2023. From the information available to me, I am satisfied an extubation on either of

those days may have lowered the risk of Karl's death; however, I am not able to say whether his death would have been prevented.

162 Nevertheless, I completely agree with the following observations made by Dr Paterson at the inquest:[106]

> It is certainly undesirable to have a patient transferred for means of psychiatric reasons, ventilated for any reason at all. It is undesirable that they have protracted ventilation in intensive care unit. It's undesirable that they leave their home base - home city. Unfortunately, it is an unfortunate consequence of the structure and limitations under which we work. It – everybody would have wanted Karl to be extubated and go to a mental health bed, but it was unable to be achieved because of structural limitations.[107]

163 I am satisfied that following Karl's death, WACHS and SMHS have implemented changes and improvements that should lead to a higher standard of monitoring and care for mental health patients who are transferred from rural and regional areas of Western Australia to metropolitan hospitals in Perth.

164 However, further improvements are required; particularly with respect to the construction of a purpose-built mental health unit at KHC. I have made a recommendation to that effect, with two other recommendations designed to further enhance the transfer practices of rural and regional mental health patients to metropolitan hospitals.

165 On behalf of the Court, and as I did at the conclusion of the inquest, I extend my condolences to the family of Karl for their sad loss.

166 I conclude with these words from Chloe:[108]

> On 12 March 2023, the love of my life Karl passed away. He tragically died on our daughter Zadie's 2nd birthday. Five months after our second daughter, Ziggy was born. One month after he'd turned 30. Just like that, the world swallowed my world leaving a massive hole that can never be filled.
>
> Karl is unforgettable. A gentle giant. The most unique character you'd ever meet. The friendliest guy who would help anyone. One thing is for sure, there is no one like Karl. Not even close.

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[106] Ts p.395

[107] Dr Paterson later confirmed that the "structural limitations" he was referring to concerned the absence of security staff: Ts p.395

[108] Exhibit 2, pp.1 and 5

> We were each other's perfect match. We got each other in ways no one else ever could. Always free to be completely ourselves together. He always had my back, and I always had his. I loved every cubic inch of Karl; how lucky I was to have had so much to cuddle. Karl and I took care of each other, mentally, emotionally and spiritually.
>
> ...
>
> While my first wish is for Karl to still be alive, my only next wish I can settle for is that the truth of exactly what happened to Karl is determined, that where human error is found, change can be enforced and followed through with and then hopefully, I can try to begin my journey into acceptance and to try find a way to enjoy my life for the sake of my children.

PJ Urquhart
Coroner
23 December 2025