JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	PHILIP JOHN URQUHART
HEARD	**:**	16 - 19 JANUARY 2024
DELIVERED	**:**	6 DECEMBER 2024
FILE NO/S	**:**	CORC 2241 of 2020
DECEASED	**:**	KINNANE, JAXON CHARLES

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:
Mr W Stops assisted the coroner
Mr J Johnson instructed by Mr I Murray (Blumers Lawyers) appeared on behalf of Mr Murray Kinnane, father of the deceased
Mr D Harwood (State Solicitor's Office) appeared on
behalf of the Department of Justice; the North Metropolitan Health Service and East Metropolitan Health Service
Mr C Beetham instructed by Ms J Earl (Minter Ellison) appeared on behalf of St John of God Health Care Inc
Ms B Burke (Belinda Burke Lawyers) appeared on behalf of Nurse Emma Tsakalos, Nurse Lyn Barnes, and Nurse Colin McKnight

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 ***Jaxon Charles KINNANE*** *with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, PERTH, on 16 – 19 January 2024, find that the identity of the deceased person was* ***Jaxon Charles KINNANE*** *and that death occurred on or about 12 October 2020 in the Swan River at or about the location of Caversham, from immersion in water (drowning) in a man with combined drug effect in the following circumstances:*

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LIST OF ABBREVIATIONS AND ACRONYMS

Abbreviation/Acronym	Meaning
the Act	*Coroners Act 1996* (WA)
ADHD	attention deficit hyperactivity disorder
ARMS	At Risk Management System
the ***Briginshaw*** principle	the accepted standard of proof a court is to apply when deciding if a matter adverse in nature has been proven on the balance of probabilities
Casuarina	Casuarina Prison
the Court	the Coroners Court
CTO	Community Treatment Order
CCU	Crisis Care Unit at Casuarina Prison
the Department	the Department of Justice
EcHO	the Department of Justice's electronic medical system used to manage the health care of prisoners
ED	Emergency Department
GP	General Practitioner
Hakea	Hakea Prison
the Manual	SJOGMH'S Mental Health Manual
the MHU	the Mental Health Unit at SJOGMH
MRI	magnetic resonance imaging
the panel	the panel of experts that undertook the SAC1 investigation
PRAG	Prisoner Risk Assessment Group
PSOLIS	Psychiatric Services On-Line Information System
SAC1	Severity Assessment Code 1
SJOGMH	St John of God Midland Hospital
Ts	Transcript

INTRODUCTION

"An hallucination is a fact, not an error. What is erroneous is a judgment based upon it."
Bertrand Russell – philosopher

1. Jaxon Charles Kinnane (Jaxon)[1] died on or about 12 October 2020, having drowned in the Swan River at or about the location of Caversham. He was 22 years old.

2. Jaxon's death was a reportable death within the meaning of section 3 of the *Coroners Act 1996* (WA) (the Act) as it was unexpected. However, an inquest into his death was not mandatory as it did not fall within any of the circumstances set out in section 22(1) of the Act.

3. However, on 19 June 2023, following the receipt of written submissions from Jaxon's family, the State Coroner determined an inquest was desirable pursuant to section 22(2) of the Act. The purpose of the inquest was to examine the medical treatment and care Jaxon received for his mental health in the lead up to his death.

4. I held an inquest into Jaxon's death at Perth from 16 to 19 January 2024. The family of Jaxon were in attendance for those four days. The following witnesses gave oral evidence:[2]

i. Colin McKnight (nurse at Casuarina Prison);
ii. Emma Tsakalos (nurse at Casuarina Prison);
iii. Lyn Mills (nurse at Casuarina Prison);
iv. Dr Lisa Smith (consultant psychiatrist at the Frankland Centre);
v. Dr Daniel De Klerk (consultant psychiatrist at Casuarina Prison);
vi. John Berkin (clinical nurse at North Metropolitan Health Service Prison In-Reach);
vii. Craig Cresswell (psychiatric liaison nurse at St John of God Midland Hospital);
viii. Shuvai Dirorimwe (nurse at St John of God Midland Hospital);
ix. Luana Rocchiccioli (social worker at St John of God Midland Hospital);
x. Jessica Biggs (nurse at St John of God Midland Hospital);

[1] As the family had requested that their relative be referred to as "Jaxon" during the inquest, I will identify him in the same manner in my finding.
[2] The citied occupations of these witnesses are the positions they held at the relevant time.

xi. Dr Devendra Makesar (consultant psychiatrist at St John of God Midland Hospital);

xii. Dr Stefan Schutte (Head of Department, Psychiatry at St John of God Midland Hospital);

xiii. Murray Kinnane (father of Jaxon);

xiv. Andrew Beck (Deputy Commissioner, Offender Services at the Department of Justice);

xv. Dr Peter Wynn Owen (consultant forensic psychiatrist, acting Head of Clinical Services at State Forensic Health Service); and

xvi. Dr Adam Brett (independent consultant psychiatrist).

5. 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.

6. At the completion of the inquest, I sought additional information from the Department of Justice (the Department). That information was in relation to the Department's Electronic Health Online (EcHO) records[3] and what access entities external to the Department had to those records. In response, the Court received a letter dated 7 March 2024 from Dr Joy Rowland, Director of Medical Services at the Department.

7. My primary function at the inquest was to investigate the quality of the medical supervision, treatment and care that was provided to Jaxon from April 2020. This covered the periods when he was a remand prisoner at Casuarina Prison (Casuarina), and when he was a patient at the Frankland Centre and St John of God Midland Hospital (SJOGMH).

8. When assessing the evidence and making my findings in this matter, I must be mindful of two key principles. The first of these principles is known as hindsight bias, which means I must not insert hindsight bias into my assessment of the action taken by Jaxon's health service providers in their treatment of him at Casuarina, the Frankland Centre and SJOGMH. Hindsight bias is the tendency, after an event, to assume that the event was more predictable or foreseeable than it actually was at the time.[4]

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[3] EcHO is the electronic medical record system used to manage the health care of prisoners under the care of the Department's Health Services.
[4] Dillion H and Hadley M, *The Australasian Coroner's Manual* (2015) 10

9. The other principle which I must apply is known as the ***Briginshaw*** principle. This principle is derived from a High Court decision in which Dixon J stated:[5]

> The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding are considerations which must affect the answer to the question whether the issue has been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences.

10. In short, the ***Briginshaw*** principle requires that the more serious the allegation, the higher the degree of probability that is required before I can be satisfied as to the truth of the allegation.

11. In this finding, I will review the actions of Jaxon's health service providers from April 2020 until his death seven months later. I will apply the ***Briginshaw*** principle and be mindful not to insert hindsight bias to my analysis of those actions.

JAXON

Background [6]

12. Jaxon was born at King Edward Memorial Hospital, Subiaco on 22 June 1998. He was the eldest child of his parents, and he had two younger sisters. He lived with his family in Bassendean and then in Woodbridge.

13. Jaxon played a number of sports growing up and enjoyed socialising with friends during primary and early high school. He also developed a keen interest in computer gaming. As a teenager, Jaxon worked at a cinema and in retail.

14. Sadly, Jaxon began using illicit drugs at a young age. He started smoking cannabis in his early teenage years and then began using methylamphetamine. He had also "doctor shopped" for benzodiazepines.

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[5] ***Briginshaw v Briginshaw*** (1938) 60 CLR 336 at 362

[6] Exhibit 1, Volume 1, Tab 21, Correspondence from Jaxon's family

Jaxon's mental health [7]

15. In 2014, Jaxon was diagnosed with attention deficit hyperactivity disorder (ADHD). A paediatrician prescribed Ritalin to treat Jaxon for this condition.

16. In February 2015, a private psychiatrist diagnosed Jaxon with excessive electronic media use disorder relating to his use of computer games, cannabis abuse, anxiety disorder (with avoidance and secondary depression), possible attachment disorder and antisocial/conduct disorder traits. His stimulant medication was ceased and by August 2016, Jaxon was being treated with dexamphetamines for his ADHD.

17. On 1 December 2016, Jaxon had his first admission to Graylands Hospital. He had been transferred from Midland Hospital after presenting in a very anxious and depressed state, with persecutory ideas and auditory hallucinations. He also had fleeting suicidal ideation. At Graylands Hospital, Jaxon was diagnosed with psychosis and amphetamine abuse. He was discharged four days later with no ongoing medication and for follow up to be organised through his GP.

18. Thereafter, Jaxon had multiple admissions to various private mental health facilities and public mental health units. These included admissions following intentional drug overdoses. Apart from his ADHD, Jaxon was diagnosed with various conditions including:

- Obsessive disorder
- Post-traumatic stress disorder (PTSD)
- Drug-induced psychosis
- Antisocial personality disorder
- Polysubstance abuse
- Emotional dysregulation
- Methamphetamine abuse
- Psychosis and delusional disorder

19. During this period, Jaxon would exhibit violent and threatening behaviour towards his family which required the intervention of police on numerous occasions. From February 2017, Jaxon had regular appearances in the Magistrates Court and had drug-related convictions in addition to convictions for assault, threats, damage and dishonesty.

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[7] Exhibit 1, Volume 1, Tab 20.2, Report of Dr Adam Brett dated 2 February 2023; Exhibit 1, Volume 1, Tab 22, Cell Placement History

Between July 2018 and June 2019, Jaxon had three separate stints in Hakea Prison (Hakea) on remand ranging from two days to 67 days.

20. Prior to 2020, the only treatment that was able to stabilise Jaxon for any length of time was monthly depot injections of paliperidone (an antipsychotic medication). This treatment was involuntary and pursuant to a Community Treatment Order (CTO). For a brief period of time at the end of 2019, Jaxon's family were able to have a welcomed respite from his previous behaviour as he remained free of psychotic symptoms.[8]

21. However, Jaxon began experiencing side-effects (including akathisia[9]) from the depot injections. Despite the lowering of the dose of paliperidone and being prescribed medication to treat his side-effects, Jaxon remained resistant to the depot injections and his behaviour subsequently deteriorated.

EVENTS OF 2020

22. Sadly, due to his behaviour, Jaxon's mother and his sisters felt they had no option other than obtaining Family Violence Restraining Orders against him.[10] This meant that from 11 February 2020, the only immediate family member Jaxon had regular contact with was his father.

Jaxon is remanded to Hakea [11]

23. On or about 31 January 2020, Jaxon was charged with offences that included common assault and criminal damage. Although he was released on bail following those charges, he was charged with breaching a condition of his bail undertaking on 17 March 2020. As a result, on 22 March 2020, Jaxon was remanded in custody to Hakea.

24. On reception to Hakea, Jaxon told a prison nurse that he had never tried to harm himself or take his own life. He disclosed that he had been treated for depression and ADHD.

25. On 2 April 2020, Jaxon advised a prison mental health nurse that he was hearing voices. The following day it was recorded that he had disclosed to another prison mental health nurse that someone had put "*a piece of rice*"

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[8] Exhibit 1, Volume 1, Tab 12, Statement of Murray Kinnane dated 8 March 2021, p.4

[9] Akathisia is a neuropsychiatric syndrome and movement disorder which makes it difficult for a person to sit or remain still. It is a recognised side-effect of antipsychotic medications.

[10] Exhibit 1, Volume 1, Tab 14, Restraining Order details

[11] Exhibit 1, Volume 1, Tab 20.2, Report of Dr Adam Brett dated 2 February 2023; Exhibit 1, Volume 1, Tab 22, Cell Placement History; Exhibit 1, Volume 1, Tab 24.1, EcHO records (extracts); History for Court – Criminal and Traffic: Jaxon Charles Kinnane

in his ear and was always talking to him. Jaxon said he was "*not doing too well*" due to the "*voices*" and that he wanted a "*death plan*".

26. After Jaxon's meeting with a prison nurse on 3 April 2020, Dr Edward Petch (Dr Petch), the prison psychiatrist at Hakea, diagnosed Jaxon had non-recent psychosis and prescribed antipsychotic medication in tablet form.

27. Over the following days, Jaxon continued to complain about a microchip that had been inserted into his head and hearing voices.

28. On 9 April 2020, Dr Petch noted that Jaxon had "*florid psychosis in context of emerging schizophrenic illness*". He was adamant that he required surgery to remove the "*transmitter*" from inside his head. He was refusing all medications, stating that no amount of medication would help. Dr Petch recommended that Jaxon be admitted to the State Forensic Unit at Graylands Hospital (the Frankland Centre) for involuntary treatment under section 25 of the *Mental Health Act 2014* (WA).

29. On 17 April 2020, Dr Petch reviewed Jaxon. He appeared distressed, was not taking his prescribed olanzapine and remained acutely psychotic, believing people wanted to kill him.

30. Dr Petch again noted that Jaxon required an urgent admission to the Frankland Centre. However, that had not taken place due to there being no bed available.

Jaxon is transferred to Casuarina [12]

31. On 18 April 2020, Jaxon was transferred to Casuarina.

32. On 21 April 2020, he was reviewed by a prison doctor and it was noted he continued to refuse any antipsychotic medication and that he was still waiting for a bed to become available at the Frankland Centre.

33. On 22 April 2020, Jaxon was reviewed by a prison psychiatrist at Casuarina, Dr Peter Wynn Owen (Dr Wynn Owen). Jaxon relayed a similar history he had given to health service providers at Hakea; namely, that bikies had inserted a "*transmitter*" into his ear which they had then used it to make him their prostitute. Dr Wynn Owen noted that Jaxon had acute paranoid psychosis and was at risk of self-harm and was a probable risk to others. He recommended antipsychotic medication (quetiapine) and diazepam, and that Jaxon be immediately placed at the Frankland Centre.

[12] Exhibit 1, Volume 1, Tab 24.1, EcHO records (extracts)

Jaxon's first admission to the Frankland Centre [13]

34. On 22 April 2020, Jaxon was admitted to the Frankland Centre. He was initially under the care of Dr Alexander van Hattem (Dr van Hattem), a consultant psychiatrist. He was managed as an involuntary patient and diagnosed with likely schizophrenia by Dr van Hattem, who prescribed increased doses of quetiapine and antidepressants.

35. In a report dated 29 April 2020, Dr van Hattem recommended that if Jaxon was granted bail, he should be referred to a mental health inpatient unit under the *Mental Health Act 2014* (WA). And if he was to remain in custody, he should have ongoing care provided by the Frankland Centre.

36. During Jaxon's admission to the Frankland Centre, his care was transferred from Dr van Hattem to another consultant psychiatrist, Dr Liz Tate (Dr Tate). On the information available to me, I am unable to determine the reason for this transfer.

37. By 7 May 2020, Dr Tate had a different view from those that had been expressed by previous psychiatrists who had treated Jaxon. Dr Tate questioned the validity of the diagnosis of schizophrenia and was of the view Jaxon was not experiencing a genuine psychotic episode. It was her opinion his main issues were drug abuse and Cluster B personality disorder.[14]

38. Consequently, Dr Tate decreased Jaxon's doses of quetiapine and he was discharged back to Casuarina on 11 May 2020.[15]

Jaxon's imprisonment at Casuarina from 11 May 2020 [16]

39. Jaxon was reviewed regularly by prison mental health service providers at Casuarina. He continued to present with paranoid delusions and was maintained on the lower dose of quetiapine and his antidepressant medication.

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[13] Exhibit 1, Volume 1, Tab 24.2, Frankland Centre records (extracts)

[14] The general features of a Cluster B personality disorder include unstable emotions and dramatic or impulsive behaviours, and include borderline personality disorder, histrionic personality disorder, narcissistic personality disorder and antisocial personality disorder: https://www.healthdirect.gov.au/health-topics

[15] I note that Dr Adam Brett, the consultant psychiatrist who undertook an independent review for the Court, expressed a view that there was evidence for a diagnosis of Cluster B personality disorder. Dr Brett noted that Jaxon had conduct disorder as a child with emotional instability, poor impulse control and self-injury. He also noted that this diagnosis would support the point of view that Jaxon's complaints of a transmitter in his ear would be motivated by his desire to remain in the Frankland Centre and achieve a more lenient sentence for his outstanding charges: Exhibit 1, Volume 1, Tab 20.2, Report of Dr Adam Brett dated 2 February 2023, p.9

[16] Exhibit 1, Volume 1, Tab 24.1, EcHO records (extracts)

40. An MRI[17] head scan was booked for 19 May 2020; however, Jaxon was under the mistaken impression that the appointment was to remove the implant he believed was in his ear.

41. From 18 May 2020, Jaxon was reviewed by Dr Daniel de Klerk (Dr de Klerk), a consultant psychiatrist at Casuarina, who noted that Jaxon had bizarre and longstanding delusions, auditory hallucinations, flat mood and poor insight into his conditions. Dr de Klerk documented that "*the presence of delusions, hallucinations and negative symptoms signify schizophrenia to me*" and that Jaxon was not on a "*sufficient dose of antipsychotic medication to treat schizophrenia*".

42. On 19 May 2020, Dr de Klerk discussed Jaxon's presentation at a peer review meeting and it was concluded that Jaxon had schizophrenia and should be returned to the Frankland Centre for further treatment.

43. On 20 May 2020, Dr de Klerk discussed Jaxon's case with Dr Tate and expressed the need for a further admission to the Frankland Centre. However, Dr Tate did not agree that Jaxon had schizophrenia and stated a transfer back to the Frankland Centre was not appropriate.

44. On 22 May 2020, Dr de Klerk recorded that Jaxon appeared very deluded with distressing, bizarre and persecutory delusions. He maintained his opinion that Jaxon had schizophrenia.

45. On 3 June 2020, Jaxon's distress regarding the microchip in his ear had escalated and he threatened to remove it himself. He had to be restrained and placed in a safe cell for his own safety. After Dr de Klerk discussed the different diagnostic opinions between prison psychiatrists and the Frankland Centre with Dr Wynn Owen, a decision was made to arrange another opinion from the experienced consultant psychiatrist, Dr Mark Hall (Dr Hall).

46. On 15 June 2020, following a further deterioration in his psychosis, another referral was made for Jaxon to be involuntarily treated at the Frankland Centre. However, as at that date, the Frankland Centre was at full capacity and there were no beds available.

47. On 18 June 2020, Jaxon was reviewed by Dr Hall who noted that Jaxon had bizarre and systematised paranoid delusions with persecutory, sexual and grandiose themes. He had auditory hallucinations, no sight into the abnormal nature of his experiences and his judgment was impaired.

[17] magnetic resonance imaging

48. Dr Hall assessed that Jaxon was a "*young man with [a] serious mental illness, namely schizophrenia*" who was "*at risk to others [and] self, due to his delusional beliefs and associated anger*". Dr Hall concluded that Jaxon lacked the capacity to provide informed consent to treatment and that in his opinion, Jaxon's "*symptoms have been erroneously dismissed as psychosis and instead attributed to malingering*". Dr Hall was of the view Jaxon required inpatient stabilisation as an involuntary patient and the commencement of depot antipsychotic medication. Although Dr Hall believed Jaxon ought to have an eventual discharge to a Community Treatment Order (CTO), he noted that commencing a CTO from prison or once he was in the community would be problematic due to Jaxon's lack of available accommodation and lack of insight into his mental health.

49. On 4 July 2020, Jaxon became increasingly distressed. He was making threats to hurt others, screaming, shouting, pacing and had punched a door.

50. On 14 July 2020, a bed eventually became available at the Frankland Centre and Jaxon was admitted that same day.

Jaxon's second admission to the Frankland Centre [18]

51. During this admission to the Frankland Centre, Jaxon was placed under the care of a different psychiatrist, Dr Lisa Smith (Dr Smith). Jaxon continued to maintain his beliefs that he had a microchip in his ear. Despite attempts by a psychologist to engage Jaxon in personality testing, he declined to do so.

52. On this occasion, Jaxon's treating team at the Frankland Centre liaised with his mother regarding his diagnostic uncertainty and previous presentations. Jaxon's mother advised that he had shown a significant improvement in his mental state when he had previously been treated with paliperidone depot injections.

53. Dr Smith formed a view there was enough evidence of psychosis to justify a retrial of paliperidone depot injections. Jaxon, however, remained strongly opposed to this treatment. Nevertheless, he was started on paliperidone injections on 20 July 2020 and received a second dose one week later.

54. Jaxon experienced appendicitis during this admission and had to be transferred to Sir Charles Gardener Hospital where he underwent surgery on 29 July 2020. When he was transferred back to the Frankland Centre

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[18] Exhibit 1, Volume 1, Tab 24.2, Frankland Centre records (extracts)

on 3 August 2020 it was noted Jaxon was more pleasant, less paranoid and less fixated on his delusional beliefs.

55. On 4 August 2020, Jaxon was discharged back to Casuarina with the plan for a paliperidone depot injection every four weeks, with the next injection due on 24 August 2020. He was also prescribed the oral medications quetiapine and sertraline (an antidepressant medication). The formal discharge diagnosis was "*psychosis, with a probable diagnosis of schizophrenia*". The discharge summary from the Frankland Centre also advised that should Jaxon refuse his depot injection in prison then he would need to be referred back to the Frankland Centre. It was also noted on the discharge summary that Jaxon had not demonstrated any capacity regarding his mental health treatment and would most likely need to be placed on a CTO when he was eventually released from prison.

Jaxon's imprisonment at Casuarina from 4 August 2020 [19]

56. On 5 August 2020, Jaxon was reviewed by a prison mental health worker who recommended that he remain in the Crisis Care Unit (CCU) on low ARMS[20] whilst he settled back into prison.

57. On 14 August 2020, Dr de Klerk reviewed Jaxon and noted that he had significantly improved. However, he remained lacking insight, stating he would not take any medications if he was released from prison. Jaxon maintained he did not have a mental illness and still believed he had a microchip in his ear.

58. On 20 August 2020, Jaxon was seen by John Berkin (Mr Berkin), a clinical nurse with the Prison In-Reach Transition Team.[21] Although Jaxon declined the offer of assistance from Mr Berkin, he admitted that if he was to be released at his next court appearance (on 27 August 2020), he would not be able to remain in the community and that he would need to be in hospital.

59. On 26 August 2020, Jaxon refused to have his depot injection of paliperidone. He agreed to continue taking his oral medications.

60. On 27 August 2020, Jaxon was granted bail by the Magistrates Court. However, one of the bail conditions was that he was to reside at his grandmother's address. Although his grandmother was prepared to be

[19] Exhibit 1, Volume 1, Tab 24.1, EcHO records (extracts)
[20] ARMS is an acronym for At Risk Management System which is the Department's framework for suicide prevention that manages prisoners deemed to be at risk of self-harm or suicide.
[21] The Prison In-Reach Transition Team is a multi-disciplinary team that provides early referral, integration, continuity of care and safe transition of prisoners into community mental health services via pre-release planning and case management.

Jaxon's surety, she declined to have him reside with her. Jaxon subsequently remained in custody at Casuarina.

61. On 2 September 2020, a prison mental health worker met with Jaxon. On this occasion he was highly distressed regarding the microchip in his ear stating he could no longer take it. Later that day he refused to take his oral antipsychotic medication.

62. On 8 September 2020, Jaxon appeared in the Midland Magistrates Court. On that occasion, he pleaded guilty to a number of offences for which he received fines. As these pleas of guilty finalised his outstanding charges, Jaxon was released from Casuarina later that same day.

Jaxon's admission to St John of God Midland Hospital [22]

63. After staying the night at a friend's house on the day of his release from Casuarina, Jaxon contacted his father stating he had suicidal ideations. Jaxon also complained of the microchip in his ear and his father took him to the ED at SJOGMH. Jaxon was subsequently admitted to the Mental Health Unit (MHU) at SJOGMH as a voluntary patient following a psychiatric review.

64. On admission, Jaxon was diagnosed with psychosis. Although he was settled in the MHU within a day, Jaxon continued to believe he had a microchip in his right ear that livestreamed his thoughts and activities. He wanted to prove the existence of this microchip with a scan. As he was a voluntary patient, Jaxon was placed in the open ward of the MHU and was allowed unescorted ground access. He agreed to take oral antipsychotic medication.

65. Dr Devendra Makesar (Dr Makesar), a consultant psychiatrist at SJOGMH, became Jaxon's psychiatrist during this admission. Dr Makesar had been Jaxon's treating psychiatrist during previous admissions to the MHU at SJOGMH.

66. Shortly after his admission, Jaxon was reviewed by Dr Makesar. He reported he had experienced suicidal ideation in prison; however, he was feeling better and felt safe in the MHU. Dr Makesar concluded Jaxon was at a low risk of self-harm and he diagnosed a likely relapse of symptoms of schizophrenia. Jaxon was prescribed oral antipsychotic and antidepressant medications, which he agreed to take.

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[22] Exhibit 1, Volume 1, Tab 25.1, SJOGMH records (extracts); Exhibit 1, Volume 1, Tab 12, Statement of Murray Kinnane dated 8 March 2021; Exhibit 1, Volume 2, Tab 7, Statement of Dr Devendra Makesar dated 27 December 2023

67. Risk assessments for Jaxon were updated on a daily basis with his risk of self-harm recorded as "*low*".

68. Although his unescorted ground access initially appeared to be going well, on 16 September 2020 Jaxon admitted to using dexamphetamine and offering it to another patient in exchange for cigarettes. A search by MHU staff found 32 mg of dexamphetamine hidden in Jaxon's mobile phone case.

69. Throughout his admission to the MHU, Jaxon and his father were keen for him to be moved to a private psychiatric unit for ongoing treatment. However, inquiries made with such units were not successful.

70. On 17 September 2020, a family meeting was held with Jaxon's father in attendance. Jaxon was reassured he did not have a microchip in his ear and was told that an MRI had confirmed this. Nevertheless, Jaxon wanted his father to get a Wi-Fi detector to find the microchip. Although Jaxon disputed the diagnosis of psychosis, it was noted that he appeared to be future focused, stating that his long-term goal was to work in the mining sector. Jaxon's father reaffirmed that Jaxon should not be discharged until he had secured appropriate accommodation.

71. On 20 September 2020, Jaxon tested positive for methamphetamine and his unescorted ground access was changed to escorted ground access.

72. On 23 September 2020, Jaxon declined assessment by an alcohol and drug counsellor, stating he did not want or need any assistance. At a review by Dr Makesar on the same day, Jaxon denied low mood, suicidal thoughts or ongoing concerns about the microchip in his head. He agreed to continue taking his oral medications and he was assessed as a low risk of self-harm. Jaxon's unescorted ground access was reinstated.

73. On 27 September 2020, Jaxon's urine drug screen was negative. However later that day his father called the MHU with concerns Jaxon might abscond after he had sent his grandmother numerous text messages regarding the device in his ear and wanting a review of his medications. As a result, Jaxon's leave status was changed to escorted ground access and his risk assessment was changed to a moderate risk of self-harm. The following day, Jaxon denied any self-harm ideation and denied sending any texts to his grandmother.

74. After being granted unescorted ground access, Jaxon tested positive for amphetamine and methamphetamine on 3 October 2020. His leave entitlements were changed back to escorted ground access.

75. On 7 October 2020, Jaxon's father called the MHU expressing concern about his son's mental state and that Jaxon was voicing suicidal and self-harm thoughts. In a review by Dr Makesar on the same day, Jaxon continued to deny self-harm thoughts and was preoccupied about pain and bleeding to his ear. He denied hearing voices from the microchip or that it was controlling his thoughts. His ear was examined and no obvious bleeding was seen. Another MRI scan of Jaxon's head was ordered by Dr Makesar.

76. On 8 October 2020, a family meeting was held where it was recorded that Jaxon stated he was feeling better and was "happy" with the medications he was on. He was reassured that the most recent MRI did not show a microchip or any abnormalities to his right ear. The Progressive Risk Assessment for that day noted Jaxon's risk of harm to self, impulsivity and absconding was "low". It was decided to keep Jaxon on oral quetiapine and antidepressant medications, and to continue with hourly observations and unescorted ground access.

77. Jaxon's father was advised about the progress of the referrals to private psychiatric units and the outcome of the referral to Ngulla Mia,[23] with the initial assessment of that referral scheduled for 13 October 2020.

EVENTS LEADING TO JAXON'S DEATH [24]

78. On the morning of 9 October 2020, the Progressive Risk Assessment for Jaxon recorded that he had a "moderate" risk for self-harm and impulsivity. He was also noted to be bright and reactive, with some underlying irritability.[25] That morning, Jaxon asked if he could meet his father in the community and that request was granted. He was advised he would be drug tested on his return.

79. Jaxon left the MHU at about midday on 9 October 2020 and was due to return at about 4.00 pm. When he failed to return at that time attempts were made by MHU staff to contact him on his mobile phone without success. At 4.50 pm, a message was then left on the mobile phone of Jaxon's father to contact the MHU.

80. At 5.20 pm, Jaxon's father contacted the MHU and advised that Jaxon was in the Midland area and that he would attempt to find him. At about

[23] A facility that provides supported accommodation for adults with mental health issues.
[24] Exhibit 1, Volume 1, Tab 2, P98 Mortuary Admission Form; Exhibit 1, Volume 1, Tab 10.1, Dispatch Task LWP 20100900824796; Exhibit 1, Volume 1, Tab 25.1, SJOGMH records (extracts); Exhibit 7, Screenshot of text message from Jaxon to his sister on 10 October 2020; Exhibit 8, Screenshot of text message from Jaxon to his father on 10 October 2020
[25] At the inquest, the nurse who made this note also recalled that Jaxon was "*so happy*" on the morning of 9 October 2020: Ts 17.1 24 (Ms Dirorimwe), p.201

6.15 pm, Jaxon's father contacted the MHU again and said that Jaxon had gone to a pharmacy in Midland to acquire some sedatives. He expressed a concern about his son's state of mind and possibility of self-harm. Police were then contacted and a missing person report was lodged for Jaxon.

81. The last known communications Jaxon was known to have had occurred on 10 October 2020. These communications were text messages to his father and sister that morning, and a phone conversation with one of his friends at an unknown time on that day.

82. At about 12.40 pm on 13 October 2020, police were called to attend the riverfront of the Mandoon Estate Winery in Caversham. Members of the public who were boating on the Swan River at that location had seen Jaxon submerged in the water. Attending police used a bystander's boat to bring Jaxon to the shoreline.

83. It was evident to police that Jaxon was obviously deceased and at 1.00 pm on 13 October 2020 an attending ambulance officer certified he was life extinct.[26]

CAUSE AND MANNER OF DEATH

Cause of death [27]

84. On 20 October 2020, Dr Nina Vagaja and Dr Rei Junckerstorff, forensic pathologists, conducted a post mortem examination on Jaxon's body. The examination found minor abrasions to Jaxon's face and knees with no internal injury or natural disease identified. There were signs of immersion in water and post mortem degenerative changes.

85. An examination of Jaxon's brain was conducted by a specialist neuropathologist which only found decomposition changes, with no other abnormalities identified.

86. Toxicological analysis detected medications that were consistent with Jaxon's recent hospital care and were all noted to be at therapeutic levels. These medications were amitriptyline (together with its metabolite, nortriptyline) and sertraline. Methylamphetamine and amphetamine were also detected at levels consistent with normal "recreational" use. Although a low level of alcohol was present in Jaxon's urine sample (0.012%) which indicated possible ingestion of alcohol before death, no alcohol was detected in his blood samples. The forensic pathologists noted that this

[26] Exhibit 1, Volume 1, Tab 4, Life Extinct Form
[27] Exhibit 1, Volume 1, Tabs 3.1-3.3, Supplementary Post Mortem Report dated 20 October 2020, Full Post Mortem Report dated 20 September 2020, Interim Post Mortem Report dated 20 October 2020; Exhibit 1, Volume 1, Tab 4, Toxicology Report dated 21 December 2020

alcohol result in the urine sample should be interpreted with caution given the decomposition changes that were present.

87. At the completion of the post mortem investigation, the forensic pathologists expressed the opinion that the cause of death was: "*Immersion in water (drowning) in a man with combined drug effect and history of seizures.*"[28]

88. The reference by the forensic pathologists to Jaxon's "*history of seizures*" was obtained from Jaxon's medical records. A deceased person's medical records are often reviewed by forensic pathologists. It was noted that Jaxon had childhood epilepsy, with the last recorded seizure two years prior to his death.[29]

89. At the Court's request, Dr Vagaja re-examined the medical records she had for Jaxon and she was only able to find two references to epilepsy, both of which were noted with a question mark.[30]

90. Mr Johnson, counsel for Jaxon's family, confirmed at the inquest that his instructions from Jaxon's parents were that he had never been diagnosed with epilepsy.[31] In those circumstances I am satisfied the Court's finding as to Jaxon's cause of death should not include a reference to a history of seizures as it would appear his advice to health professionals that he had epilepsy was an attempt to obtain medications.

91. In those circumstances, I find that the cause of death was immersion in water (drowning) in a man with combined drug effect.

Manner of death [32]

92. It is not entirely clear how Jaxon's death occurred. Mr Johnson, on behalf of the family, submitted there was sufficient evidence for a finding that the manner of death was by way of suicide.[33] In contrast, Mr Beetham, counsel for St John of God Health Care Inc. and SJOGMH witnesses appearing at the inquest, submitted that it was appropriate for an open finding to be made as to the manner of death.[34]

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[28] Exhibit 1, Volume 1, Tab 3.1, Supplementary Post Mortem Report dated 20 October 2020, p.1
[29] Exhibit 1, Volume 1, Tab 3.1, Supplementary Post Mortem Report dated 20 October 2020, p.2
[30] Ts 19.1.24, p.343
[31] Ts 19.1.24, p.343
[32] Exhibit 1, Volume 1, Tab 2, P98 Mortuary Admission Form; Exhibit 1, Volume 1, Tab 6, Email from Dr Nina Vagaja dated 8 May 2023; Exhibit 1, Volume 1, Tab 10.1, Dispatch Task LWP 20100900824796; Exhibit 1, Volume 1, Tab 16, Screenshot of a note from Jaxon's mobile phone; Exhibit 1, Volume 1, Tab 25.1, SJOGMH records (extracts); Exhibit 7, Screenshot of text message from Jaxon to his sister on 10 October 2020; Exhibit 8, Screenshot of text message form Jaxon to his father on 10 October 2020.
[33] Ts 19.1.24 (closing submissions of Mr Johnson), pp.458-461
[34] Ts 19.1.24 (closing submissions of Mr Beetham), pp.492-498

93. It is necessary to note the Act provides that for a discretionary inquest (as this inquest was), a coroner is not under a duty to make a finding as to the manner of death, even if it is possible to do so, if "*the coroner determines that there is no public interest to be served in making a finding as to how the death occurred.*"[35]

94. As to the meaning of the term "public interest", the High Court has stated that when "*used in a statute, the term derives its content from 'the subject matter and the scope and purpose' of the enactment in which it appears.*"[36]

95. Given the reasons why the Court determined it was desirable to hold an inquest into Jaxon's death, I am satisfied there is a public interest for me to determine, if possible, how his death occurred. I will first address the available information that the death occurred by way of suicide and then the information supporting a finding that Jaxon's death occurred by some other way (such as by accident). Finally, I will determine whether I am in a position to make a finding as to the precise manner of death.

96. In the period before his death, Jaxon had stated the following:

- On 17 September 2020, he entered a note into his mobile phone which I am satisfied indicated an intention to end his life, referencing the "*microphone inside my head*" as a reason why he had that intention.
- On 7 October 2020, Jaxon's father called SJOGMH with concerns regarding Jaxon's mental state as he was raising self-harm and suicidal ideation.
- After the family meeting at SJOGMH on 8 October 2020, Jaxon said to his father: "*Dad, I'm tired. No one believes me.*[37] *I don't think I can do this anymore.*"[38]
- At 9.47 am on 10 October 2020 (the day after Jaxon failed to return to SJOGMH), he forwarded a text to his sister which read: "*Fuck I'm not doing to good hey ... fucken over shit aye! Just in midland. Can't handle this shit*".[39]

97. There is no doubt Jaxon had a number of very high-risk factors for suicide and I agree with that observation made by Dr Brett at the inquest.[40] Prior

[35] *Coroners Act 1996* (WA) s 25(1)(a)
[36] ***Hogan v Hinch*** (2011) 243 CLR 506 [31] (French CJ)
[37] This is a reference to the microchip Jaxon believed was in his ear which the MRI scan on 8 October 2020 showed did not exist.
[38] Ts 18.1.24 (Jaxon's father), p.326
[39] This is an exact replication of how the message read.
[40] Ts 19.1.24 (Dr Brett), p.411

to 2020, Jaxon had had previous hospital admissions following intentional drug overdoses.

98. At the inquest, Dr Brett was asked if he had a view as to whether the manner of Jaxon's death was by way of suicide. Dr Brett answered:[41]

> I think from the evidence available to me, all I can say, really, was that he had a lot of very high-risk factors for suicide. He has had four admissions twice a year following overdoses, which is significant suicide attempts. He had been expressing suicidal ideation. He had … texted his sister with information which was consistent with the suicide note.[42] He had chronic mental health issues, and he had used substances fairly recently before the offence. So, obviously, the substances may have impacted on his mental state, and it could have been accidental, but I think there was a lot of flags for suicide.

99. Later in his evidence, Dr Brett was advised of the evidence from Jaxon's father regarding Jaxon's reaction to the results of the MRI on 8 October 2020. Dr Brett agreed that this further information reinforced a conclusion that Jaxon's death was by way of suicide rather than an accident.[43]

100. The information available to me indicating that Jaxon's death was not by suicide included the following:

- At the family meeting on 8 October 2020, it was recorded that Jaxon reported "*feeling better now*" and that he was "*happy with current medications*".
- On 9 October 2020, it was recorded that Jaxon was "*bright and reactive*" before he left the MHU.
- On 9 October 2020, Jaxon had an appointment with a doctor at the Swan Medical Centre and "*seemed relatively normal in the circumstances*" and was provided with a script for amitriptyline.
- On the morning of 10 October 2020, Jaxon sent a text message to his father which read: "*Hey, I'm just going for a walk at the moment its helping.*"
- On 10 October 2020, Jaxon spoke to a friend and said he was safe and fine, and the friend had no welfare concerns for him.

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[41] Ts 19.1.24 (Dr Brett), p.411
[42] This is a reference to the note in Jaxon's mobile phone that was made on 17 September 2020.
[43] Ts 19.1.24 (Dr Brett), p.420

- Intentional drowning is a rare form of suicide and is in sharp contrast to the manner used by Jaxon in his previous suicide attempts.
- Despite Jaxon's previous attempts to self-harm/suicide by drug overdoses, the antidepressant medications in his system were at normal levels.
- A factor complicating a finding of suicide is that a person's suicidal ideation can fluctuate, sometimes in a relatively short time frame.

101. The significance of Jaxon's text message to his sister on 10 October 2020 indicating suicidal ideation is reduced by the forensic pathologist's estimation as to when Jaxon's death occurred. Dr Vagaja, citing the relevant forensic pathology reference book, was of the view that although it was very difficult to know with certainty, she would say the time of death was "*at least eight hours, and if we go by the book up to 36 hours, and if the river was cold at that time, potentially longer.*"[44]

102. Jaxon's body was found at about 12.30 pm on 13 October 2020. Consequently, the best estimate of the time of death would be from about 12.30 am on 12 October 2020 to 4.30 am on 13 October 2020. As Mr Beetham correctly submitted at the inquest, "*we don't know what occurred in any of that period.*"[45] There is no contemporaneous information indicating Jaxon intended to end his life during this timeframe. In fact, the last known communications Jaxon had with other people were on 10 October 2020 and even those did not all suggest he had this intention.

103. There is also information from the forensic pathologists that raises the possibility of Jaxon's death occurring by way of accident due to a medical event. After noting the presence of the antidepressant medications and methylamphetamine in Jaxon's system, the forensic pathologists reported:[46]

> Combining antidepressants with stimulants such as methylamphetamine can increase the risk of adverse reactions, including serotonin syndrome, which is a toxic state caused mainly by excess serotonin within the central nervous system. Serotonin syndrome cannot be diagnosed on post mortem examination, rather this is a clinical diagnosis. Signs and symptoms include agitation or restlessness, confusion, loss of muscle co-ordination

[44] Exhibit 1, Volume 1, Tab 6, Email from Dr Nina Vagaja to counsel assisting dated 8 May 2023
[45] Ts 19.1.24 (closing submissions of Mr Beetham), p.497
[46] Exhibit 1, Volume 1, Tab 3.1, Supplementary Post Mortem Report, p.2

> or twitching muscles and, if severe, high fever, seizures and irregular heartbeat, followed by unconsciousness.

104. Finally, I note that Jaxon was wearing clothing and only had a sock on his left foot when he was found. This information does not assist in determining the question as to how his death occurred.

105. After giving careful consideration to the question of whether I can make a finding as to the manner of Jaxon's death, I have decided I am not able to do so. Although there is information supporting a finding that death was by way of suicide, there is other information to suggest the death may have been by another means, most notably by way of accident.

106. Accordingly, I make an open finding as to the manner of death.

THE CLINICAL INCIDENT INVESTIGATION (SAC1) REPORT [47]

107. Jaxon's death was investigated through a Route Cause Analysis inquiry process. These internal inquiries by hospitals include cases where there is a clinical incident which has, or could have, caused serious harm or death to a patient that was attributable to the provision of health care (or lack thereof), rather than the patient's underlying illness. These clinical incidents are categorised as Severity Assessment Code 1 (SAC1). The circumstances of Jaxon's death were felt to fall within SAC1 and consequently a clinical investigation was conducted into the care of Jaxon by SJOGMH during his final admission at the MHU.

108. A clinical incident investigation report was prepared by a panel of experts (the panel). The panel comprised of a Director of Medical Services, two consultant psychiatrists (one of whom was an external panel member), a nursing director, and a nurse manager and registered nurse from the MHU.

109. After completing its investigation, the panel concluded:[48]

> The panel agreed that it is difficult to identify contributory/causative factors for this significant incident. The patient was a habitual drug user who declined support from DASS[49] whilst an inpatient, however, was in agreement to transfer to a private facility for support with drug and alcohol addiction, and this was being planned. Allowing UGA[50] was the less restrictive method for treating this voluntary patient who regularly accessed UGA without incident; acknowledging the two occasions when

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[47] Exhibit 1, Volume 1, Tab 17, SAC1 Clinical Incident Investigation Report
[48] Exhibit 1, Volume 1, Tab 17, SAC1 Clinical Incident Investigation Report, p.13
[49] Depression Anxiety and Stress Scale: a self-reporting instrument designed to measure the three related negative emotional states of depression, anxiety and stress.
[50] unescorted ground access

he returned a positive UDS[51], and managed appropriately if the patient deviated from the agreed plan. It was identified that the patient felt safe while in hospital and the treating team did not feel that discharging him to the street was in the best interest for the patient. The family's concerns were taken into consideration and MDT[52] meetings involved both the family and the patient to determine the best treatment and discharge plan.

ISSUES RAISED AT THE INQUEST

Should Jaxon have remained at the Frankland Centre as an involuntary patient for his second admission

110. As already outlined above, Jaxon began depot injections of paliperidone on 20 July 2020 at the Frankland Centre. As at 4 August 2020, his psychosis had improved with the depot medication. He was less preoccupied and paranoid, and less fixated on his delusional beliefs.[53] Notwithstanding these improvements, Jaxon disagreed with the continuation of the depot injections.

111. By 4 August 2020, Dr Smith (Jaxon's treating psychiatrist) was of the view he could not remain in the Frankland Centre under the *Mental Health Act 2014* (WA) as his mental state had improved.[54] As Dr Smith explained at the inquest: [55]

> His risks had reduced and I was no longer concerned that he was going to try and cut this microchip out of his ear with something. I didn't have concerns that he was going to harm himself. He hadn't at any point during the admission being suicidal.
>
> …
>
> I don't think he fulfilled that criteria under an inpatient treatment order. And I also don't think we were following less restrictive practices by keeping him in hospital. His preference was to go back to prison. Even if everyone else doesn't agree with his preference, we still need to take that into consideration. And at that point, looking at the inpatient treatment criteria, those two criteria, I didn't feel were any longer met and therefore he needed to be made a voluntary patient.

112. The two criteria referred to by Dr Smith relate to "significant" risks occurring because of the patient's mental illness. These risks are cited in section 25 of the *Mental Health Act 2014* (WA) which deals with the criteria for an involuntary treatment order. Specifically, section 25(1)(b)

[51] urine drug screen
[52] Multi-Disciplinary Team
[53] Exhibit, Volume 2, Tab 8, Statement of Dr Lisa Smith dated 3 January 2024, p.13
[54] Ts 16.1.24 (Dr Smith), p.108
[55] Ts 16.1.24 (Dr Smith), p.108

states that a person is only in need of an inpatient treatment order if, because of the person's mental illness, there is "*(i) a significant risk to the health or safety of the person or to the safety of another person or; (ii) a significant risk of serious harm to the person or to another person*".

113. I am satisfied, for the reasons advanced by Dr Smith, that Jaxon had no longer met the criteria for an involuntary treatment order by 4 August 2020. In those circumstances, the only option was to discharge him back to Casuarina; even though it was virtually inevitable Jaxon would refuse his next depot injection. And the outcome would be his mental health would deteriorate and he would eventually return to the state he was in when he was admitted to the Frankland Centre on 14 July 2020. As Dr Smith noted at the inquest: "*This is the conundrum of the Mental Health Act*".[56]

Actions by Casuarina mental health service providers after Jaxon refused his depot injection

114. Unsurprisingly, Jaxon refused to have his depot injection of paliperidone on 26 August 2020. He stated he did not like having it and that he did not need it. Jaxon was "*bright and reactive*" and although he believed the microchip in his ear was still there, he was "*not distressed or frustrated with it*".[57]

115. By 2 September 2020, there had been a deterioration in Jaxon's mental health. On that date he was seen by Ms Emma Tsakalos (Ms Tsakalos), a mental health nurse at Casuarina, for the purpose of an ARMS assessment. Ms Tsakalos was to present that assessment at the Prisoner Risk Assessment Group (PRAG) meeting later that day. Ms Tsakalos noted Jaxon was in a highly anxious and distressed state regarding the chip in his ear. He was tearful and stated that he "*can no longer take it*". However, when questioned further he strongly denied having an intent to self-harm or having any suicidal ideation.[58] Jaxon repeated that he did not want the depot injection and maintained he was not psychotic.

116. Contrary to what he had said about the microchip on 26 August 2020, Jaxon was now very stressed about it picking up Wi-Fi signals. Ms Tsakalos noted that Jaxon had "*nil insight and impaired judgement*", and she recommended he "*stay on ARMS due to refusal of medications which will cause further deterioration in his mental state.*"[59]

[56] Ts 16.1.24 (Dr Smith), p.109
[57] Exhibit 1, Volume 1, Tab 24.1, EcHO records (extracts), p.2 of 65
[58] Exhibit 1, Volume 1, Tab 24.1, EcHO records (extracts), p.1 of 65
[59] Exhibit 1, Volume 1, Tab 24.1, EcHO records (extracts), p.2 of 65

117. In his closing submissions at the inquest, Mr Johnson submitted there was a failure to have an expedited psychiatric review performed after Jaxon had refused his depot injection on 26 August 2020.

118. Dr de Klerk had previously conducted a psychiatric review for Jaxon on 14 August 2020. He noted a "*vast improvement from two months ago*" and that Jaxon had said the microchip in his ear was not bothering him so much.[60]

119. On 19 August 2020, Dr de Klerk had seen Jaxon "*opportunistically in CCU*". Although Dr de Klerk was scheduled to see Jaxon two days later, he determined that as there had been no change to Jaxon's presentation from 14 August 2020, there was no need for him to see Jaxon at that scheduled appointment.[61]

120. At 3.45 pm on 21 August 2020, Lyn Mills (Ms Mills), a prison nurse, scheduled a psychiatrist appointment for Jaxon on 11 September 2020.[62] I am satisfied Ms Mills made that appointment as a consequence of Dr de Klerk not seeing Jaxon on 21 August 2020.[63]

121. Ms Mills was also the allocated nurse who was to give Jaxon his depot injection on 26 August 2020.

122. At the inquest, Ms Mills testified that as of 26 August 2020, Jaxon would not have met the criteria for an involuntary treatment order under section 25(1) of the *Mental Health Act 2014* (WA) as he was not at risk to himself or to others and that he was prepared to accept some of his treatment, namely his oral medications.[64]

123. When Ms Mills was asked whether she did anything to have Jaxon reviewed for an assessment that he be placed on a Form 1A,[65] she said that Jaxon would have been placed on the list to see the psychiatrist and as he was in the CCU, prison nurses would have been seeing him regularly.[66]

124. Ms Mills also said there would have been an appointment booked for Jaxon to see the prison psychiatrist, and although she could not remember if that was done in this particular instance, she stated: "*If somebody is*

[60] Exhibit 1, Volume 1, Tab 24.1, EcHO records (extracts), p.4 of 65
[61] Exhibit 1, Volume 1, Tab 24.1, EcHO records (extracts), p.3 of 65
[62] Exhibit 2, Psychiatric appointment time for Jaxon
[63] Ts 17.1.24 (submission of counsel assisting), p.169
[64] Ts 16.1.24 (Ms Mills), p.76
[65] A Form 1A is a referral for an examination by a psychiatrist if it is reasonably suspected that a person needs an involuntary treatment order. It must be completed by a medical practitioner or an authorised mental health practitioner.
[66] Ts 16.1.24 (Ms Mills), P.92

refusing the depot, we as a rule, we tend to book them in to see the psychiatrist as soon as possible."[67]

125. It only emerged later in the inquest that Ms Mills had already booked an appointment for Jaxon to see Dr de Klerk on 11 September 2020. As noted above, this booking had been made five days earlier on 21 August 2020. Although she did not have a recollection of doing so, I am satisfied that when Jaxon refused his depot injection, Ms Mills had either (i) recalled making the booking on 21 August 2020 and decided there was no need to bring that appointment forward, or (ii) when she went to make the booking on 26 August 2020, she saw that Jaxon was already scheduled to see Dr de Klerk and determined that was appropriate.

126. I am satisfied that no criticism can be made of Ms Mills for taking that course of action. To find otherwise would be inserting impermissible hindsight bias.

127. I am also satisfied that with respect to 2 September 2020 it was not necessary for Ms Tsakalos to have Jaxon's scheduled appointment on 11 September 2020 brought forward for the purpose of determining whether he required an involuntary treatment order. In so finding, I have noted that during his assessment by Ms Tsakalos on 2 September 2020, Jaxon denied any intent to self-harm or having any suicidal ideation.

128. On the afternoon of 2 September 2020, the PRAG meeting determined that Jaxon was to remain in the CCU and that he was also to remain on four hourly ARMS observations.[68] It is therefore clear there was to be a continuation of the close monitoring of Jaxon by health service providers and other prison staff at Casuarina. Had there been a further escalation in his behaviour, then I am satisfied there would have been an opportunity for the psychiatric review to be brought forward.

129. It is also relevant to note that the psychiatric assessment seven days later at SJOGMH determined that Jaxon did not meet the criteria for an involuntary patient.

Should Jaxon have been placed on a CTO when he was released from Casuarina on 8 September 2020

130. Upon release from prison, either as a remand or sentenced prisoner, a prisoner can be the subject of a CTO if deemed necessary by the prison's mental health service providers.

[67] Ts 16.1.24 (Ms Mills), P.94
[68] Exhibit 1, Volume 1, Tab 23.3, ARMS information

131. However, a consideration of that option for Jaxon was not undertaken due to his unexpected release from Casuarina on 8 September 2020. As Colin McKnight (Mr McKnight), a mental health nurse at Casuarina, explained at the inquest: "*We had no idea he would be getting released. None whatsoever.*"[69] Mr McKnight agreed that with the benefit of hindsight, Jaxon should have been released on a CTO.[70]

132. Ms Tsakalos also agreed that the option of a CTO upon his release should have happened for Jaxon.[71]

133. However, as Dr Smith noted in her evidence at the inquest:[72]

> If he was well enough to go into the community, we would have tried to set up a CTO, or discharged him on a CTO. But CTOs are complicated, in that you need an address. You need the person to have stable accommodation. You need a phone number in order to contact them. You need a mental health team with a psychiatrist that is willingly to accept the CTO. And these things take time to organise.

134. Mr Berkin (the clinical nurse at the Prison In-Reach Team) identified similar difficulties placing prisoners on a CTO when they are about to be discharged from prison.[73] Dr Peter Wynn Owen (Dr Wynn Owen), consultant forensic psychiatrist, acting Head of Clinical Services at State Forensic Health Service, also said that: "*CTOs from prison can be very difficult to arrange. Extremely difficult on short notice.*"[74]

135. There were clearly several obstacles preventing a CTO being put in place for Jaxon. The most obvious one was his unanticipated release from prison. There were also two others: he had no residential address and he had refused the offer of support from the Prison In-Reach Team.

136. It was therefore not surprising Mr Johnson, on behalf of Jaxon's family, accepted that the making of a CTO at the time of Jaxon's discharge "*was not practically possible*".[75] Accordingly, although there would have been a sound basis for Jaxon to be on a CTO following his release from Casuarina, there can be no criticism of the Department for not arranging that to take place.

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[69] Ts 16.1.24 (Mr McKnight) p.25
[70] Ts 16.1.24 (Mr McKnight) p.41
[71] Ts 16.1.24 (Ms Tsakalos), pp.56-57
[72] Ts 16.1.24 (Dr Smith), p.110
[73] Ts 17.1.24 (Mr Berkin), pp.182-183
[74] Ts 19.1.24 (Dr Wynn Owen), p.373
[75] Ts 19.1.24 (closing submissions of Mr Johnson), p.436

Did Jaxon's treatment team at SJOGMH consider information from the Frankland Centre?

137. The Court heard evidence at the inquest that collateral information from the Frankland Centre was considered by Jaxon's treatment team at SJOGMH.

138. Craig Cresswell (Mr Cresswell) was a psychiatric liaison nurse at the ED of SJOGMH. Mr Cresswell assessed Jaxon when he came to the ED with his father on 9 September 2020. His evidence at the inquest was that he reviewed the two discharge summaries from the Frankland Centre on Psychiatric Services Online Information System (PSOLIS).[76] PSOLIS is an electronic information system that records information regarding patients' mental health.

139. Dr Makesar also gave evidence that he was aware of Jaxon's two admissions to the Frankland Centre and that it was his usual practice for either himself or the registrar on the patient's treatment team to access PSOLIS as part of the review for a patient under his care.[77]

140. I am therefore satisfied that Jaxon's treatment team at SJOGMH considered the relevant information from the Frankland Centre when determining Jaxon's treatment regime.

Did Jaxon's treatment team at SJOGMH consider information from EcHO?

141. Unlike their access to PSOLIS, community health services do not have direct access to EcHO and have to make requests to the Department. The current process for providing information from EcHO to community health services is either through emergency requests (with or without patient consent) or non-emergency requests made with patient consent.[78]

142. Dr Makesar did not request any information from Jaxon's EcHO records and accepted it was "*possible*" for him to make such a request.[79] As to why he did not make that request, Dr Makesar gave two reasons. The first concerned "*the barrier of accessing those notes from in the prison setting*" and secondly, "*they wouldn't have changed the management plan*".[80]

143. At the inquest, Dr Brett said that Jaxon's treating team at SJOGMH "*should have*" requested the notes of his treatment at Casuarina, although

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[76] Ts 17.1.24 (Mr Cresswell), p.187
[77] Ts 18.1.24 (Dr Makesar), pp.248-249
[78] Letter from Dr Joy Rowland to counsel assisting dated 7 March 2024, p.1
[79] Ts 18.1.24 (Dr Makesar), p.293
[80] Ts 18.1.24 (Dr Makesar), p.293

he accepted it was "*very difficult*" to get such information from the Department.[81]

144. I accept Mr Beetham's submission that the evidence of the experts who were asked about the relevance of the EcHO material indicated "*it was of limited significance to the care of Jaxon*".[82] However, as noted by Mr Johnson, that evidence was made with the benefit of hindsight.[83]

145. I am satisfied there was a missed opportunity by Jaxon's SJOGMH treating team to make a request of the Department for access to relevant EcHO material from Casuarina. Had that been done and the material provided, Dr Makesar may not have made the conclusion that Jaxon was on "*a really small dose of quetiapine*" when he was in Casuarina.[84] Dr Makesar testified that a change was made at SJOGMH to increase the amount of quetiapine to 600 mg per day which was, as he described, "*a terribly big dosage*".[85] Dr Makesar said that Jaxon's dosage of quetiapine, "*had to be increased to a dose which was more therapeutic*."[86]

146. However, it was recorded in EcHO that Jaxon was already on a daily dose of 600 mg of quetiapine when he was at Casuarina.[87] I therefore agree with this submission from Mr Johnson:[88]

> He [Dr Makesar] also expressed a view that the dose of medication that Jaxon had been on whilst he was in prison was too low and that that was part of his problem. In fact, the records clearly show that the dose Jaxon was receiving in prison was exactly the same as he received at St John's. So that error by Dr Makesar would have been avoided if those records had been obtained. They also would have been obviously useful in terms of an assessment of his fluctuation symptoms and what things were triggering improvement or deterioration.

Whether Jaxon should have been made an involuntary patient at SJOGMH

147. After his final admission to SJOGMH, Jaxon remained as a voluntary patient in the MHU.

148. Dr Makesar's explanation for not making Jaxon an involuntary patient was as follows:[89]

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[81] Ts 19.1.24 (Dr Brett), p.414
[82] Ts 19.1.24 (closing submissions of Mr Beetham), p.468
[83] Ts 19.1.24 (closing submissions of Mr Johnson), pp.441-442
[84] Ts 18.1.24 (Dr Makesar), p.290
[85] Ts 18.1.24 (Dr Makesar), p.290
[86] Ts 18.1.24 (Dr Makesar), p.293
[87] Exhibit 1, Volume 1, Tab 24.1, EcHO records (extracts), p.5
[88] Ts 19.1.24 (closing submissions of Mr Johnson), p.442
[89] Exhibit 1, Volume 2, Tab 7, Statement of Dr Devendra Makesar dated 27 December 2023, pp.5-6

> The making of an involuntary inpatient treatment order under the *Mental Health Act 2014* (WA) is based on least restrictive principals. That is, I can only make an involuntary inpatient treatment order if the person to whom the order will apply cannot be adequately provided with treatment in a way that would involve less restrictions on the person's freedom of choice and movement than making an inpatient treatment order.
>
> An example of when I would apply a form to a patient is in circumstances when I have a patient who is extremely unwell, is refusing medication and is refusing to stay in hospital for treatment.
>
> In Mr Kinnane's case:
>
> (a) he presented to the hospital and sought hospital admission;
>
> (b) he was taking his medications;
>
> (c) he was willingly staying in the hospital;
>
> (d) he expressed that he wanted to stay in the hospital;
>
> (e) he had capacity;
>
> (f) his medications were having a positive effect and his psychosis was settling down over the course of his admission;
>
> (g) he was future focused.
>
> …
>
> In my opinion, Mr Kinnane did not meet the criteria for the making of an involuntary inpatient treatment order.

149. At the inquest, Dr Brett was asked whether Jaxon should have been made an involuntary patient or whether he should have remained as a voluntary patient during his final admission at SJOGMH. Dr Brett answered:[90]

> That's a very difficult question, and I think it's a line-ball one, which is difficult to review just on the notes. I can understand the logic in keeping him as a voluntary patient, but I think it would have been easy to justify making him an involuntary patient as well.

150. However, Dr Brett also acknowledged that had Jaxon been made an involuntary patient, it would not have changed a lot of what was already being done for him (although it would have had more of an impact on his leave requests).[91]

151. Jaxon's family did not contend he ought to have been made an involuntary patient during his final admission at SJOGMH. As outlined by Mr Johnson in his closing submissions at the inquest:[92]

[90] Ts 19.1.24 (Dr Brett), p.407
[91] Ts 19.1.24 (Dr Brett), p.408
[92] Ts 19.1.24 (closing submissions of Mr Johnson), p.443

> The next issue is whether he ought to have been an involuntary patient at St John's and we accept that that was not appropriate in the circumstances. That as long as he was as he was, content to remain a patient at the hospital and to accept the treatment recommended, then no involuntary patient order was necessary or appropriate. This would, however, have changed had he, for instance, refused depot medication if that had been recommended or insisted upon or had he sought to be discharged. But in the way that the events transpired, it was reasonable that that call was not made because at all times he was content to remain there and accepting of the treatment that was agreed with the treating team.

152. In light of that submission, and bearing in mind the clear intent of the *Mental Health Act 2014* (WA) that the care and treatment of persons with mental health issues be carried out in the least restrictive way, I am satisfied it was appropriate for Jaxon's treating team at SJOGMH to keep him as a voluntary patient.

Whether Jaxon's treatment team at SJOGMH appropriately considered the use of antipsychotic depot injections

153. Dr Makesar did not prescribe antipsychotic depot injections for Jaxon during his final admission at SJOGMH.

154. However, Dr Makesar had prescribed paliperidone depot injections to Jaxon during a previous admission to SJOGMH in 2019.[93] Dr Makesar was also aware that Jaxon had been administered paliperidone depot injections during his second admission to the Frankland Centre and that Jaxon was resistant to this treatment.[94]

155. At the inquest, Dr Makesar accepted he did not speak to Jaxon's family during Jaxon's final admission to SJOGMH regarding the benefits of paliperidone depot injections, stating it was not needed.[95] He also accepted that he did not speak to Jaxon regarding a treatment option which included antipsychotic depot medication.[96]

156. Dr Makesar had personal knowledge of the significant side-effect (akathisia) that Jaxon had from previous paliperidone depot injections. As a result, Jaxon had attended the ED at SJOGMH on 15 November 2019 and was initially admitted to the MHU for the management of this side-effect under the care of Dr Makesar.[97]

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[93] Ts 18.1.24 (Dr Makesar) p.249
[94] Ts 18.1.24 (Dr Makesar), p. 249
[95] Ts 18.1.24 (Dr Makesar), p.290
[96] Ts 18.1.24 (Dr Makesar), p.291
[97] Exhibit 1, Volume 2, Tab 7, Statement of Dr Devendra Makesar dated 27 December 2023, p.4

157. At the time of Jaxon's final admission to SJOGMH, Dr Makesar was aware from the Frankland Centre discharge summary that Jaxon had reported restlessness in his legs (a symptom of akathisia) following the paliperidone depot injection he had received there.[98]

158. Dr Makesar had prescribed the following medications for Jaxon during his final admission: lorazepam (a benzodiazepine that was used as a sedative), quetiapine (an antipsychotic), sertraline (an antidepressant) and clonazepam (to treat anxiety).[99] Each of these medications were given orally and Dr Makesar was of the view Jaxon was on an optimal dose and that there was "*no reason to change medications because he was happy to take it and it was beneficial*".[100]

159. At the inquest, Mr Johnson submitted that Dr Makesar's assertion that Jaxon's psychosis was "*settled or resolving*"[101] in the final two weeks of his last admission in SJOGMH was not accurate, and he contended Dr Makesar gave insufficient attention to the consideration of paliperidone depot injections as a treatment plan for Jaxon.[102]

160. I am satisfied it was not accurate to describe Jaxon's psychosis as "*settled or resolving*" in the days leading up to 9 October 2020. An examination of entries in the Progress Notes supports that conclusion. On 5 October 2020, an entry stated that Jaxon "*remains fixated on chip in his head showing messages from friend as proof he planted the chip*." On 6 October 2020, a Progress Note entry recorded that Jaxon was complaining of "*severe pain in the right ear as a result of the microphone*". On 7 October 2020, Jaxon experienced a somatic hallucination that he was bleeding from his ear. And on 8 October 2020, after the family meeting that day, Jaxon was having an auditory hallucination as he "*was observed talking to himself and giggling whilst in the courtyard.*"[103]

161. At the inquest, Dr Makesar disagreed that the above entries showed it was inaccurate to say Jaxon was stable and improving. Instead, he maintained "*there was definitely changes in his symptomology for the better*".[104] Notwithstanding this evidence from Dr Makesar, I agree with Mr Johnson's submission that these events did not suggest a settling or resolving of Jaxon's psychosis.

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[98] Ts 18.1.24 (Dr Makesar), p.251; Exhibit 1, Volume 1, Tab 24.2, Frankland Centre medical records (extracts), Discharge Summary dated 4 August 2020, p.3
[99] Exhibit 1, Volume 2, Tab 7, Statement of Dr Devendra Makesar dated 27 December 2023, p.4
[100] Exhibit 1, Volume 2, Tab 7, Statement of Dr Devendra Makesar dated 27 December 2023, p.5
[101] Exhibit 1, Volume 2, Tab 7, Statement of Dr Devendra Makesar dated 27 December 2023, p.5
[102] Ts 19.1.24 (closing submissions of Mr Johnson), p.447
[103] Exhibit 1, Volume 1, Tab 25.1, SJOGMH records (extracts), Progress Notes
[104] Ts 18.1.24 (Dr Makesar), p.298

162. I accept that Dr Makesar was faced with an unenviable dilemma regarding the option to use antipsychotic depot injections to treat Jaxon's psychosis. On the one hand, he had credible information before him that Jaxon's psychotic episodes were significantly reduced with the introduction of paliperidone depot injections. However, Dr Makesar was also acutely aware that Jaxon stridently opposed having these injections voluntarily and was also aware of the significant side-effect Jaxon had from previous depot injections of paliperidone. As Dr Makesar testified at the inquest:[105]

> It is our usual practice to offer people medications which is acceptable to them which do not cause side-effects. The reason being the issue is the compliance of people. We have regularly seen that people who do not like their medication will stop the medication once they go in the community. That has high implications in the sense of relapse of psychosis, being unwell, and that's why it is very important that basically people will be on medications which is acceptable to them.

163. I accept this evidence from Dr Makesar. Nevertheless, I am satisfied there was a missed opportunity for Dr Makesar to at least have a discussion with Jaxon regarding the evidence that showed the benefits for him to recommence paliperidone depot injections. In reaching that conclusion I note that Mr Beetham made the appropriate concession that: "*Perhaps it ought to have been discussed with Jaxon*".[106] I also accept what Mr Beetham then submitted:[107]

> But the reality is, with respect, that given the history, it's unlikely Jaxon would have acquiesced to that treatment which would have returned the treating team back to the question of whether to make Jaxon involuntary and there was no basis to do so.

164. I am also satisfied there was a missed opportunity for Dr Makesar to speak to Jaxon's family about how they felt he was progressing during his final admission compared to when he was receiving paliperidone depot injections. Had he done that, Jaxon's family would have had an opportunity to provide their views as to this alternative treatment option for Jaxon and potentially how he could be persuaded to consent to it. It may have also helped dispel the family's concerns (whether held rightly or wrongly) that they were being ignored.

[105] Ts 18.1.24 (Dr Makesar), p.295
[106] Ts 19.1.24 (closing submissions of Mr Beetham) p.470
[107] Ts 19.1.24 (closing submissions of Mr Beetham) pp.470-471

Was it appropriate to complete an MRI scan and communicate the results to Jaxon on 8 October 2020?

165. Despite an MRI head scan taken during a previous admission to SJOGMH in late 2019 that found no foreign object in Jaxon's ear,[108] another MRI scan of Jaxon's head was ordered by Dr Makesar on 7 October 2020. As already outlined above, Jaxon was advised the next day that this MRI did not show a microchip or any other abnormalities to his ear.

166. At the inquest, Dr Brett was asked for his opinion as to whether it was appropriate to have another MRI scan taken and then communicating the results to Jaxon. Dr Brett answered:[109]

> Well, look, my understanding is that Jaxon believed he had a microchip in his brain for around four years, and I think that was quite a chronic belief. I think he was less obsessed about it when he was treated, and he was better, but I think that belief was consistent, and just became more apparent when he was unwell. It was clear during that final admission that he continued to believe he had a microchip in his brain that was impacting on his mental health. I think it terrified him. It was causing him pain. And I don't think an MRI would have altered his beliefs whether he had microchip in his brain or not. I think, if anything, it's likely that he would have interpreted that in other ways, such as they're not telling him the truth; they don't believe him. It would have exacerbated his mental health.
>
> Ok. So, is it your evidence that communicating the results to him may have actually had a negative impact or did have a negative impact?---I think it may well have, and I wouldn't have performed the MRI.
>
> Ok.---In fact, it would have been contraindicated anyway if he did have a microchip.
>
> So, you're saying that even without the benefit of hindsight?---Yes. When people experience psychosis – and he had been experiencing psychosis for some time – sometimes they try and give explanations as to why they're having them, and so it's not uncommon that people believe that something has been put in their brain which is controlling them and trying to talk them out of that delusional belief usually doesn't work. The essence of delusions is that they don't take on evidence to the contrary. So, I don't think it would have changed his opinion on whether he had microchip.
>
> Right. What if it was the case that his parents were asking that that be done?---Yes.

[108] Exhibit 1, Volume 1, Tab 25.1, SJOGMH records (extracts), p.258
[109] Ts 19.1.24 (Dr Brett), p.409

> Would that change a psychiatrist's mind as to the efficacy of ordering another MRI scan?---Well, no, I don't think it should. I think it should have been explained to the parents why it wouldn't be a good idea.

167. When he was later asked that if, after giving the above explanation to the family, they and Jaxon still insisted on the MRI scan, Dr Brett said he would still have refused to do it.[110]

168. In his closing submissions, Mr Johnson submitted that it was not appropriate for Dr Makesar to conduct another MRI scan for the reasons articulated by Dr Brett.[111]

169. At the inquest, Dr Makesar explained that the purpose of the second MRI head scan was to compare it with the previous MRI scan to see if anything had changed and if there was no change, to explain to Jaxon that two MRI scans had not shown any chip and "*that would be therapeutically beneficial for him in terms of challenging his delusion.*"[112]

170. In his closing submissions, Mr Beetham submitted the context in which Dr Makesar ordered another MRI scan was important.[113] That context was:

- Jaxon had wanted a scan done when he had presented to the ED at SJOGMH on 9 September 2020.[114]
- At the family meeting on 17 September 2020, Jaxon repeated that he wanted an MRI scan, in addition to the use of a Wi-Fi detector and a referral to an Ear, Nose and Throat specialist.[115]
- Despite Jaxon's father subsequently using a Wi-Fi detector next to Jaxon's head without an alarm sounding and Jaxon's apparent acceptance of that,[116] it was subsequently recorded on 5 October 2020 that Jaxon's father was "*insistent*" that another MRI scan be done to rule out the presence of a microchip in Jaxon's ear.[117]
- On 7 October 2020, Jaxon's father rang SJOGMH and raised, amongst other matters, the need for another MRI head scan.[118]

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[110] Ts 19.1.24 (Dr Brett), p.423
[111] Ts 19.1.24 (closing submissions of Mr Johnson), p.448
[112] Ts 18.1.24 (Dr Makesar), p.256
[113] Ts 19.1.24 (closing submissions of Mr Beetham), p.472
[114] Ts 17.1.24 (Mr Cresswell), p.186
[115] Exhibit 1, Volume 1, Tab 25.1, SJOGMH records (extracts), p.259
[116] Exhibit 1, Volume 1, Tab 25.1, SJOGMH records (extracts), p.276
[117] Exhibit 1, Volume 1, Tab 25.1, SJOGMH records (extracts), p.297
[118] Exhibit 1, Volume 1, Tab 25.1, SJOGMH records (extracts), p.302

- Jaxon had said that the microchip had been inserted after the previous MRI scan that was taken at SJOGMH in late 2019.[119]

171. Whether or not to have another MRI scan would have undoubtedly been yet another vexed issue for Jaxon's treatment team at SJOGMH. Applying the ***Briginshaw*** principle, and being mindful not to insert hindsight bias, I am satisfied it was not inappropriate for Dr Makesar to order another MRI scan and advise Jaxon of the results.

172. However, given the evidence of Dr Brett to the contrary, I have made that finding only by the merest of margins. What has persuaded me was the important need for Jaxon's treating team at SJOGMH to maintain a therapeutic relationship with him. As noted by Dr Brett, Jaxon did not trust his clinicians,[120] and I accept Dr Makesar's explanation of the need to enhance his therapeutic relationship with Jaxon.

Was it appropriate for Jaxon to be granted unescorted leave on 9 October 2020?

173. As I have already outlined above, Jaxon was granted unescorted leave from SJOGMH on the morning of 9 October 2020. The only condition imposed was he had to have a urine drug screen when he returned.[121]

174. Mr Johnson submitted that if there had been a proper analysis of Jaxon's risk on 9 October 2020, he would not have been given permission to take leave. He also made the alternative submission that if it was appropriate for leave to be granted, then Jaxon's father should have been notified in order to ensure Jaxon could be supervised whilst on that leave.[122]

175. Dr Makesar maintained his view that it was appropriate for Jaxon to be granted unsupervised leave on 9 October 2020. When he was asked at the inquest whether he thought he should have done anything differently, Dr Makesar answered: "*Look, I don't think I could have done anything differently.*"[123]

176. Dr Brett was asked if Jaxon should not have been granted unsupervised leave. He answered:[124]

> No, I don't think so. I think from – I just think there was a mismatch of information. I think the problems with Jaxon started long before his

[119] Exhibit 1, Volume 1, Tab 25.1, SJOGMH records (extracts), p.14
[120] Exhibit 1, Volume 1, Tab 20.2, Report of Dr Adam Brett dated 2 February 2023, p.20
[121] Exhibit 1, Volume 1, Tab 25.1, SJOGMH records (extracts), p.311
[122] Ts 19.1.24 (closing submissions of Mr Johnson), p.458
[123] Ts 18.1.24 (Dr Makesar), p.265
[124] Ts 19.1.24 (Dr Brett), p.411

> hospital admission. I think – yes. I don't think his mental health issues were really understood longitudinally. And so, I think in that kind of time from the documentation of the treating team on the information they documented, I think giving him leave was appropriate.

177. In his closing submissions on this point, Mr Beetham submitted that Jaxon was a voluntary adult patient who had utilised unsupervised ground and leave access on most occasions without any issues. This included only two days earlier (7 October 2020) when Jaxon was granted unescorted leave to attend the Midland Gate Shopping Centre, from which he returned early without any issues.[125]

178. Contrary to previous assessments noting Jaxon's risk of harm to himself as "low", the Progressive Risk Assessment on 9 October 2020 recorded this risk as "moderate". The nurse who conducted this assessment was Shuvai Dirorimwe (Ms Dirorimwe). She had not done any previous Progressive Risk Assessments for Jaxon. Her reason for noting Jaxon's risk of harm to himself on that occasion as "moderate" and not "low", was as follows:[126]

> When using the PRA form at that time it was my usual practice to put ticks to the left of the moderate column when I had assessed that the risk was a chronic risk, that I could not say was not *there*, but there was no immediate risk at the time of doing the assessment.

179. Ms Dirorimwe also said that on the morning of 9 October 2020:[127]

> Mr Kinnane wasn't presenting as self-harm when I assessed him. He presented as bright and reactive, and very happy and excited to go out on leave. I remember he was so happy; he was showing off some new sneakers and was in a happy way that day.

180. Not without some hesitation, I am satisfied that it was appropriate for Dr Makesar to approve Jaxon's request for unsupervised leave from SJOGMH on 9 October 2020. In making that finding, I have not overlooked the evidence of Jaxon's father of what he did after he and Jaxon spent some time together following the family meeting on 8 October 2020.[128] The evidence from Jaxon's father at the inquest was that after he had signed Jaxon back in: "*I called the nurse to one side. I*

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[125] Ts 19.1.24 (closing submissions of Mr Beetham), p.478
[126] Exhibit 1, Volume 2, Tab 15, Statement of Shuvai Dirorimwe (unsigned), p.2
[127] Exhibit 1, Volume 2, Tab 15, Statement of Shuvai Dirorimwe (unsigned), p.2
[128] This was the time when Jaxon told him: "*Dad, I'm tired. No one believes me. I don't think I can do this anymore*"

said, 'You're going to have to watch him. He's not in a very good place'."[129]

181. Unfortunately, there is no entry in any of Jaxon's medical records that noted this conversation. Nor is there any evidence these concerns of Jaxon's father were brought to the attention of Dr Makesar.

182. I am satisfied to the required standard that Jaxon's father did have this conversation with an unidentified nurse at SJOGMH. When asked how confident he was in his recollections that day, including what he said to the nurse, Jaxon's father answered:[130]

> Clear as day because it was the last time I saw my son alive. I mean, that sort of thing just gets etched into your son because you go through the what ifs and all that sort of side of it and that memory stuck.

183. There ought to have been a written record by the nurse of this conversation. Other conversations Jaxon's father had with SJOGMH staff had been noted in the Progress Notes. As the identity of this female nurse who Jaxon's father spoke to is unknown, it has not been possible to account for the absence of an entry. One plausible explanation may be that the nurse was attending to a number of matters regarding other patients at or about the time Jaxon's father spoke to her, and she had subsequently overlooked recording an entry.

184. Had he been aware of what Jaxon's father had said the day before, I expect Dr Makesar would have personally made further enquiries of Jaxon regarding his plans for what he was going to do and who he was going to be with during his leave on 9 October 2020. Whether or not that would have changed the outcome of Jaxon's request for unsupervised leave is not known. And even if Dr Makesar had declined the request, there was nothing preventing Jaxon from leaving if he had wanted to.

185. As to nursing staff not contacting Jaxon's father to verify he was meeting his son on 9 October 2020, Dr Makesar stated that he did not think it was necessary.[131] His explanation for that was because Jaxon had utilised unescorted community leave on his own and had always returned, most recently just two days earlier. Dr Makesar was also of the view there had been a "*very positive pathway of care outcome*" on 8 October 2020 and that Jaxon had a good connection with his father.[132] Dr Makesar also cited

[129] Ts 18.1.24 (Jaxon's father), p.326
[130] Ts 18.1.24 (Jaxon's father), pp.326-327
[131] Ts 18.1.24 (Dr Makesar), p.261
[132] Ts 18.1.24 (Dr Makesar), p.261

the importance of the therapeutic relationship between him and Jaxon which meant "*having a mutual trust in each other*".[133]

186. When Dr Makesar was asked that one way of ensuring his relationship with Jaxon would not be affected was to advise nursing staff that Jaxon could have leave, provided his father picked him up from SJOGMH. Dr Makesar answered that proposition as follows:[134]

> Jaxon was utilising unescorted and ground access on a regular basis. … at [the] end of the day, it is the basic principle of managing people with [a] psychiatric illness with least restrictions. Asking for him to wait for his father and I don't know how long he would have to wait. If he would – if he had arranged to meet his father somewhere … outside in the community, I wanted to help him move - expedite that.
>
> Certainly. But you say "if". You actually didn't know that; did you?--- … [A]s I said, given the relationship, given the frequency his father was coming over to visit him, it was a general presumption. Because – there were no other visits – as I am aware of – with Jaxon had from anyone else.

187. There had been a previous occasion, on 1 October 2020, when Dr Makesar determined Jaxon could only have his request for community access granted if he was collected from SJOGMH by his father.[135] At the inquest, Dr Makesar noted that on this occasion Jaxon wanted to attend a vape shop. Dr Makesar identified that fact as an important distinction from Jaxon's request on 9 October 2020, stating:[136]

> It is very important that in – once people are in the hospital is to encourage them healthy lifestyle and he (indistinct) that he wanted to go to a vape shop and I would have – and that was one of the reasons I wanted him to go with his father and – and take him there.

188. I am satisfied with this explanation from Dr Makesar.

189. I also accept Mr Beetham's contention in his closing submissions that there was neither a clinical nor a legal reason to notify Jaxon's father.[137] Mr Beetham also submitted that as Jaxon was a voluntary patient he could not be prevented from leaving. He also raised the question that if the call had been made to Jaxon's father and it had not been answered, what would SJOGMH staff do then. Mr Beetham submitted:[138]

[133] Ts 18.1.24 (Dr Makesar), p.263
[134] Ts 18.1.24 (Dr Makesar), p.263
[135] SJOGMH records, electronic version, p.119
[136] Ts 18.1.24 (Dr Makesar), p.278
[137] Ts 19.1.24 (closing submissions of Mr Beetham), p.478
[138] Ts 19.1.24 (closing submissions of Mr Beetham), pp.488-489

> Do they detain Jaxon until they make another phone call or there is a return call? It's a very speculative area to which your Honour treads if your Honour decides that a phone call ought to have been made, and what is the lawful basis to prevent Jaxon from leaving at that point in time? There is none, in my respectful submission.

190. At the inquest, Dr Makesar accepted that with the advantage of hindsight he would have asked the nursing staff to contact Jaxon's father to verify the arrangements that Jaxon had said he had made.[139]

191. Of course, I am not permitted to make a finding based on the benefit of hindsight. Accordingly, and applying the ***Briginshaw*** principle, I am not satisfied that Dr Makesar should have instructed nursing staff to contact Jaxon's father to confirm there were arrangements for him to meet Jaxon on that day.

192. Another issue that arose as to Jaxon's leave request on 9 October 2020 was whether the relevant provisions of SJOGMH's Mental Health Manual (the Manual) were followed when Jaxon's leave was approved by Dr Makesar on 9 October 2020.

193. There was a discrepancy in the evidence between the accounts of Ms Dirorimwe and Dr Makesar regarding the steps taken in the approval process. These discrepancies were neatly summarised by Mr Beetham in his closing submissions:[140]

> On the nurse's evidence, Dr Makesar attended and performed an assessment and granted leave. Entirely proper thing to do. That's the nurse's evidence. On the doctor's evidence, an assessment was conducted by the nurse. He has a phone call. He says if the patient is settled and stable…[then] Jaxon is okay to go. Again, an entirely proper and appropriate thing to do. On either version of events the core is consistent. There was an assessment, there was a conversation and there was a decision arrived at by the clinical staff with Jaxon's care.

194. The Manual provides: "*Medical staff will use a PRA*[141] *when authorising or changing a patient's Ground Access and Leave*".[142]

195. The only Progressive Risk Assessment entered on 9 October 2020 and prior to Jaxon going on leave, was the one performed by Ms Dirorimwe.[143]

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[139] Ts 18.1.24 (Dr Makesar), p.266
[140] Ts 19.1.24 (closing submissions of Mr Beetham), p.481
[141] Progressive Risk Assessment
[142] Exhibit 3, SJOGMH Mental Health Manual version 2, p.29
[143] Although Dr Makesar completed a Progressive Risk Assessment regarding his assessment as of 9 October 2020 which was based on his conversation with Ms Diorama, that assessment was not written until the morning of 12 October 2020: Exhibit 1, Volume 1, Tab 25.1, SJOGMH records (extracts), p.316

196. In his closing submissions, Mr Johnson contended that the Manual's use of the phrase "*medical staff*" in the sentence cited above must only refer to doctors and therefore, it was not followed as Dr Makesar's evidence was that he did not see Jaxon on 9 October 2020 and complete his own Progressive Risk Assessment.[144] In contrast, Mr Beetham submitted that the phrase "*medical staff*" as it appeared in the Manual would also include nurses.[145]

197. This phrase is not defined in the Manual, nor does it appear anywhere else in it. I have therefore undertaken a search of various definitions of this phrase. I am satisfied that in a majority of cases, nurses are regarded as being part of a hospital's "medical staff".[146] Accordingly, I am of the view that this part of the Manual was followed.

198. However, I am satisfied that the following provision in the Manual was not complied with: "*For instances of leave from the hospital grounds, written approval from the treating doctor (or medical delegate) must be obtained and recorded in the patient's health record*".[147] Mr Beetham accepted that this written approval had not been made by Dr Makesar.[148]

199. Notwithstanding this procedural deficiency, given the information that was available to Dr Makesar at the time, I am satisfied that he made an appropriate assessment of Jaxon's request to be given leave.

CHANGES AND IMPROVEMENTS AT SJOGMH SINCE JAXON'S DEATH

200. As would be expected of all hospitals, SJOGMH is always on the pathway of continual improvements with respect to the treatment and care of patients who require its services. Given there is ordinarily a gap of some duration between the date of the death that is the subject of a coronial investigation and the inquest's date, entities connected to the death will often implement changes that are designed to improve practices and procedures before the inquest is heard.

201. In addition, when the death occurs in a hospital setting, a SAC1 investigation is usually completed well before the inquest is commenced.

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[144] Ts 19.1.24 (closing submissions of Mr Johnson), p.451
[145] Ts 19.1.24 (closing submissions of Mr Beetham), p.483
[146] For example: "Medical staff members are those licensed healthcare providers (physicians, nurses, allied health professionals, and other health care workers) who are authorised by the state law and hospital's bylaws to provide medical care within a health care establishment: https://digitalismedical.com/blog/medical-staff-responsiblities/; see also: https://www.lawinsider.com/dictionary/medical-staff
[147] Exhibit 3, SJOGMH Mental Health Manual version 2, p.12
[148] Ts 19.1.24 (closing submissions of Mr Beetham), p.482

SAC1 investigations will frequently make recommendations designed to make improvements.

202. At the request of the Court, Dr Stefan Shutte (Dr Shutte), Head of Department, Psychiatry at SJOGMH, prepared a report that included the addressing of any changes or improvements relevant to the treatment, care and supervision of patients within the MHU at SJOGMH that have been implemented since Jaxon's death.[149] Dr Shutte reported on a number of changes and improvements which included the following.

Mental health emergency centre

203. Part of SJOGMH's expansion project to cater for increasing demands for its services includes the construction of a dedicated mental health emergency centre which would address the ED's current lack of suitable private spaces to conduct mental health assessments. A business case for this expansion has been submitted to Treasury for funding approval. The construction of the expansion will take about 12 months and would include a six bed short-stay (two to three days) mental health unit and a behaviour assessment unit.[150]

Suicide prevention training courses

204. Since May 2022, physician and nursing staff working in psychiatry at SJOGMH have been able to attend a two-day training course for a model of care which deals with suicide prevention by "proactive detection". This model of care focuses on "appropriate risk formulation and management", rather than risk prediction, and seeks to establish a relationship with the patient using empathetic communication and understanding of pain that the patient may be experiencing. This training is specifically focused on the management of suicidal patients.[151]

Replacement of Progressive Risk Assessment forms

205. At the time of the inquest, Dr Shutte was in the process of replacing the Progressive Risk Assessment forms that were used at the time of Jaxon's final admission to SJOGMH. Dr Shutte had noted that these forms recorded a static assessment of risk i.e. a "here and now" assessment. Dr Shutte is of the view that it would be more useful clinically if there was a document which recorded a dynamic risk assessment that incorporated safety planning. In that regard, he generally agreed with Dr Brett's

[149] Exhibit 1, Volume 2, Tab 5, Letter from Dr Stefan Shutte to counsel assisting (undated)
[150] Exhibit 1, Volume 2, Tab 5, Letter from Dr Stefan Shutte to counsel assisting (undated), p.7
[151] Exhibit 1, Volume 2, Tab 5, Letter from Dr Stefan Shutte to counsel assisting (undated), pp.7-8

criticism of the Progressive Risk Assessment form that had been used for Jaxon.[152]

206. Dr Shutte attached a draft to his report of a new document he wants to introduce at SJOGMH. If it is introduced, clinicians and nursing staff would still be required to conduct risk assessments, but those assessments would be documented directly into the inpatient's notes.[153]

Changes to the recording of patients' hospital leave

207. At the time of Jaxon's final admission, SJOGMH staff would record when a patient goes on leave in a document called a "Patient Leave Log". There was one leave log for each ward and that log did not form part of the patient's hospital records.

208. SJOGMH now have in place a Leave Log for each individual patient which is used when that patient is out on leave. It replaces the form used when Jaxon had been admitted and is now included as part of each patient's health care record.

209. In addition, there is now a patient information leave card which was introduced in 2024. There are two versions of the card: one for accompanied leave and one for unaccompanied leave. The card will be given to the patient when on unaccompanied leave or the patient's carer for accompanied leave. A record is kept on patient's leave log form whenever the card is provided to the patient or the carer.[154]

I commend SJOGMH and Dr Shutte for these changes. I am satisfied they will enhance the supervision, treatment and care of patients admitted to the MHU at SJOGMH.

QUALITY OF JAXON'S SUPERVISION, TREATMENT AND CARE

210. It was Dr Brett's opinion that Jaxon's mental disorder "*appeared atypical and complex*".[155] I agree with that assessment. Management of Jaxon's mental disorder was further complicated by his refusal to accept he was psychotic and his aversion to treatment with paliperidone depot injections, which appeared to be the most effective form of treatment for his psychosis.

[152] Exhibit 1, Volume 2, Tab 5, Letter from Dr Stefan Shutte to counsel assisting (undated), p.8
[153] Exhibit 1, Volume 2, Tab 5, Letter from Dr Stefan Shutte to counsel assisting (undated), p.9
[154] Exhibit 1, Volume 2, Tab 5, Letter from Dr Stefan Shutte to counsel assisting (undated), pp.10-11
[155] Exhibit 1, Volume 1, Tab 20.2, Report of Dr Adam Brett dated 2 February 2023, p.24

Jaxon's supervision, treatment and care at Casuarina

211. This Court is acutely aware of the chronic shortage of mental health service providers, not just at Casuarina, but in prisons throughout this State. The current situation regarding staff numbers in this area remains suboptimal.

212. I am all too aware from previous inquests that the Department is committed to filling vacancies in the critically important area of prison mental health service providers. Sadly, the fact remains that there is a shortage of mental health nurses and psychiatrists in the community. That shortage is compounded for the Department as the prospect of working in a prison setting does not appeal to many of those in these professions.

213. In those circumstances, I agree with the assessment made by Dr Brett, "*that the mental health treatment Jaxon received in custody was good, given the resources available*" (underlining added).[156] The evidence I heard at this inquest simply reaffirmed my view that those health service providers who are employed in prisons are dedicated and committed individuals who have to undertake significant caseloads in very stressful environments.

214. The lack of resources referred to by Dr Brett extends to the constant shortage of beds in the Frankland Centre that are available for prisoners with chronic mental health issues. As I have already outlined above, Jaxon's mental health service providers at Casuarina experienced delays in having him admitted to the Frankland Centre. This situation has not improved since Jaxon's death. Dr Wynn Owen advised the Court of this very concerning statistic: "*During December 2023 and to date in January 2024, there have been approximately 24 prisoners waitlisted for acute admission to the Frankland Centre*".[157]

215. Dr Wynn Owen also advised the Court that the State Government has committed to a new secure Forensic Mental Health facility to be built on the grounds of Graylands Hospital. This would result in "*freeing up the 30 bed Frankland Centre to function as an acute care forensic mental health facility, better meeting the needs of the prison population.*"[158] That will mean 30 beds will be able to serve the adult prison population (which currently is well above 6,000). That is certainly an improvement on the eight beds that Dr Wynn Owen calculated as being currently available for

[156] Exhibit 1, Volume 1, Tab 20.2, Report of Dr Adam Brett dated 2 February 2023, p.21
[157] Exhibit 1, Volume 2, Tab 16, Report of Dr Peter Wynn Owen dated 15 January 2024, p.3
[158] Exhibit 1, Volume 2, Tab 16, Report of Dr Peter Wynn Owen dated 15 January 2024, p.3

this cohort.[159] Dr Wynn Owen does not anticipate this facility opening before 2029.[160]

216. Once these additional beds eventually become available, I fear that because of the high incidence of acute mental health disorders amongst prisoners, long waiting lists for mental health beds will remain a blight on the provision of timely treatment for these very vulnerable prisoners.

Jaxon's supervision, treatment and care at SJOGMH

217. I have no doubt that Jaxon's treatment team at SJOGMH did their best to provide Jaxon with appropriate supervision, treatment and care. However, as he was a voluntary patient, it meant that treatment options were limited to those that he agreed with. This ruled out the antipsychotic treatment regime that was the most effective in treating his psychosis. Jaxon's treatment was then further complicated by his ongoing use of methylamphetamine, and his longstanding delusional thought there was a harmful microchip in his ear.

218. After careful consideration of the documentary and oral evidence, I am satisfied that Jaxon's supervision, treatment and care at SJOGMH during his final admission was appropriate. Although I have identified several missed opportunities that may have provided a higher level of care had they been followed up, I am satisfied any findings of a more serious nature could only be made with the impermissible use of hindsight bias.

RECOMMENDATIONS

219. One matter that concerned me regarding Jaxon's treatment when in custody was his release from the Frankland Centre after his second admission. Although his psychosis had resolved to the extent he was able to be released, it was inevitable he would refuse to have his next paliperidone depot injection in a prison setting.

220. This eventuated on 26 August 2020, with the consequence that his psychosis would most likely deteriorate over time and the gains he had made during his treatment at the Frankland Centre would be lost.

221. However, as at the date of that refusal, it was not possible for a doctor or an authorised mental health practitioner at Casuarina to make an involuntary treatment order for Jaxon. That was because the criteria set out in section 25(1)(b) of the *Mental Health Act 2014* (WA) had not been met and would remain unmet for the foreseeable future. This meant that if

[159] Exhibit 1, Volume 2, Tab 16, Report of Dr Peter Wynn Owen dated 15 January 2024, p.3
[160] Exhibit 1, Volume 2, Tab 16, Report of Dr Peter Wynn Owen dated 15 January 2024, p.3

Jaxon had remained in prison and had there been a decline in his mental health, an involuntary admission to the Frankland Centre was only available once he posed a significant risk to his own health or safety or the safety of another person; or if there was a significant risk of serious harm to himself or to another person.[161]

222. It is my view that this is an unsatisfactory way of treating a prisoner such as Jaxon who (i) has a serious mental illness and (ii) does not consent to a treatment regime that is known to have been successful, with the almost inevitable outcome that one or more of the significant risks outlined above will occur. Section 25(1)(b) of the *Mental Health Act 2014* (WA) does not permit the making of an involuntary treatment order if one or more of the significant risks are expected to occur in the future but are not currently in existence.

223. One way of overcoming that situation would be to make available the use of CTOs within the prison environment. Those CTOs could either be made by a psychiatrist within the prison or by a psychiatrist in the Frankland Centre once a prisoner who has been treated there is discharged back to prison.

224. Section 25(2)(b) of the *Mental Health Act 2014* (WA) sets out the criteria for a CTO. It has an additional criteria relating to the significant risks arising from the person's mental illness. A CTO can be imposed upon a person if there is, because of their mental illness, "*a significant risk of the person suffering serious physical or mental deterioration*."[162] I am of the view that this can be read as including a significant risk of a future "serious mental deterioration".

225. Jaxon's treating team at the Frankland Centre would have been satisfied there was a significant future risk of serious mental deterioration as Jaxon had made it clear he would not be consenting to depot injections once he was at Casuarina. His discharge summary included the following:

> He requested transfer back to prison, so that he did not have to be "*under the Mental Health Act as I don't want the depot*". He stated he would not accept the depot going forward … Jaxon shows extremely poor insight into his mental health symptoms and benefits of treatment. He does not demonstrate capacity re: mental health treatment and will likely need to be on a CTO when he eventually leaves prison.

226. Therefore, had Jaxon been the subject of a CTO when he was discharged from the Frankland Centre, it would have enabled him to be sent back

[161] *Mental Health Act 2014* (WA), s 25(1)(b)
[162] *Mental Health Act 2014* (WA), s 25(2)(b)(iii)

there when he refused his depot injection in Casuarina, as that refusal would have been in breach of the CTO.

227. As Dr Wynn Owen explained at the inquest, if a prisoner was subject to a CTO within a prison setting:[163]

> … what that could mean is that a person that currently refused their depot, rather than waiting for them to become very acutely unwell and potentially put themselves at significant risk, a breach [of the CTO] could be put in place and they could be immediately transferred for further assessment and potentially for treatment and care in a therapeutic setting. This is the way this is done in a couple of other states in Australia, and I understand it has been done effectively. I have personal experience having liaised with the Chief Psychiatrist of working in immigration detention, which is a very similar custodial setting, and using a Community Treatment Order for patients of mine in both Perth Airport and at Yongah Hill immigration detention centres and enabling them to get more rapid access to care.

228. As Dr Wynn Owen explained "community" for the purposes of a CTO is essentially, "*anything outside the hospital*".[164]

229. To make it clear, I am not advocating the use of a CTO on a prisoner to enable the involuntary administration of medication within the prison setting. I agree with the following comments of Dr Wynn Owen with respect to that:[165]

> I note that it is my strongly held opinion that a CTO should never be used to enforce involuntary medication on a patient in a custodial setting. This would violate a fundamental principle to which the World Health Organisation and the RANZCP[166] adhere. … In my view there could be a role for a CTO in prison when treating a person with a clearly established diagnosis of a mental illness and a history of good treatment response, who consistently refuses treatment when well, adversely impacting their quality of life. … So, if a CTO was to be used in prison, a prisoner who breached it by refusing to adhere to a treatment plan, could be referred (only) to the Frankland Centre for enforced medication when apparently well but refusing treatment, potentially preventing a relapse or reducing the impact of deterioration or relapse.

230. Another advantage is that if a prisoner on a CTO within a prison setting and who is then suddenly or unexpectedly released, there would be a transfer of that CTO to a supervising psychiatrist in the community. Dr Wynn Owen

[163] Ts 19.1.24 (Dr Wynn-Owen), p.370
[164] Ts 19.1.24 (Dr Wynn Owen), p.370
[165] Exhibit 1, Volume 2, Tab 16, Report of Dr Peter Wynn Owen dated 15 January 2024, p.6
[166] Royal Australian and New Zealand College of Psychiatrists

agreed that the problem that existed with Jaxon's unanticipated release from Casuarina would be avoided and "*could enhance the continuity of file*".[167]

231. Although Dr Wynn Owen said that CTOs are used in this manner in South Australia and Victoria, they are not currently used in this way in Western Australia.[168] Dr Wynn Owen said that it was his understanding the Chief Psychiatrist in this State does not currently support the use of CTOs in prison.[169]

232. I am firmly of the view that a consideration should be given for the use of CTOs in a prison setting in this State. It would have certainly been beneficial for Jaxon if he had been discharged from the Frankland Centre on a CTO to Casuarina on 4 August 2020. Had such a CTO been in existence then Casuarina mental health service providers would have had the option of breaching Jaxon when he refused to have the depot medication on 26 August 2020. As Jaxon's stay at the Frankland Centre for the purpose of receiving that depot injection would have been of a very short duration, there may have been a potential for him to attend the Frankland Centre for the purpose of that injection within a short period of time after 26 August 2020 (notwithstanding the usual lengthy waitlist for a bed at the Frankland Centre for acute mentally unwell prisoners).

233. For the reasons outlined above, I have concluded that the following recommendation is appropriate:

Recommendation

In order to potentially improve the effective management of prisoners with serious mental health conditions, the Office of the Chief Psychiatrist undertakes an assessment of the use of Community Treatment Orders within the prison setting.

234. Although it is my practice to invite submissions from the interested parties at the inquest to recommendations I am considering, I have not done so in this instance for three reasons. First, my recommendation is addressed to the Office of the Chief Psychiatrist, which was not an interested party at the inquest. Secondly, I had an expectation that as Dr Wynn Owen was strongly supporting the use of CTOs within the prison setting, the

[167] Ts 19.1.24 (Dr Wynn Owen), p.303
[168] Ts 19.1.24 (Dr Wynn Owen), p.371
[169] Exhibit 1, Volume 2, Tab 16, Report of Dr Peter Wynn Owen dated 15 January 2024, p.6

Department (which was an interested party) would also support this recommendation. Thirdly, my recommendation does not state that CTOs should be used in prisons; only that an assessment be made as to their use.

235. This inquest dealt with involuntary treatment orders and CTOs for prisoners in some detail. These areas had already been examined at an inquest earlier this year before Coroner Jenkin who subsequently made three recommendations that were either directly or indirectly related to the coronial investigation into the death of Jaxon.[170] I have formed the view that those recommendations are of considerable merit and would see improvements in the management of prisoners with serious mental health conditions if they were introduced.

236. I therefore support the implementation of these recommendations made by Coroner Jenkin.[171]

CONCLUSION

237. This inquest involved a very tragic case as it dealt with the death of a deeply troubled, but much loved young man.

238. Jaxon had a chronic mental health condition marked by an enduring psychosis. His long-held lack of insight regarding his mental health made him an extremely challenging person to manage in the community and in prison.

239. There was obviously another side of Jaxon to the one I heard so much about at the inquest. That other side was eloquently stated by one of Jaxon's sisters:[172]

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[170] ***Inquest into the death of Joseph Charles Abela*** [2004] WACOR 32, delivered on 31 July 2024

[171] **Recommendation No.1**

The Department of Justice should amend relevant policies to ensure that when a prisoner who is being held on remand and is the subject of a Form 1A under the *Mental Health Act 2014* (WA) (requiring the person to be examined by a psychiatrist at an authorised hospital), appears before any court in relation to an application for bail or sentence, the presiding judicial officer of that court is made aware of the existence of the Form 1A, and the options which are available to the Court in terms of dealing with that prisoner.

Recommendation No.2

In order to ensure that the mental health of prisoners can be more effectively managed, the Department of Justice (the Department) should seek approval from State Forensic Mental Health Services for all psychiatrists and mental health clinicians employed by the Department to have read-only access to the Psychiatric Services Online Information System, otherwise known as PSOLIS.

Recommendation No.3

The Department of Justice and the Department of Health should confer and identify and implement strategies to ensure the effective management of the mental health of persons admitted to prison whilst the subject of a Community Treatment Order made under the *Mental Health Act 2014* (WA), who are subsequently released.

[172] Exhibit 1, Volume 1, Tab 21, Letter from Nicola Kinnane to the Court dated 4 November 2021, p.2

> Jaxon Charles Kinnane, behind his complex mental state and polysubstance abuse issues, was an incredibly soft, gentle, intelligent person. He was a great big brother to me and Georgia as well as a great son, grandson, nephew, and friend. The fact that so many people loved him speaks to his goofy laugh, his cheesy grin, his lanky demeanour. I will never know him beyond my fading memories of our good times together, which breaks my heart.

240. In relation to the management of Jaxon's mental illness, and having carefully examined the available evidence, I was satisfied the supervision, treatment and care Jaxon received at Casuarina and Frankland Centre was appropriate. Although I identified some missed opportunities, I was also satisfied that the supervision, treatment and care provided to Jaxon at SJOGMH during his last admission was appropriate.

241. From the evidence I heard at the inquest, I remain concerned regarding the resources available in this State to treat prisoners with acute mental health conditions. The small number of beds in the Frankland Centre to treat these prisoners when they require hospitalisation had Dr Wynn Owen agreeing this number was "*woefully inadequate*".[173] An increase in the number of those beds still remains some years away.

242. I determined that it was appropriate for me to make one recommendation that addressed the use of CTOs within a prison setting. It is my earnest hope that that recommendation will be undertaken by the Office of the Chief Psychiatrist and that, if deemed suitable, a change will be introduced which will see the availability of CTOs in a prison setting.

243. I have also endorsed the three recommendations by Coroner Jenkin in an inquest finding handed down earlier this year that dealt with the care and treatment of mentally unwell prisoners.[174]

244. Finally, as I did at the conclusion of the inquest, I extend my heartfelt condolences to Jaxon's family for their sad loss.

PJ Urquhart
Coroner
6 December 2024

[173] Ts 19.1.24 (Dr Wynn Owen), p.364
[174] ***Inquest into the death of Joseph Charles Abela*** [2024] WACOR 32