CORONER'S COURT OF THE AUSTRALIAN CAPITAL TERRITORY

Case Title:	**Inquest into the death of LIAM FLETCHER MOORS**
Citation:	**[2023] ACTCD 10**
Hearing Date:	27 June 2023
Decision Date:	28 June 2023
Before:	**Coroner Russell**
Decision:	See [35]
Catchwords:	**CORONIAL LAW** – death in care – cause and manner of death – whether issue with quality of care, treatment or supervision – whether matter of public safety arises.
Legislation Cited:	*Coroners Act 1997* (ACT) sections 13(1)(i), 34A(2), 52, 74
Cases Cited:	*Inquest into the Death of Dean Christopher Brice* [2022] ACTCD 1
Counsel Assisting:	Ms Xiao Lin King
File Number	CD 222/2022

CORONER RUSSELL

1. Liam Fletcher Moors died between the evening of 9 August 2022 and the afternoon of 11 August 2022. He was 46 years of age.

2. Mr Moors was found deceased on the afternoon of 11 August 2022 by a worker employed by Catholic Care in the bathroom of unit 14/143 Goodwin Street, Lyneham, ACT. The unit was in disarray with evidence of prolonged drug use, including home-made smoking devices and 'numerous' discarded used syringes. Police officers located discarded syringes and two empty small clip seal bags in the bathroom sink.

3. At the time of his death, Mr Moors was subject to a Psychiatric Treatment Order ('PTO') which was made on 21 July 2022 for a period of 6 months.

A. Background

4. Liam Moors was born on New Years Eve, 1977. He grew up in Canberra. His mother, Kerrin Rae Madden, said he was a delightful child. He completed Year 12 and obtained a TAFE certificate. She described him as a sensitive soul who was kind and generous. He loved animals and they, she said, loved him. Even after the onset of his illness, he tried hard and was, for years, compliant with his medication. It is clear that he was loved.

B. Jurisdiction

5. An inquest, including a hearing, is mandatory in relation to Mr Moors' death. The death of a person subject to a PTO is a *death in care* defined in s3BB of the *Coroners Act 1997* ('the ACT'). A Coroner must hold an inquest into the manner and cause of death of a person who dies in care (s13(1)(i)) and, in such circumstances, a Coroner must not dispense with a hearing (s34A(2)).

6. Section 52 of the Act sets out, relevantly, the principal functions of a Coroner conducting an inquest. Those are to record the identity of the person who has died, the date and place of his death and the manner and cause of that death. The Coroner must also state whether a matter of public safety is found to arise in connection with the inquest and, if so, comment on the matter.

7. In relation to a death in care, section 74 of the Act requires that findings also be made about the quality of care, treatment and supervision of the deceased person that, in the opinion of the Coroner, contributed to the cause of death.

C. Cause of Death

8. On 17 August 2022, Dr Peter Ellis, the forensic pathologist performed an autopsy examination. Dr Ellis identified a possible puncture mark on the right antecubital fossa. Toxicological examination of samples taken at autopsy revealed a quantity of methylamphetamine in post-mortem blood that, in Dr Ellis's opinion, would '[u]nder "normal" circumstances … be sufficient to explain death'.

9. However, Dr Ellis found the presence of a significant quantity of pus in the pericardial cavity surrounding the heart which was associated with obvious inflammation of the pericardium and the heart surface. A small number of bacteria was present in that pus. The length of time between the autopsy and death was, in Dr Ellis's opinion, a possible explanation for the "relatively light growth" of bacteria from the sample and, it was his opinion that acute purulent pericarditis was the cause of Mr Moors' death. In those circumstances, Dr Ellis concluded that the quantity of methylamphetamine found 'should be considered toxic but not necessarily fatal on its own'.

10. Dr Ellis considered it likely that the microorganism responsible for the fatal pericarditis was introduced by way of 'a non-sterile injection at the time of the administration of methylamphetamine'.

11. I find that Liam Moors' death was caused by acute purulent pericarditis, as a consequence of an infected injection, in the presence of methylamphetamine toxicity.

D. Circumstances of Death

12. The records of mental health clinicians treating Mr Moors, note his use of methylamphetamine, including by intravenous injection.

13. He had been staying at the unit in Goodwin Street for a few days after meeting the occupier, SN, on a tram on 1 August 2022. At that unit, SN and Mr Moors smoked cannabis and injected methylamphetamine.

14. On 4 August, Mr Moors went to his mother's home in O'Connor and asked her for money. His mother, spoke to him briefly before he walked away. That was the last time she saw him.

15. On the evening of Tuesday, 9 August, SD was also at the unit. SN, SD and Mr Moors injected themselves with methylamphetamine. At some point, Mr Moors went into the bathroom and locked the door behind him. This was the last time he was seen alive.

16. On Wednesday 10 August, SN and SD continued to use methylamphetamine. SN left the unit at some time either on 10 August or 11 August and SD left on 11 August, not returning until 4pm, after Mr Moors' body had been located.

E. Findings required by s 52

17. I find that the infection which caused Mr Moors' death was the result of self-administration of methylamphetamine by injection with an infected syringe.

18. The evidence establishes, and I find, that Liam Moors died at unit 14/143 Goodwin Street, Lyneham in the Australian Capital Territory.

19. I find that Liam Moors died between the evening of 9 August 2022 and the afternoon of 11 August 2022.

F. Quality of Care, Treatment and Supervision

20. Mr Moors was first diagnosed with schizophrenia at the age of 20, in 1997. The mental health notes refer to the use of illicit drugs and, at least by 2005, those records note the use of methylamphetamine. Mr Moors' struggles with mental health problems continued and he was involuntarily admitted to hospital and placed on compulsory treatment orders. There was, however, a period of some years in which he was relatively stable and did not require involuntary admission to a hospital. The mental health records reflect the fact that that period coincided with a time when he was being treated with clozapine which, at least in the latter part of that period, was being taken orally.

21. The period of relative stability ended in early 2019 when he stopped taking clozapine. It is not clear from the medical records why Mr Moors stopped taking clozapine at that time, but clinicians suspected the ongoing use of cannabis and amphetamines may have been implicated.

Drug treatment regime

22. Ms Madden has expressed concerns about whether, from February 2019, her son should have been placed back on clozapine for the management of his schizophrenia. With those concerns in mind, I have carefully considered the records which detail Mr Moors' treatment in hospital and in the community.

23. When his treating clinicians became aware that he was no longer taking clozapine, a hospital admission was organised for its safe reintroduction by titration. Mr Moors attended the hospital on 15 February 2019, for that purpose, but left before he could be treated.

24. In the following days, he was involuntarily admitted to hospital with psychosis in the context of the suspected recent use of amphetamine. During a lengthy admission he indicated a willingness to take olanzapine but was refusing clozapine. He was again placed on a PTO.

25. The acute psychosis resolved on an olanzapine treatment regime and he was released from the Adult Mental Health Unit ('AMHU') of The Canberra Hospital on olanzapine by depot injection. The clinicians treating him at that stage, considered trying to reintroduce clozapine when he was more mentally stable. Nonetheless, during his stay at the AMHU, he repeatedly expressed a reluctance to restart taking clozapine and, when the acute psychosis had resolved, he told the clinicians he was happy to take olanzapine, despite it being prescribed to him by depot injection.

26. The records of early 2019 note that Mr Moors suffered from long term leukocytosis. Clinicians queried whether that was connected to clozapine use.

27. Mr Moors continued to receive olanzapine by depot injection in the community but was very often late for his injection. The records indicate strenuous efforts on the part of the mental health staff to engage with Mr Moors and have him attend for his injection. There were repeated involuntary admissions to hospital over the following two and a half years.

28. The records indicate that, over that time, clinicians tried to encourage Mr Moors to consider changing to clozapine. At times, he was prepared to engage in those discussions and admissions were arranged for him to hospital so that it could be reintroduced safely. Ultimately, however, he could not be brought to the point of actually being prepared to attend. Although the records note that he did not complain of such side effects when he was stable on clozapine, he told clinicians that he had nightmares on clozapine and that it was a 'terrible' drug for him. He was often highly resistant to mental health clinicians attempts to have him reconsider taking it, while, at the same time, agreeing to continue on olanzapine.

29. The records indicate that, conscious of the requirement imposed upon them to treat Mr Moors with respect and to provide him with treatment in a way which was least restrictive or intrusive to him, clinicians were continually assessing his drug regime and decisions were made to keep him on olanzapine while he was relatively compliant with it and while it was effective, because that accorded with his strongly expressed wishes. In coming to those decisions, clinicians also took into account, what they considered would be, his preparedness to comply with a clozapine regime while in the community. When his health and his compliance deteriorated in 2022, a

decision was made, in June 2022, to replace olanzapine with paliperidone and, at the time of his death he was being transitioned onto that drug.

30. The records demonstrate, and I find, that Mr Moors' treating clinicians were diligently assessing him and that the clinical decisions made about his drug treatment regime, while difficult, were not inappropriate.

Illicit drug use

31. The records further demonstrate that clinicians were aware, at times, of Mr Moors' use of illicit drugs and, at other times, suspected that he was using such drugs, including methylamphetamine. They attempted to bring him to the point where he would engage in drug rehabilitation programs. Such engagement could not be enforced, however, under the PTO to which he was subject.[1]

32. With respect to the ACT Mental Health Services, the records do not support any finding that the quality of care, treatment and supervision of Mr Moors contributed to the cause of his death.

G. Matter of Public Safety

33. Mr Moors died of acute purulent pericarditis, as a consequence of self-administered methylamphetamine by injection with an infected syringe. The City Mental Health Team were actively engaged with him and attempting to assist him in the months leading to his death. I can make no finding that the care provided to Mr Moors by ACT Mental health agencies was deficient. I am satisfied that no matter of public safety arises in connection with this inquest.

F. Closing remarks

34. Mr Moors was loved by his family. Although his illness, at times, made him difficult, his mother maintained involvement with the services treating him. It is clear that she feels his loss deeply. I extend my condolences to her and to his family and all who cared for him.

E. Formal findings

35. I make the following findings as required by s 52 of the Act:

Place of death

Liam Fletcher Moors died at 14/143 Goodwin Street, Lyneham in the Australian Capital Territory.

Date of death

He died between the evening of 9 August 2022 and the afternoon of 11 August 2022.

Cause of death

[1] I respectfully adopt the findings of His Honour Magistrate Morrison in Inquest into the Death of Dean Christopher Brice [2022] ACTCD 1 in this respect.

1. Direct cause

    a. Acute purulent pericarditis, *as a consequence of*
    b. an infected injection

2. Other significant conditions

    a. Methylamphetamine toxicity

***Manner of death**:*

Self-administration of methylamphetamine by injection with an infected syringe.

36. I close this inquest.

I certify that the preceding thirty six [36] numbered paragraphs are a true copy of the Reasons for Decision of her Honour Coroner Russell.

Lawyer: Xiao Lin King

Date: 28 June 2023