JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	BRENDYN DEAN NELSON, CORONER
HEARD	**:**	16 JULY 2026
DELIVERED	**:**	7 AUGUST 2026
FILE NO/S	**:**	CORC 83 of 2025
DECEASED	**:**	BUSWELL, BRADLEY CRAIG

Catchwords:

Nil

Legislation:

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

Counsel Appearing:

Mr G Chin assisted the Coroner

Ms K Dias and Ms H Quinlan (State Solicitor's Office) appeared on behalf of the WA Country Health Service

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

Nil

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Brendyn Dean Nelson, Coroner, having investigated the death of ***Bradley Craig BUSWELL*** *with an inquest held at Bunbury Magistrates Court, 3 Stephen Street, BUNBURY, on 16 July 2026, find that the identity of the deceased person was* ***Bradley Craig BUSWELL*** *and that death occurred* ***on 31 March 2025*** *at* ***13 Bobin Street, Eaton****, from* ***combined drug toxicity*** *in the following circumstances:*

Table of contents

Introduction

1 Bradley Craig Buswell died on 31 March 2025 at his home in Eaton, at 41 years' of age. Bradley[1] was a much-loved member of his extended family.

2 Bradley had been diagnosed with schizophrenia in 2021 after a precipitous decline in his mental health in the preceding 12 months.

3 His illness was ultimately determined to be treatment-resistant, and was characterised by chronic psychotic symptoms (particularly somatic and persecutory delusions), limited insight and negative symptoms with marked social and occupational impairment.[2]

4 At discharge from Bunbury Hospital in May 2021 (following transfer from Graylands Hospital), Bradley was made the subject of a community treatment order under the *Mental Health Act 2014* (WA), to be managed by the Bunbury Community Mental Health Team (**BCMHT**).

5 Bradley consistently engaged with his case managers and supervising and treating psychiatrists within that service, including with the strong support of his grandmother, with whom he lived in Eaton, as well as his father and his sister. He also enjoyed effective and consistent care from a support worker provided through NDIS funding.

6 Bradley was the subject of a further community treatment order made on 12 August 2022 (**CTO**), which was continued periodically after that date, and until Bradley's death.

7 The CTO was continued regularly in the context of Bradley's diagnosed illness, his need for ongoing treatment, the risks involved should he relapse, his limited capacity to consent to treatment, and where he had conceded that he would disengage from mental health services and stop taking medication if not compelled to do so.

8 In the late morning of 31 March 2025, Bradley was found in his bedroom by his great-aunt. He appeared to have collapsed and was not breathing. Despite the sustained efforts of family members who were present, his support worker and paramedics, he could not be resuscitated.

[1] Bradley's family requested that he be referred to by his first name at the inquest, and I have adopted the same approach in these findings.
[2] Exhibit 1, tab 21, par [27].

9 The CTO was an involuntary treatment order[3] which remained in place as at the date of Bradley's death, and as a consequence:

(a) Bradley was an involuntary patient under the *Mental Health Act* immediately prior to his death;[4]

(b) Bradley was therefore a '*person held in care*' within the definition of that term in the *Coroners Act 1996* (WA);[5] and

(c) an inquest was required to be held to investigate his death.[6]

10 I held the mandatory inquest in Bunbury on 16 July 2026.

11 Bradley's family, including his sister, father, grandmother and great-aunt, attended the inquest. Prior to the hearing, Bradley's family provided a succinct, objective and highly articulate letter to the Court, outlining their views as to the circumstances of his death, and their concerns about systemic issues that they consider impacted on his treatment.

12 The letter was to the tremendous credit of Bradley's family – not just because it assisted the Court, and the WA Country Health Service (**WACHS**) (appearing as an interested party, as the health service encompassing the BCMHT) to clarify the issues, but because of its grace in expressing gratitude to the staff of the BCMHT for the personalised care, compassion and genuine concern they extended to Bradley.[7]

13 As part of the inquest, I am required to make findings as to Bradley's cause and manner of death, if possible.[8]

14 Postmortem pathological testing demonstrated that at the time of his death, there were very high, and in some cases fatal, levels of olanzapine, mirtazapine and doxylamine in Bradley's system. The forensic pathologist who conducted Bradley's postmortem examination formed the opinion that the cause of his death was combined drug toxicity.

15 Bradley's ingestion of medication prior to his death was unwitnessed.

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[3] *Mental Health Act* s 21(2)(b).
[4] *Mental Health Act* s 21(1).
[5] *Coroners Act* s 3.
[6] *Coroners Act* s 22(1)(a).
[7] Exhibit 1, tab 20, p 4.
[8] *Coroners Act* s 25.

16 There was also very limited evidentiary material, beyond the toxicological findings, from which findings could be inferred about exactly how, when and why Bradley ingested substantial amounts of his medications.

17 As a consequence, to assist in making a finding as to manner of death, evidence was sought from witnesses to best understand Bradley's presentation in the lead up to his death.

18 An expert opinion was also obtained from Dr David Joyce, a qualified medical practitioner and Emeritus Professor at the University of Western Australia, with specialties in pharmacology and forensic toxicology, who provided the Court an expert opinion on the results of the postmortem toxicology, including what could be inferred as to timing, and quantities of the medications ingested.

19 For the reasons that follow, although I am satisfied that Bradley's cause of death was combined drug toxicity, it has not been possible to make a finding as to the manner of Bradley's death and I make an open finding.

20 I am also required to comment on the quality of the supervision, treatment, and care that Bradley received whilst subject to the CTO,[9] and may comment on any matter connected with Bradley's death, including public health or safety or the administration of justice.[10]

21 Having regard to the documentary material, including the letter from Bradley's family, the inquest focused on issues including:

(a) the quality of the care Bradley received while on the CTO, generally;

(b) whether there were any treatment options available to Bradley that were not pursued but ought to have been, including a further attempt at trialling clozapine after an unsuccessful attempt in 2022;

(c) attempts made by the BCMHT to refer Bradley for maintenance electroconvulsive therapy (**ECT**) in Fremantle, after initial ECT appeared to have caused improvement;

(d) Bradley's compliance with prescribed medications, including his concerns about and attitude towards oral olanzapine;

[9] *Coroners Act* s 25(3).
[10] *Coroners Act* s 25(2).

(e) relatedly, how depot olanzapine came to be unavailable in mid-2024, and its impact on Bradley's treatment and care;

(f) Bradley's presentation to family, his support worker and BCMHT clinicians in the week prior to his death, particularly during a clinical review with his supervising psychiatrist, treating psychiatrist and case manager on 27 March 2025;

(g) relatedly, whether there were any indications (including during the 27 March review) that Bradley may have been stockpiling his medications;

(h) whether existing prescription regimes, including controls, are adequate to manage the risk of mental health patients stockpiling medication and overdosing; and

(i) the quality of communication between the BCMHT and Bradley's family, generally and closer to the date of his death.

22 To address all of these matters, I received the documentary evidence in the coronial brief, and the following witnesses gave evidence:

(a) Dr Joyce;

(b) Mr Antonio Zampogna, who was Bradley's support worker from Care Support Connect;

(c) Mr Luke Hislop, a registered nurse with qualifications and experience in mental health nursing, who was Bradley's BCMHT case manager at the date of his death;[11]

(d) Dr Daniel de Klerk, a consultant psychiatrist within the BCMHT since 2020 with over 25 years' experience in psychiatry, and from August 2022 Bradley's consultant and supervising psychiatrist for the purposes of his CTO;[12] and

(e) Dr David Townsend, a psychiatry registrar within the South West Mental Health Service from 3 February 2025,[13] who was part of the BCMHT review with Bradley on 27 March.

[11] Exhibit 1, tab 19, pars [1]-[8].
[12] Exhibit 1, tab 21, pars [1]-[14].
[13] Exhibit 1, tab 18, pars [1]-[5].

23 At the conclusion of the oral evidence, I invited Bradley's family, in attendance at the inquest, to provide any additional information.

24 Bradley's sister addressed the Court about the course of her brother's illness, and what the family had observed at different times, including his extreme fear of death, reflected in the somatic complaints consistently observed by clinicians during Bradley's treatment.

25 Bradley's family also supplied some further information to the Court after the inquest about Bradley's personality, hobbies and background, which I have not received as a formal exhibit, but which I have read and relied upon in making my findings, as follows.

26 In response to questions that arose during the inquest about the availability of ECT in Bunbury, and Bradley's consent for WACHS to release information to his family, the solicitors acting for WACHS produced a response, by letter dated 27 July 2026 from the Executive Director Clinical Excellence.

27 That letter was tendered as exhibit 4, and I am grateful to WACHS and its solicitors for the prompt provision of that information.

Factual findings

28 In this part, I make factual findings about Bradley's background, health (including his diagnosis and treatment) and the circumstances leading up to and including Bradley's death, in order to make findings and comments in relation to the issues identified above.

Bradley's personal background

29 Bradley was born in Bunbury.[14] He spent his childhood with his parents and older sister in Eaton. He was creative, and a very capable builder from a young age. He loved the outdoors, including spending time with his father catching prawns and crabs in the Leschenault Inlet, and heading out into bushland in the Collie hills to collect firewood.

30 Bradley was diagnosed with attention deficit hyperactivity disorder as a child, and treated briefly with medication.[15] He was known by his family to be kind and observant, and able to make people feel at ease when in his presence. He was a passionate and talented footballer and developed lifelong friendships with teammates.

[14] Exhibit 1, tab 7, p 2.
[15] Exhibit 1, tab 18, par [21].

31 Bradley attended Eaton Primary School, and then Australind Senior High School. He left school soon after turning fifteen years of age, and began working at a family-run business before moving to another business where he worked on cars and trucks.

32 He was employed in various trades' assistant roles during his working years, including occasionally in fly-in-fly-out roles.[16]

33 For about five years leading up to his death, Bradley was living with his grandmother in Eaton. He had strong and special relationships with many of his family members, including his two nephews. Despite the decline in his mental health, his care and love for those around him, particularly his family, was unwavering.

34 As identified above, his family were all heavily involved in his care over his lifetime.[17]

First admission to Graylands Hospital

35 In August 2020, Bradley was reviewed by Dr Gliddon, his general practitioner over two consultations.

36 Bradley reported that he had been experiencing anxiety for the past ten years, and had difficulty concentrating. He explained that he experienced feelings of hopelessness but no suicidal ideation.

37 Dr Gliddon diagnosed him with anxiety and depression, and prescribed antidepressant medication (desvenlafaxine).[18]

38 It is clear from the evidence that Bradley struggled with sleep for an extended period of time,[19] and it was not uncommon for him to get only one or two hours of sleep at night.[20] His sister recalls that sleep was an issue for Bradley for about ten years, including a lengthy period before he received a diagnosis of schizophrenia. Prior to his diagnosis, he would often remain awake throughout the night, and would self-medicate with alcohol. Bradley would later say that the auditory hallucinations he experienced were often loudest during the night.

39 In early September 2020, Bradley returned to Dr Gliddon.

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[16] Exhibit 1, tab 7, p 2.
[17] Exhibit 1, tab 21, par [26].
[18] Exhibit 1, tab 7, p 4; tab 11, consultations dated 11 and 12 August 2020.
[19] Exhibit 1, tab 8, par [9]; see also, e.g. tab 11, consultations dated 4 December 2018 and 6 September 2022.
[20] Exhibit 1, tab 8, par [6].

40 During that consultation, Bradley appeared paranoid, making claims that his radio was talking to him in relation to his gambling, and that he had been hired for a job recently by someone who told him that they might get an outlaw motorcycle gang onto him.

41 Dr Gliddon suspected a schizophrenic affective disorder. He directed Bradley to continue with the desvenlafaxine, and referred Bradley to the South West Mental Health Service.[21]

42 In 2021, Bradley saw Dr Gliddon again, in March and April.

43 During the April consultation, he said that he felt '*empty*' and had trouble holding onto his thoughts. He said that he was worried that he had physical health conditions like a stroke and cancer.

44 Dr Gliddon considered that he was catastrophising his symptoms and he was re-referred to the South West Mental Health Service.[22]

45 In April, Bradley was brought into Sir Charles Gairdner Hospital (**SCGH**) by his sister on the basis of his family's concerns about his mental state. They had observed him experiencing a 12-month precipitous decline in his mental health, with increasing somatic delusions and fear about multiple medical issues. Bradley was known by family to make comments about his mortality, saying things like he did not have long to live, and he was frightened of dying.[23]

46 Bradley was seen by the psychiatric liaison nurse at SCGH and transferred to Graylands Hospital.[24]

47 Bradley was admitted there from 12 to 21 April 2021 (before being transferred to the psychiatric unit at Bunbury Hospital, where he was admitted until 21 May 2021).

48 During the admission at Graylands Hospital he complained that outlaw motorcycle gang members were going to get him, and he expressed a desire to have a heart attack so that he could be treated palliatively – to the extent he ran laps to attempt to trigger a cardiac event.[25]

[21] Exhibit 1, tab 7, p 4; tab 11, consultation dated 2 September 2020.
[22] Exhibit 11, consultation dated 6 April 2021.
[23] Exhibit 1, tab 9, par [5].
[24] Exhibit 1, tab 11, discharge summary dated 21 May 2021.
[25] Exhibit 1, tab 12, discharge summary dated 21 May 2021.

Incident on 17 April 2021

49 At about 8 pm on 17 April 2021, Bradley was at Graylands Hospital when he was observed suddenly charging head-first towards and into the TV cover in the activity room.

50 Bradley suffered a 7cm laceration and bled profusely.[26]

51 Bradley was transferred for treatment of his physical injury, and he was reviewed by a psychiatrist in hospital the following day.

52 The reviewing psychiatrist formed the view that Bradley's act of running into the television appeared to be in response to psychotic symptoms.

53 Although he denied having any suicidal thoughts or wanting to die, Bradley reported having racing thoughts and that he felt like he was '*staring into the eyes of death*' and as an inpatient may be '*hit over the head or chopped up to pieces*'. It was observed that he continued to have somatic concerns, as well as persecutory and self-referential delusions.[27]

54 The psychiatrist observed that he was a high risk of acting on delusional beliefs and self-harming, as demonstrated by his behaviour the previous day. He also opined that Bradley was unpredictable and psychotic with features indicating a high risk to self.[28]

55 Bradley later told Dr Gliddon that he did not like Graylands Hospital and that he had run into the TV head first '*to get out of there*'.[29]

Discharge and first community treatment order

56 Bradley was determined during his admission to be suffering persecutory and somatic delusions, which were treated with olanzapine and a paliperidone depot.

57 He was ultimately discharged on a community treatment order,[30] with Dr Ben Sketcher as the supervising psychiatrist and the BCMHT as the case managing service.[31]

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[26] Exhibit 3.
[27] Exhibit 3.
[28] Exhibit 3.
[29] Exhibit 1, tab 11, consultation dated 24 May 2011.
[30] Exhibit 1, tab 12, discharge summaries dated 18 November 2021 and 11 July 2022.
[31] Exhibit 1, tab 12, discharge summary dated 21 May 2021.

58 In a letter to Dr Gliddon dated 28 July 2021, Dr Sketcher observed that Bradley had experienced a psychosis with a seemingly insidious onset, which Bradley had previously self-medicated using alcohol, possibly for many years.[32]

59 Dr Sketcher stated that it was '*almost certainly schizophrenia*' and that Bradley was not reliable with oral medications. Dr Sketcher recommended a trial of mirtazapine in order to target his ongoing insomnia.[33]

Re-admission to hospital

60 Bradley was admitted to the Acute Psychiatric Unit (**APU**) at Bunbury Hospital on 7 October 2021, following concerned calls from family and friends to BCMHT.

61 Bradley had contacted family, saying goodbye and that he was organising his funeral. He was convinced that he was suffering from throat cancer and fatal insomnia. He had been preoccupied with thoughts that outlaw motorcycle gang members were after him at work.

62 Bradley was started on an aripiprazole depot, and prescribed olanzapine and fluoxetine.

63 He was discharged on 18 November 2021, after a 43-day admission, to a Step-Up Step-Down facility under the CTO.[34]

64 During a discussion between Dr Gliddon and Dr de Klerk in March 2022, Dr de Klerk reassured Dr Gliddon that Bradley was '*always on their radar*' (which I infer to mean the BCMHT) and that he was having weekly contact with his case manager.

65 It was noted at that time that Bradley was not taking any oral antipsychotics, and that the plan was to admit him to a psychiatric unit so that clozapine could be trialled.[35]

[32] I note that this view is consistent with the reflections of Bradley's family about his health prior to his formal mental health diagnosis, as expressed to me at the end of the inquest.
[33] Exhibit 1, tab 11, letter dated 28 July 2021.
[34] Exhibit 1, tab 12, discharge summary dated 18 November 2021.
[35] Exhibit 1, tab 11, consultation dated 3 March 2022.

Clozapine trial

66 Bradley was re-admitted to the APU on 26 April 2022 for the purpose of clozapine initiation.

67 Unfortunately, during the trial, Bradley developed:

(a) hospital acquired pneumonia (with fever, cough and occasional vomiting); and

(b) more concerningly, myocarditis,

which meant that the clozapine trial had to be ceased.

68 In discharge documentation, it was identified that Bradley's persecutory delusions and other first rank symptoms of schizophrenia (including thought insertion, withdrawal and broadcast) put him at a high risk of volatility and impaired his decision-making.

69 It was observed that the treating team considered that a course of ECT would help with symptom resolution.

70 Bradley was ultimately transferred to Fremantle Hospital for the purposes of receiving ECT.[36]

ECT

71 Bradley received 12 ECT sessions which Dr de Klerk considered resulted in both an objective and subjective improvement in his mental state.[37]

72 In August 2022, Dr Gliddon wrote to Dr de Klerk observing that he had seen Bradley for the first time in some months and that he did not appear to be doing any better. In that correspondence, Dr Gliddon referred to the fact that Bradley's family had been seeing him in Perth, and that they reported that Bradley had responded well to ECT.[38]

73 Another course of ECT was favoured by Dr de Klerk including upon peer review, with the possibility of maintenance ECT.

[36] Exhibit 1, tab 12, discharge summary dated 11 July 2022.
[37] Exhibit 1, tab 14, medical report dated 27 September 2024.
[38] Exhibit 1, tab 11, letter dated 23 August 2022.

74 Negotiations were commenced with Fremantle Hospital, but broke down as the hospital was eventually not willing to have Bradley, or to give him maintenance ECT.[39]

75 At the inquest, Dr de Klerk clarified that, upon his recollection, the consultant psychiatrist at Fremantle Hospital was of the opinion that a further course of ECT was not indicated, and maintained that view in consultation with Dr de Klerk, and despite Dr de Klerk advocating on Bradley's behalf.[40]

76 I am satisfied that:

(a) the BCMHT, including Dr de Klerk, took active steps to attempt to obtain further maintenance ECT therapy for Bradley (including based on their own clinical judgment, and presumably having regard to the corresponding views of Bradley's family); and

(b) apart from one occasion in February 2023 when he indicated some, seemingly temporary, resistance,[41] Bradley was amenable to ECT.

Management from late 2022 to mid-2024

77 The final CTO (which Bradley remained on at the date of his death) commenced as of 12 August 2022 and was continued periodically from time to time, after that date. This is not uncommon for patients like Bradley who dispute that they are ill and therefore remain at risk of not voluntarily accepting treatment.[42]

78 Dr de Klerk's diagnosis of Bradley was that he had treatment-resistant schizophrenia.[43] That illness describes a presentation that has not responded adequately to trial of multiple antipsychotic medications.[44]

79 Dr de Klerk usually conducted Bradley's monthly reviews required by the CTO and the *Mental Health Act* personally, and considered that he had a good relationship with Bradley.[45] I agree, based on my review of the evidence.

[39] Exhibit 1, tab 14, medical report dated 27 September 2024.
[40] Exhibit 1, tab 21, par [33].
[41] Exhibit 1, tab 13, progress note dated 2 February 2023.
[42] Exhibit 1, tab 21, par [25].
[43] Exhibit 1, tab 13, progress note dated 1 April 2025.
[44] Exhibit 1, tab 18, par [20].
[45] Exhibit 1, tab 21, par [24].

80 In November 2022, Dr Gliddon wrote to Dr de Klerk, advising that Bradley continued to vocalise concerns that he had been poisoned in March 2021, and that he was requesting medication to help with sleep.[46]

81 Bradley's case manager at that time, Ms Wood, spoke with Bradley's father about the family's concerns – including his then ongoing talk about being euthanised and dying.

82 Ms Wood and Bradley's father discussed Bradley's ability to mask his thoughts when in the presence of clinicians.

83 Ms Wood confirmed that clinicians were aware of how guarded Bradley could be when interacting with them.[47]

84 In early 2024, Dr de Klerk observed that Bradley's illness was being well managed with regular olanzapine depot, and that concerted efforts to engage Bradley in social rehabilitation and abstain from illicit substances had been very encouraging.

85 Dr de Klerk recommended a focus for Bradley in the new year on his sleeping habits, and included a warning that he should not use temazepam, which he declined to prescribe as had been requested.[48]

86 At this time, Dr de Klerk considered that Bradley was presenting with predominantly '*negative*', psychosocial signs of the illness compared to overt '*positive*' symptoms, such as somatic delusions.[49]

Olanzapine depot supply shortage

87 A nation-wide shortage of olanzapine depot resulted in Bradley being unable to be administered a depot on 15 August 2024 as planned, and thereafter.[50]

88 On 4 November 2024, Bradley's sister reported that his mental state had deteriorated over about two weeks.

89 When contacted, Bradley denied stopping the oral olanzapine and declined to be seen, so Dr de Klerk brought his review forward.

[46] Exhibit 1, tab 11, letter dated 17 November 2022.
[47] Exhibit 1, tab 13, progress note dated 7 November 2022.
[48] Exhibit 1, tab 13, progress note dated 1 February 2024.
[49] Exhibit 1, tab 13, progress note dated 4 January 2024.
[50] Exhibit 1, tab 13, progress note dated 15 August 2024

90 Bradley attended on 6 November 2024 with his grandmother, and refused re-admission to hospital but accepted the depot, so aripiprazole 400 mg intramuscularly every four weeks was commenced.[51]

91 The treatment plan was to restart oral olanzapine in conjunction with the aripiprazole depot to manage ongoing delusions and distress, with the aim of restarting the olanzapine depot once supply became available.[52]

92 Dr de Klerk explained to Bradley that the aripiprazole depot was not as effective, and the need to restart the oral olanzapine.[53]

93 Given his concern about Bradley's adherence, and possible deterioration if not compliant, Dr de Klerk arranged to see Bradley more regularly in order to monitor his mental state.[54]

94 Mr Hislop considered that Bradley's presentations during his time as case manager were fairly steady.[55]

95 He would occasionally express feelings that something was wrong and he was going to die, but it was not unusual for him to bring up such matters at appointments (as he did, for example, on 29 July 2024).[56]

96 Mr Hislop did not observe any noticeable changes in Bradley's presentation following the change from the olanzapine depot to the olanzapine wafers.[57]

Events in January and February 2025

97 During a review on 2 January 2025, Bradley reported ongoing sleep issues and '*some preoccupation with disasters*'. He said that he was taking his olanzapine tablets daily, and reported that his mood was '*not too bad*'. His medication regime was continued.[58]

[51] Exhibit 1, tab 21, par [47].
[52] A nation-wide shortage of olanzapine depot had resulted in a depot being unable to be administered on 15 August 2024 and thereafter: exhibit 1, tab 13, progress note dated 15 August 2024.
[53] Exhibit 1, tab 13, progress note dated 4 December 2024.
[54] Exhibit 1, tab 14, medical report dated 27 September 2024; tab 21, pars [41]-[42].
[55] Exhibit 1, tab 19, par [15].
[56] Exhibit 1, tab 19, par [19].
[57] Exhibit 1, tab 19, par [21].
[58] Exhibit 1, tab 13, progress note dated 29 March 2025.

98 On 23 January 2025, Dr de Klerk ordered that the CTO should continue for a further 2 months and 30 days.[59] That decision was affirmed by the Mental Health Tribunal after a hearing on 27 March 2025.[60]

99 Bradley attended for his depot injection on 30 January 2025.

100 He was pleasant and polite, although he expressed that he was not doing well '*as he drank poison over 4 years ago and that induced his mental illness*'. There were no risk factors identified, and he presented as a low risk to himself or others.[61]

101 Bradley attended the clinic for an appointment and administration of his depot again on 27 February 2025.

102 His speech was appropriate in rate, rhythm and volume. He reported difficulties sleeping, and feeling ill and vomiting when lying on his back. He denied thoughts of harm to himself or others. The depot was administered without issue.[62]

Presentation on 27 March 2025

103 On 27 March 2025, Bradley was initially seen by Dr de Klerk, Dr Townsend and Mr Hislop.[63] This was Dr Townsend's only direct clinical involvement with Bradley.[64]

104 Bradley reported improved sleep with mirtazapine, which he had obtained from his GP about a year before. He said he had taken two tablets over the preceding days,[65] and it had been helpful, so he wanted to trial it.[66]

105 He reported intermittent use of olanzapine, primarily for sleep, and that he last took olanzapine four days prior to the appointment. He stated that the olanzapine made him '*feel like shit*'.[67] He considered that the oral olanzapine caused him weight gain and increased anxiety.[68]

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[59] Exhibit 1, tab 14, Form 5B dated 23 January 2025.
[60] Exhibit 1, tab 14, Mental Health Tribunal notice of decision dated 27 March 2025.
[61] Exhibit 1, tab 13, progress note dated 30 January 2025.
[62] Exhibit 1, tab 13, progress note dated 1 April 2025.
[63] Exhibit 1, tab 18, par [27].
[64] Exhibit 1, tab 18, pars [9], [18].
[65] Exhibit 1, tab 18, par [24].
[66] Exhibit 1, tab 18, par [29].
[67] Exhibit 1, tab 13, progress note dated 1 April 2025.
[68] Exhibit 1, tab 18, par [24].

106 Bradley did not report any suicidal ideation during the consultation (including when asked directly by Dr Townsend)[69], and did not complain of impending death or fatal insomnia as he had on previous occasions.

107 Dr Townsend considered that Bradley's presentation did not raise any concern about acute relapse or risk to self.[70] He was initially concerned by Bradley wearing sunglasses indoors, which he did not remove.[71]

108 However, Dr Townsend was able, from his vantage point, to observe that Bradley was not displaying any symptoms of visual or auditory hallucinations, such as staring, appearing distracted, or talking or whispering in response to stimuli.[72]

109 He was reported to have been cooperative, and engaged in banter with the clinicians. His speech was normal in rate and volume, and he was coherent. His mood was euthymic. He did not display any signs of hallucinations and demonstrated improved insight into medication effects, recognising the impact of olanzapine on his wellbeing.

110 Dr de Klerk considered him to remain at significant risk of serious harm to himself should he repeat a suicide attempt in response to delusional beliefs. I infer that this statement was a reference to his actions on 17 April 2021 at Graylands Hospital.[73]

111 Dr de Klerk advised Bradley that his intention was to recommend the continuation of the CTO given his diagnosed illness, his need for ongoing treatment, the risks involved should he relapse, and his limited capacity to consent to treatment. It was noted that Bradley had previously conceded that he would disengage from mental health services and stop taking medication if not compelled to do so.[74]

112 The treatment plan was to continue the aripiprazole depot, and '*to investigate the appropriate dose of mirtazapine for potential prescription*' with Bradley asked to take a photo of the medication he had been previously prescribed and provide it to the clinic.[75]

[69] Exhibit 1, tab 18, par [33].
[70] Exhibit 1, tab 18, par [30].
[71] Exhibit 1, tab 18, par [31].
[72] Exhibit 1, tab 18, par [32].
[73] Exhibit 1, tab 13, progress note dated 1 April 2025.
[74] Exhibit 1, tab 13, progress note dated 1 April 2025; tab 21, par [37].
[75] Exhibit 1, tab 18, par [35].

113 Dr de Klerk noted that consideration may be given to discontinuing the olanzapine if Bradley is not taking it regularly.[76]

114 Dr de Klerk left the consultation, and Dr Townsend continued the consultation with Mr Hislop remaining present.[77]

115 Dr Townsend did not observe any signs of current psychotic symptoms, and Bradley did not display any delusional thought content during the review.[78]

116 After the appointment, Dr Townsend reviewed Bradley's dispensing history in his electronic health record, and confirmed that mirtazapine 15 mg had previously been dispensed to him. He discussed prescribing the same dose to Bradley with Dr de Klerk, who agreed.[79]

117 Dr Townsend saw no cause for concern in prescribing this medication, arising either from Bradley's presentation on 27 March[80] or the dispensing record he was able to access.[81] He did not identify any signs indicating a risk of overdose.[82]

118 Mr Hislop did not consider that there were any indicators of acute risk, or immediate risk to self, even with the benefit of hindsight.[83] He also did not consider that Bradley presented with any risks of overdose.[84]

119 Dr Townsend then issued prescriptions for mirtazapine 15 mg to be taken at night (30 tablets, with 5 repeats)[85], olanzapine 10 mg to be taken on an '*as required*' basis (28 units, with 5 repeats) and pantoprazole 20 mg to be taken in the morning. The prescriptions were sent by text message to Bradley.[86]

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[76] Exhibit 1, tab 13, progress note dated 1 April 2025.
[77] Exhibit 1, tab 18, par [28].
[78] Exhibit 1, tab 13, progress note dated 29 March 2025.
[79] Exhibit 1, tab 18, par [36].
[80] Exhibit 1, tab 18, par [51].
[81] Exhibit 1, tab 18, par [48].
[82] Exhibit 1, tab 18, par [54].
[83] Exhibit 1, tab 19, par [25].
[84] Exhibit 1, tab 19, par [28].
[85] As observed by Dr Townsend, multiple repeats would not be capable of being dispensed at a single dispensing, and the prescriptions were in standard PBS scheme quantities: exhibit 1, tab 18, par [50].
[86] Exhibit 1, tab 18, par [36].

120 The olanzapine was clearly PRN, and expressly for the purpose of new breakthrough symptoms or mental state deterioration.[87] There was also a note for consideration of referring Bradley to a sleep study if sleep issues persisted despite the trial of mirtazapine.[88]

121 Bradley received his depot injection for aripiprazole 400 mg IM.[89]

122 Dr Townsend sent a letter to Bradley's general practitioner, setting out the treatment plan, including a request for routine physical and metabolic monitoring, blood tests and an electrocardiogram.[90]

Prescriptions filled by Bradley

123 Bradley's grandmother was aware that he was prescribed medication for his medical condition, but was not sure how often he filled his prescriptions and whether he took the medication.[91]

124 The Court sought the Pharmaceutical Benefits Scheme (**PBS**) claims history for Bradley for the period between 30 September 2024 to 31 March 2025, in order to clarify what prescriptions Bradley filled in late 2024 and 2025, including after the consultation on 27 March 2025.

125 The information supplied to the Court[92] by the PBS indicates that prescriptions were issued and supplied to Bradley as follows:

Supply date	Supplied by	Item name[93]	Quantity	Date prescribed	Prescription by
30/09/24	Southwest Hospital Pharmacy	Olanzapine	28	16/08/24	Dr de Klerk
14/10/24	Southwest Hospital Pharmacy	Olanzapine	28	16/08/24	Dr de Klerk
07/11/24	Southwest Hospital Pharmacy	Aripiprazole	1	06/11/24	Dr de Klerk

[87] Exhibit 1, tab 22.
[88] Exhibit 1, tab 22.
[89] Exhibit 1, tab 13, progress note dated 27 March 2025.
[90] Exhibit 1, tab 18, par [41].
[91] Exhibit 1, tab 8, par [5].
[92] Exhibit 2.
[93] The information from the PBS did not contain, expressly, the dose/strength of the medication, but I infer, from the evidence in the P98 (at exhibit 1, tab 3) that all olanzapine prescribed to Bradley was 20mg dosage.

05/12/24	Southwest Hospital Pharmacy	Aripiprazole	1	06/11/24	Dr de Klerk
10/12/24	Southwest Hospital Pharmacy	Olanzapine	28	09/12/24	Dr de Klerk
31/12/24	Southwest Hospital Pharmacy	Olanzapine	28	09/12/24	Dr Abel[94]
02/01/25	Eaton Community Pharmacy	Pantoprazole	30	29/11/24	Dr Asomugha
09/01/25	Southwest Hospital Pharmacy	Aripiprazole	1	06/11/24	Dr de Klerk
05/02/25	Southwest Hospital Pharmacy	Aripiprazole	1	06/11/24	Dr de Klerk
21/02/25	Southwest Hospital Pharmacy	Olanzapine	28	09/12/24	Dr Abel
18/03/25	Southwest Hospital Pharmacy	Aripiprazole	1	06/11/24	Dr de Klerk
27/03/25	Eaton Community Pharmacy	Pantoprazole	30	27/03/25	Dr Townsend
27/03/25	Eaton Community Pharmacy	Mirtazapine	30	27/03/25	Dr Townsend

126 The above information is significant in a number of respects.

127 First, it indicates that directly after the consultation on 27 March, Bradley filled part of the prescription issued to him by Dr Townsend, consistently with the treating team's recommendations. In my view, this corroborates the evidence of the clinicians that Bradley was engaged and understood the advice being given to him during the consultation.

128 Secondly, and perhaps more significantly, the PBS information suggests that Bradley *did not* fill any prescription for olanzapine despite:

(a) presumably having at least two more refills from the prescription issued to him on 9 December 2024 for olanzapine 20mg; and

[94] Dr Townsend confirmed at the inquest that Dr Abel formed part of the BCMHT.

(b) being provided with the prescription for 10mg olanzapine by Dr Townsend on 27 March 2025.

129 The fact that he did not fill either prescription militates against any inference that Bradley, at least as of 27 March 2025, had formed an intention to self-harm by olanzapine or polypharmacy overdose (either because he was suicidal, or psychotic, or both). If he had formed such an intention, it is reasonable to infer that he would have filled the prescription he had received from Dr Townsend, if not an existing refill.

130 In my view, this is cogent evidence that any overdose on 31 March 2025 was more likely than not the result of an impulsive act, rather than a carefully planned act. The last supply of olanzapine was on 21 February 2025, over a month before the overdose. If Bradley had formed a plan to overdose using olanzapine, there was no apparent barrier to his getting more such medication, including on 27 March 2025, but he did not.

Events between 28 March and 30 March 2025

131 Mr Zampogna was engaged as a support worker for Bradley through NDIS funding.[95] It was his role to get Bradley to engage in daily life including engagement with exercise and medical treatment.[96]

132 Mr Zampogna ordinarily spent a few hours with Bradley every Monday, Wednesday and Friday.[97]

133 Mr Zampogna observed that when he started working with Bradley, he would rarely leave his room, but they clicked and although it took effort, Bradley started going out, engaging in social activities, and engaging more consistently with treatment.[98]

134 Mr Zampogna last saw Bradley in person on 28 March 2025.

135 His impression was that Bradley '*wasn't very good*'.[99]

136 Bradley wanted to go to the bank to withdraw a substantial amount of cash to pay money in relation to something where he did not owe any money.

[95] Exhibit 1, tab 15, pars [4]-[5].
[96] Exhibit 1, tab 15, pars [9]-[10].
[97] Exhibit 1, tab 15, par [11].
[98] Exhibit 1, tab 15, pars [13]-[21].
[99] Exhibit 1, tab 15, pars [31]-[32].

137 He mentioned something about a specific outlaw motorcycle gang that he was afraid of, and so he was going to pay money for that reason.[100]

138 Mr Zampogna told Bradley that he was not going to take him to do that, and dropped him home.

139 I note Dr de Klerk's evidence at the inquest that he was not aware of this behaviour by Bradley on the day, and agreed that it was reflective of delusionary thinking that Bradley exhibited when unwell.

140 Mr Zampogna tried to call the BCMHT, because although this was relatively normal behaviour for Bradley it was '*a bit over the line*'.[101]

141 Mr Zampogna's call, at 4 pm that day, was not answered by the BCMHT.

142 I accept Mr Zampogna's evidence at the inquest that the behaviour was not so concerning as to prompt him to contact police, for example. Mr Zampogna had also made plans to see Bradley the next day at his place.

143 Although Bradley did not attend the following day as planned, he and Mr Zampogna did text message each other and Bradley seemed his usual self.[102]

144 On 30 March 2025, Bradley texted Mr Zampogna and told him that he wanted to go into respite. He told Bradley that they would talk about it the following day.[103]

Events of 31 March 2025

145 Bradley's grandmother saw him at 9.30 am.[104]

146 He was in the bathroom at their home, leaning over the bathroom sink.

147 Bradley told his grandmother that he was not feeling well,[105] but he did not specify what was wrong.[106]

[100] Exhibit 1, tab 15, pars [33]-[34].
[101] Exhibit 1, tab 15, pars [35]-[36].
[102] Exhibit 1, tab 15, pars [37]-[40].
[103] Exhibit 1, tab 15, pars [41]-[43].
[104] Exhibit 1, tab 8, par [10].
[105] Exhibit 1, tab 8, par [12].
[106] Exhibit 1, tab 7, p 2.

148 It was later reported to ambulance officers that Bradley had said he felt like he was '*going to die*',[107] but the evidence shows that he would make statements like this to family and Mr Zampogna often.[108] For that reason, I infer that his grandmother did not find the remark unusual or unduly concerning at that time.

149 Bradley's grandmother described Bradley as '*looking confused*', in her discussion with Dr de Klerk the day after his death.[109]

150 Bradley's grandmother had some difficulty in identifying whether he was showing any physical symptoms of illness, but he did not appear to be sweating, and his skin did not appear to be pale.[110]

151 Bradley's grandmother suggested he take a shower,[111] but he declined and went back to his bedroom, closing the bedroom door.[112]

152 I interpose that given the limited evidence about his behaviour, I am unable to infer, with any precision, whether Bradley had ingested quantities of medication by this point in time, and if so, how much.

153 Bradley's grandmother left the home before 10 am,[113] at which time Bradley was still in his bedroom.[114]

154 She returned at about 11.30 am. She did not see Bradley on her return, and assumed he was still resting in his bedroom.[115]

155 Bradley's grandmother did not hear or see anything (either before leaving home, or after having returned) which indicated to her that he was in trouble or having any sort of medical episode.[116]

156 Again, I am not in a position to be able to make precise findings about whether Bradley took the medications between 10.00 and 11.30 am, and if so, how much.

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[107] Exhibit 1, tab 10.1, p 3.
[108] See, e.g., exhibit 1, tab 15, par [30].
[109] Exhibit 1, tab 13, progress note dated 3 April 2025.
[110] Exhibit 1, tab 8, par [13].
[111] Exhibit 1, tab 8, par [14].
[112] Exhibit 1, tab 7, p 3; exhibit 1, tab 8, par [15].
[113] Exhibit 1, tab 8, par [17].
[114] Exhibit 1, tab 8, par [16].
[115] Exhibit 1, tab 7, p 3; exhibit 1, tab 8, par [18].
[116] Exhibit 1, tab 8, par [22].

157 Bradley's great-aunt came over a short time after, and went to go wake Bradley because she had seen that Mr Zampogna had arrived and was in his car, parked in the driveway.[117]

158 She opened the door[118] to Bradley's bedroom at about 11.50 am.

159 He was lying face-down on the carpeted floor in front of the closet,[119] with his arms by his side.[120] She directed Bradley's grandmother to go outside and get Mr Zampogna.[121]

160 Bradley was not breathing.[122]

161 Bradley's great-aunt called emergency services,[123] and she and Mr Zampogna commenced CPR.[124]

162 Ambulance officers attended at 12.16 pm,[125] and took over resuscitation efforts. Paramedics moved Bradley from his bedroom to the living room to provide further medical assistance.[126]

163 Those paramedics efforts included the use of a defibrillator and LUCAS machine, as well as administration of adrenaline and oxygen. Paramedics also successfully performed a cricothyrotomy in order to obtain an effective airway.[127]

164 Ultimately, despite maximum efforts, a return of spontaneous circulation could not be achieved and Bradley's rhythm continued to be asystole.

165 Paramedics determined that CPR efforts should be terminated, and Bradley was declared deceased at 12.51 pm.[128]

Police investigation

166 Police officers attended Bradley's home address at about 2.30 pm.[129]

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[117] Exhibit 1, tab 15, par [49].
[118] Exhibit 1, tab 9, par [7].
[119] Exhibit 1, tab 8, par [19]; tab 10.1, p 3.
[120] Exhibit 1, tab 9, par [8].
[121] Exhibit 1, tab 8, par [20]; tab 9, par [9]; tab 15, par [44].
[122] Exhibit 1, tab 9, par [9].
[123] Exhibit 1, tab 10.
[124] Exhibit 1, tab 9, par [10]-[13]. Attending ambulance officers observed on attendance that Bradley's great-aunt's compressions were of good quality: exhibit 1, tab 7, p 3.
[125] Exhibit 1, tab 10.1, p 1.
[126] Exhibit 1, tab 7, p 3; tab 10.1, p 3.
[127] Exhibit 1, tab 10.1, p 4; tab 10.2, p 2.
[128] Exhibit 1, tab 2; tab 10.1, p 3.

167 The officers observed that Bradley had lividity on his head, back and left arm, and blood had clotted in his nose.[130]

168 Police officers did not identify any evidence at the scene such as a suicide note, or similar, indicating that Bradley had made a deliberate attempt to end his own life.[131]

169 Attending police officers seized prescription medication packets which were located in Bradley's bedroom, on top of the chest of drawers, as well as empty medication boxes and blister packs from a bin by the bed.[132]

170 The packets located, and the amounts of medication remaining in those packets, were as follows:[133]

Supply date	Supplied by	Item name	Quantity prescribed	Quantity remaining
10/12/24	Southwest Hospital Pharmacy	Olanzapine 20mg	28	4
31/12/24	Southwest Hospital Pharmacy	Olanzapine 20 mg	28	None
21/02/25	Southwest Hospital Pharmacy	Olanzapine 20mg	28	All
27/03/25	Eaton Community Pharmacy	Pantoprazole 20mg	30	All
27/03/25	Eaton Community Pharmacy	Mirtazapine 15mg	30	2
Unknown	Unknown	Doxylamine 25mg	20	None

[129] Exhibit 1, tab 7, p 1.
[130] Exhibit 1, tab 7, p 1.
[131] Exhibit 1, tab 7, p 3.
[132] Exhibit 1, tab 7, p 2.
[133] Exhibit 1, tab 3.

171 As identified by Dr Joyce, the above permits the following findings:

(a) between 10 December 2024 and the date of Bradley's death, being a period of 111 days, 86 units of the 20 mg olanzapine had been dispensed, with 34 units remaining in the packaging; and

(b) accepting the above, Bradley had not been taking olanzapine according to the prescription.

172 Further, as noted by Dr Joyce, the medication packets alone do not permit a finding as to how many of the other 52 tablets were taken, including close to the time of death.[134]

173 With the mirtazapine having only been dispensed on 27 March 2025, the implication is that 24 doses were taken in excess of prescribed amounts.[135]

174 Given doxylamine can be sold over the counter, there is no ability to identify the date of dispensing in assist in drawing an inference as to how many of the doses were taken from the packaging shortly before death.[136]

Cause of death

Post mortem examination

175 A forensic pathologist conducted a post mortem examination, identifying soft atheroma formation in the coronary arteries, which very focally amounted to moderate to severe luminal narrowing.

176 No other significant abnormalities were seen.

177 There were minor abrasions to the knees and left elbow, which the pathologist considered were consistent with a collapse.[137]

178 The forensic pathologist ordered further ancillary tests be performed.

Ancillary testing

179 Limited histological examination showed diffuse vascular congestion, but no other significant abnormality to the lungs.[138]

[134] Exhibit 1, tab 17, par [8].
[135] Exhibit 1, tab 17, par [9].
[136] Exhibit 1, tab 17, par [10].
[137] Exhibit 1, tab 5, p 1.
[138] Exhibit 1, tab 5, p 2.

180 No infection or thromboembolism was evident.[139]

181 Post mortem biochemistry testing was unremarkable.[140]

Toxicology

182 Toxicological analysis detected the antipsychotic medication olanzapine, the antidepressant mirtazapine, and the antihistamine doxylamine.

183 Aripiprazole was also detected, but not quantified. Alcohol and other common drugs were not detected.[141]

Olanzapine

184 Olanzapine was quantified at:

(a) approximately 1.7mg/L in a preserved femoral blood sample;

(b) at approximately 25 mg/kg in a liver sample; and

(c) approximately 15 mg in the stomach contents (of a total weight of stomach contents of 155 grams).[142]

185 In ten reported cases of olanzapine concentrations in mortuary admission blood where olanzapine was a contributory or principal cause of death, the range was 0.2 to 1.8 mg/L, with a mean of 0.83 mg/L.[143]

186 In eleven reported cases of olanzapine concentrations in liver samples where olanzapine was a contributory or principal cause of death, the range was 3 to 27 mg/kg, with a mean of 9.7 mg/kg.[144]

187 The report from the toxicologist also noted a case in which a 43-year-old man who was known to have intentionally ingested 600 mg of olanzapine had a postmortem blood concentration of 1.2 mg/L.[145]

188 According to Dr Joyce, post-mortem redistribution needs to be considered in any interpretation of post-mortem drug concentrations.

189 Olanzapine is liable to post-mortem distribution.[146]

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[139] Exhibit 1, tab 5, p 2.
[140] Exhibit 1, tab 5, p 2.
[141] Exhibit 1, tab 6, pp 1-2.
[142] Exhibit 1, tab 6, pp 1-2.
[143] Exhibit 1, tab 6, p 2.
[144] Exhibit 1, tab 6, p 2.
[145] Exhibit 1, tab 6, p 2.

190 The fact that the femoral blood sample was collected at the time of mortuary admission minimises the time available for post-mortem redistribution.[147]

191 The average plasma concentration of olanzapine in a patient taking 20 mg daily is 0.026 mg/L, corresponding to a concentration in whole blood of around this level.

192 The concentration measured in Bradley's blood is 65 times higher which, according to Dr Joyce, confirms a recent overdose of olanzapine.[148]

193 Although the prospect of post-mortem distribution raises some difficulty, 52 tablets taken together over a short period of time would sufficiently explain the concentration of olanzapine in the blood sample, with the amount in the stomach contents confirming recent ingestion.[149]

194 Given the above, I find that Bradley ingested around or about 50 units of olanzapine during the morning of 31 March 2025, although the precise timing cannot be known.

Mirtazapine

195 Mirtazapine was quantified at:

(a) 0.6 mg/L in the blood sample;

(b) approximately 9 mg/kg in the liver sample and

(c) approximately 6.5 mg in the stomach contents.[150]

196 Toxic to fatal mirtazapine concentrations in 35 cases involving mortuary admission blood resulted in an average of 1.05 mg/L, a range of 0.1 to 6.8 mg/L, and a median of 0.6 mg/L.[151]

197 Toxic to fatal mirtazapine concentrations in 54 cases involving liver samples resulted in an average of 10.5 mg/kg, a range of 1.6 to 61 mg/kg, and a median of 6.1 mg/kg.[152]

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[146] Exhibit 1, tab 17, par [17].
[147] Exhibit 1, tab 17, par [17].
[148] Exhibit 1, tab 17, par [19].
[149] Exhibit 1, tab 17, par [19].
[150] Exhibit 1, tab 6, pp 1-2.
[151] Exhibit 1, tab 6, p 3.
[152] Exhibit 1, tab 6, p 3.

198 In eight mirtazapine-related deaths of adults, the postmortem blood concentration average was 2.1 mg/L, with a range of 1 to 4.4 mg/L.[153]

199 Mirtazapine is not liable to post-mortem distribution.[154]

200 Limited publications point towards an expected blood concentration of around 0.005 to 0.036 mg/L in adults taking mirtazapine daily (with the latter being a better comparator given it can be inferred, from the stomach contents, that Bradley was still in the phase of drug absorption).

201 The concentration in Bradley's blood sample was 17 times higher, which confirms a recent overdose of mirtazapine.[155]

202 From this, it can be safely inferred that Bradley had ingested 17 or more of the 15 mg mirtazapine tablets over a short period of time.[156] I find accordingly, that Bradley ingested 17 or more tablets of mirtazapine during the morning of 31 March 2025.

Doxylamine

203 Doxylamine was quantified at:

(a) 1.8 mg/L in the blood sample;

(b) approximately 8.6 mg/kg in the liver sample; and

(c) approximately 3.8 mg in the stomach contents.[157]

204 In two cases where death was believed to be due solely to doxylamine ingestion, the postmortem blood concentrations were 22 and 59 mg/L.[158]

205 A study of non-intoxication cases involving doxylamine found an average concentration of 0.19 mg/L in 14 cases, and 0.62 mg/kg in seven cases for blood and liver respectively.[159]

206 Doxylamine is liable to post-mortem distribution.[160]

[153] Exhibit 1, tab 6, p 3.
[154] Exhibit 1, tab 17, par [17].
[155] Exhibit 1, tab 17, par [20].
[156] Exhibit 1, tab 17, par [20].
[157] Exhibit 1, tab 6, pp 1-2.
[158] Exhibit 1, tab 6, p 3.
[159] Exhibit 1, tab 6, p 3.
[160] Exhibit 1, tab 17, par [17].

207 The average peak concentration of doxylamine in plasma after a 25 mg dose is 0.099 mg/L.

208 Bradley's dose of 50 mg would be expected to give a peak concentration in plasma of around 0.2 mg/L, corresponding to around 0.15 mg/L in whole blood.

209 Bradley's concentration was 12 times higher, confirming a recent overdose of doxylamine.

210 The concentration can be explained by consumption of the 20 tablets missing from the packaging, and again the stomach contents suggests recent ingestion.[161] I find, accordingly, that 20 tablets were ingested in the morning of 31 March 2025, but am unable to make further findings are about exactly when the tablets were ingested.

Conclusions

211 The forensic pathologist noted that all three medications have sedating properties and in combination pose significant risk of central nervous system depression, coma and death. Doxylamine and olanzapine can have anticholinergic side effects which can impact the cardiovascular system. Mirtazapine at very high doses can lead to seizures and serotonin toxicity, as well as coma.

212 Dr Joyce noted that the risks differ between the three medications taken by Bradley in overdose. Lethal poisoning with mirtazapine is rare. The amount of doxylamine was likely poisoning but might have been survivable if the only drug present. The olanzapine is three times the average concentration in the series of ten deaths due solely to olanzapine poisoning.[162]

213 At the conclusion of the examination, the forensic pathologist formed the opinion that the cause of death was combined drug toxicity.

214 Dr Joyce noted that forms of drug toxicity that can arise with the drug mixture in Bradley's system include central nervous system depression sufficient to suppress breathing, as well as cardiac arrythmia and epileptiform seizures (although the last is least likely given the absence of other physical findings).[163]

[161] Exhibit 1, tab 17, par [21].
[162] Exhibit 1, tab 17, par [27].
[163] Exhibit 1, tab 17, par [27].

215 Dr Joyce also noted that drugs that have overlapping patterns of toxicity will behave additively when co-ingested in excessive dose.

216 The concentration of olanzapine may have been enough to cause death on its own, but doxylamine and mirtazapine are likely to have contributed given their overlapping toxicity.[164]

217 Dr Joyce noted that post-mortem toxicological analysis substantiates the forensic pathologist's opinion that the cause of death was combined drug toxicity.[165]

218 I respectfully agree with and adopt that conclusion as my finding for the purposes of s 25(1)(c) of the Act.

Manner of death

219 The key question in relation to the manner of Bradley's death is whether Bradley overdosed with the intention to end his own life, or the overdose was accidental.

220 Historically, because of the dire consequences which once flowed from such a verdict, there was a common law presumption against suicide.[166]

221 Whilst the law and community views about suicide have changed, a verdict of suicide must be based on clear evidence that a deceased intended to take their life. Where a coroner is satisfied that, on the balance of probabilities, a deceased person intended to take their life, they would record a verdict of suicide.[167]

222 In this case, suicide arises as a potential verdict by inference, due to the quantity of medications I have found that Bradley consumed in a relatively short period of time.

223 As identified, the amounts of olanzapine that Bradley must have consumed in order to reach the post-mortem level are substantial. The sheer volume militates against a finding that overdose was accidental.

224 The evidence of Bradley's attitude towards, and views on the efficacy of, oral olanzapine also militates against a finding that he took large quantities in order to sleep, and accidentally overdosed because he was seeking potential therapeutic benefits.

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[164] Exhibit 1, tab 17, par [28].
[165] Exhibit 1, tab 17, par [30].
[166] *Blackstone's Commentaries*, Book IV, Chapter 14 (Homicide).
[167] *Jervis on Coroners* at [13-21] to [13-23].

225 There are, however, many circumstances and parts of the evidence that militate against a finding of suicide by intentional overdose. They include:

(a) that there is only one documented instance of Bradley self-harming historically, being the incident on 17 April 2021, which appeared to occur during an episode of psychosis;

(b) relatedly, there is no evidence that Bradley attempted suicide or self-harm by medication overdose in the past;

(c) that Bradley routinely took a myriad of medications to help him get sleep[168] and was known to take large doses of medication like Restavit because low doses would not have an impact;[169]

(d) that Bradley does not appear to have made any recent threat of self-harm, and there is only one historical instance of him threatening self-harm or suicide (by different means); [170]

(e) there is no other physical evidence sometimes seen in the context of suicide, including a note or instructions regarding an estate;

(f) Bradley's well-documented fear of death – in circumstances where that preoccupation caused Dr Townsend to form the view that Bradley was in fact at a reduced risk of suicide because he appeared to place value on his own life.[171]

226 Bradley's family feel strongly that his death was unintentional.

227 Bradley's grandmother speculated to Dr de Klerk on 1 April 2025 that Bradley may have taken too much medication, not on purpose but trying to help himself.[172]

228 I accept – as explained by his family – that some of Bradley's symptoms were particularly insidious at nightmare, and exacerbated by poor sleep, and that this was a consistent issue for him.

229 On that basis, I accept that there was a greater capacity for potential overdose by Bradley at night, or in the very early morning.

[168] Exhibit 1, tab 8, par [7].
[169] Exhibit 1, tab 15, par [25].
[170] Exhibit 1, tab 15, par [26].
[171] Exhibit 1, tab 18, par [53].
[172] Exhibit 1, tab 13, progress note dated 3 April 2025.

230 However, I still have considerable doubt regarding the potential for Bradley to have consumed the quantity of medication he did, purely on the basis he believed it would assist him in obtaining sleep.

231 Bradley's family observed that he lived in constant fear – fear of dying from the many imagined diseases he believed he had, and fear of outlaw motorcycle gang members harming him. His family stated '*For a man so terrified of death, the idea that he would deliberately take his own life makes no sense to us*'.[173]

232 I understand and empathise with that view, having examined all of the evidence. However, the sheer quantity of the medication that Bradley consumed, as well as the fact that he ingested copious amounts of more than one medication, militate against a conclusion that he was attempting to help himself get rest, for example, and inadvertently overdosed.

233 In their submission to the Court, Bradley's family articulated their view that Bradley must have had impaired judgment and unmanaged symptoms to have taken the actions that he did.[174]

234 I accept this is a real possibility.

235 Having reviewed all of the evidence, including the history of Bradley's most profound symptoms and accounts of his previous episodes of psychosis, I am unable to exclude the possibility that Bradley took the medication during a psychotic episode.

236 Dr de Klerk's reports, following his assessments of Bradley, routinely refer not to a risk of suicide due to any suicidal ideation or self-harm, but a risk of self-injurious behaviour upon an acute relapse of psychosis, as he considers occurred in April 2021.[175]

237 Where it has been acknowledged that the depot medication being administered prior to death was unlikely to have been as efficacious as the previous depot, and where it appears that Bradley was not being consistently compliant with the oral olanzapine, I consider that there is a prospect that he was experiencing psychosis on 31 March 2025, and ingested medication as a manifestation of the self-injurious behaviour that Dr de Klerk had previously recognised as a risk.

[173] Exhibit 1, tab 20, p 3.
[174] Exhibit 1, tab 20, p 4.
[175] Exhibit 1, tab 21, par [39].

238 Although there was no indication during his presentation on 27 March that he was acutely preoccupied with death or fatal familial insomnia in the manner that had previously caused concern,[176] it is apparent that he was expressing some delusional thinking to Mr Zampogna in the days prior to his overdose. I also accept that Bradley had an ability to mask symptoms and use learned responses in dealing with to clinicians.[177]

239 Given the persistent nature of his historical somatic and delusionary complaints, it is questionable whether he would have been able to mask all symptoms when dealing with clinicians on 27 March, or even when speaking with his grandmother in the morning on 31 March. Dr de Klerk's evidence at the inquest, which I accept, is that it is possible.

240 Having carefully considered all of the evidence, I am unable to make a finding as to the manner of Bradley's death, to the requisite standard.

241 I am unable to exclude the possibility of suicide given the findings regarding the quantities of medication ingested, but I am also conscious of the real possibility that Bradley died from self-injurious behaviour during a psychotic episode, for which there is some evidence in support. In that case, there would be doubt as to whether Bradley possessed the necessary intention, and his death would be properly characterised as accidental.

242 Where I cannot exclude either of those possibilities on the existing evidence, I make an open finding as to the manner of Bradley's death for the purposes of s 25(1)(b) of the Act.

Quality of Bradley's supervision, treatment and care

243 As identified above, Bradley's family provided a letter to the Court ahead of the inquest, in which they expressed gratitude for the personalised care by the staff within the BCMHT, and their compassion and genuine concern for Bradley.[178]

244 Having examined the evidence, I understand the family's motivation in conveying those sentiments. The records of the BCMHT demonstrate a consistent and concerted engagement with Bradley and his support

[176] Exhibit 1, tab 21, par [68].
[177] Exhibit 1, tab 20, p 1.
[178] Exhibit 1, tab 20, p 4.

network, in order to not just manage his acute symptoms but also to develop treatment plans for his psychosocial symptoms.

245 I find that, generally, the BCMHT's supervision, treatment and care of Bradley was of a high standard.

246 There were challenges, which I address below, which occurred during an apparent decline in his health in late 2024 and early 2025, but they were not issues that were unidentified or unaddressed. As is ordinarily the case, there are also parts of the care that could have been improved. It was expressly conceded by treating staff that gave evidence at the inquest that engagement with Bradley's family was less consistent than it had previously been, and there is always scope for improvement in that regard. Those concessions were appropriately made, and reflect that the BCMHT was and remains a team genuinely engaged in pursuing best practice and improvement.

How did WACHS address the shortage in supply of depot olanzapine?

247 I accept the evidence of Dr Townsend that supply shortages occur in relation to medications from time to time, reflective of the relatively small size of the Australian market and manufacturers miscalculating supply requirements.[179] Although trite, I accept that WACHS does not have any control in relation to those matters, and can only model their treatment mindful that shortages might arise unexpectedly, and address the effects as best they can when shortages do occur.

248 In this case, I accept that the shortage of supply of depot olanzapine was unavoidable from WACHS's perspective.

249 I am satisfied, based on Dr de Klerk's evidence, that he and other treating clinicians in BCMHT choose which medications to prescribe mindful of those that have historically been subject to supply shortages.

250 It is also patently clear that, as a result of the shortage in supply, Bradley's treating team:

(a) identified and prescribed other forms of medications which were potentially not as efficacious, but were the best alternative;

(b) expressly advised Bradley about the shortage and the need to prescribe the alternatives, and what that might mean in terms of his ongoing health; and

[179] Exhibit 1, tab 18, par [23].

(c) implemented more regular monitoring, including by Dr de Klerk, than would have otherwise been the case.[180]

251 The only potential area for improvement in this respect is that not all parts of Bradley's family who provided him support were aware of the change in his depot medication, including introduction of oral medication in part substitution for the depot olanzapine.[181]

252 I infer that this information might not have been provided to Bradley's sister or father, for example, where Mr Hislop had assumed case management more recently and interacted primarily with Bradley's grandmother, and Mr Zampogna.[182]

253 There is no basis to criticise him for having done so, given:

(a) the consent to release information form signed by Bradley on 24 October 2024 in which he consented to Mr Zampogna being contacted; and

(b) the previous release form in August 2023 in which he consented to Mr Zampogna being contacted in addition to Dr Gliddon and '*family*' with a reference to his grandmother, with a note that Bradley be asked first before calling.[183]

254 My review of the documentation suggests that the previous case manager engaged more frequently with Bradley's father and sister (including where Bradley's sister was recorded as his next of kin in the Webpas system, presumably as a result of information provided by Bradley when engaging with WACHS during previous admissions),[184] and that this part of the communication between the treating team and Bradley's family '*waned*'[185] following the change in case management.

255 This one area for potential improvement should not detract from what, overall, struck me as a case where there was frequently good communication between the family and the treating team, and responsive and assertive action taken by the BCMHT when concerns were expressed including through obtaining useful collateral information.

[180] Exhibit 1, tab 18, par [23].
[181] Exhibit 1, tab 20, pp 2-3.
[182] Exhibit 1, tab 19, par [9].
[183] Exhibit 1, tab 19, par [9].
[184] Exhibit 4.
[185] Exhibit 1, tab 20, p 1.

256 There were two good examples of this in November and December 2024.

257 As identified above at pars [88]-[93], when Bradley's sister communicated her concern in November 2024 about a potential decline, Dr de Klerk took prompt and assertive action by:

(a) bringing Bradley's review forward in time; and

(b) engaging with him a direct and assertive way, such that Bradley became amenable to accepting the depot aripiprazole as a compromise.

258 Further, in December 2024, Mr Zampogna raised a concern about Bradley speaking about death and dying more frequently than usual around that time.[186] The records suggest that this prompted immediate and effective action by Mr Hislop as case manager.[187]

259 These examples satisfy me that communication in respect of Bradley's health and treatment, between his family and supports on the one hand, and clinicians and treating team on the other, was generally very good, including in late 2024.

Was there evidence that Bradley was stockpiling medications?

260 An issue arising from both the Court's initial review of the evidence, and correspondence from the family, was the question of Bradley having access to the fatal quantities of medication resulting in overdose.

261 I am satisfied, having now reviewed all the available documentary evidence as well as hearing from the clinicians, that there was no evidence that Bradley was stockpiling medications, or '*prescription shopping*'.

262 There is no evidence of attempts by Bradley to obtain multiple prescriptions for the same medication from different clinicians, including general practitioners, or to refill prescriptions prematurely. The PBS information, in fact, suggests the contrary.

263 As identified above, if Bradley was deliberately seeking to stockpile medication, it can be assumed he would have filled a prescription for olanzapine on or after 27 March 2025.

[186] Exhibit 1, tab 19, par [22].
[187] Exhibit 1, tab 19, par [22].

264 I accept the evidence of Dr de Klerk and Dr Townsend that there were no signs on 27 March that Bradley was seeking to obtain prescriptions in order to stockpile medication.

265 His request for mirtazapine was made in the context of his ongoing sleep difficulties and his having previously been prescribed the mediation, and was only issued following Dr Townsend undertaking appropriate inquiries and consulting Dr de Klerk.

266 I also accept Dr Townsend's evidence that to not prescribe the oral olanzapine to Bradley on that occasion would have been to accept a risk of deterioration in mental state given the ongoing inability to administer olanzapine via depot.[188]

267 I do not consider that the issue of the prescriptions on 27 March, including the quantity, was inappropriate. Prescribing the mirtazapine, for example, in a Webster pack would not have precluded Bradley from taking the quantity of that medication that he ingested on 31 March. Given his history, and his presentation on 27 March, I do not consider that there was any identifiable or appreciable risk of overdose on that date that would have warranted the clinicians considering staged or controlled dispensing.

268 In response to the expression of concern by the family about this possible systemic issue,[189] I am satisfied that tightly controlled staging is a practice which can be employed to mitigate identifiable risks.[190]

Did BCMHT exhaust all further treatment options?

269 Bradley's family expressed the concern that his treatment seemed to plateau,[191] and in that context queried whether all treatment options had been pursued, including some that were trialled early in Bradley's care by BCMHT and not seemingly revisited.

270 I note, as identified above, that Bradley's illness manifested in acute '*positive*' symptoms when he was very unwell, and '*negative*' symptoms which were psychosocial in nature and ongoing. It is clear that Dr de Klerk recognised this, and sought to try and focus on the latter when possible.

[188] Exhibit 1, tab 18, par [37].
[189] Exhibit 1, tab 20, p 3.
[190] Exhibit 1, tab 18, par [52].
[191] Exhibit 1, tab 20, p 1.

271 I consider it would have been inherently more difficult to treat those symptoms, which are not capable of treatment purely by pharmacological means, and required ongoing and concerted effort by Bradley including with his social supports.

272 I am satisfied that Dr de Klerk took all appropriate steps to pursue ECT, which I address further below.

273 Perhaps the only area which might have been revisited or trialled again at a later stage, but was not, was clozapine.[192] Dr de Klerk accepted at the inquest this this was trialled again, but I do not consider there is any basis for criticism in this respect – both because of the prospect of recurrence of the myocarditis that stymied the first attempt, but also because trialling the clozapine would have required a hospital admission, and I question whether that was warranted, at least on the basis of how Bradley was presenting to clinicians in 2024 and 2025.

274 The evidence suggests that the BCMHT pursued treatment options and were mindful about identifying means to improve Bradley's health.

Recommendation - ECT in Bunbury

275 The evidence demonstrated that both Bradley's family and Dr de Klerk considered that ECT resulted in improvement.[193] Dr de Klerk considered that ECT produced the most marked improvement of any single intervention during Bradley's acute inpatient treatment in 2022.[194]

276 At the inquest, I queried the availability of ECT in the Bunbury region, based on the evidence that Bradley had been unable to obtain readmission to Fremantle and where – at the time – Albany might have been the only regional alternative.

277 In response to the Court's inquiry, WACHS has advised:

> ECT services in Bunbury are anticipated to commence during this financial year.[195]

278 It will obviously be a positive advancement for patients like Bradley in the Bunbury region to have access to ECT where clinically indicated.

[192] Exhibit 1, tab 20, p 1.
[193] Exhibit 1, tab 20, p 2.
[194] Exhibit 1, tab 21, par [32].
[195] Exhibit 4.

279 In the absence of evidence of any clear impediments, it would be expected that services should be capable of being provided well before mid-2027.

280 As such I recommend as follows:

The WA Country Health Service prioritise any remaining steps to allow electroconvulsive therapy to be available to patients in Bunbury as soon as practicable.

Conclusions

281 As noted by his family, Bradley's life was not defined by the challenges he faced due to his mental health. He enjoyed love and support from family and friends due to the way he engaged with others over the course of his lifetime, despite the recent debilitating symptoms of his illness.

282 His death is a tragic outcome, and as I expressed at the inquest, there is no expectation that a family will obtain closure from an inquest process.

283 However, I hope that the evidence at the inquest and these findings provide the family with further information that supplements their understanding of the circumstances of Bradley's death, and while some questions necessarily remain unanswered, all aspects of Bradley's care have been closely considered.

BD Nelson
Coroner
7 August 2026