CORONER'S COURT OF THE AUSTRALIAN CAPITAL TERRITORY

Case Title:	**Inquest into the death of Stanley McIntyre**
Citation:	**[2025] ACTCD 5**
Hearing Date:	13 December 2024
Decision Date:	12 August 2025
Before:	Coroner Archer
Findings:	[66]
Catchwords:	**CORONIAL LAW** – death in care – pulmonary emphysema – whether issue with quality of care, treatment, and supervision – whether matter of public safety arises
Legislation Cited:	*Coroners Act 1997* (ACT) ss 3BA, 3BB, 13, 52, 74 *Mental Health Act 2015* (ACT) ss 58-65 *Crimes Act 1900* (ACT) s 309
Texts Cited:	*Royal Commission into Victoria's Mental Health System* (Final Report, March 2021)
Representation:	**Counsel Assisting the Coroner** Xiao Lin King
File Number:	CD 181 of 2021

CORONER ARCHER:

Introduction

1. On 23 June 2021, the death of Stanley McIntyre was reported to the Australian Capital Territory (**ACT**) Coroner's Court. I will, with respect, refer to Mr McIntyre as Stanley in these findings.

2. At the time of his death, Stanley was 63 years old and was subject to a Psychiatric Treatment Order (**PTO**), which was made by the ACT Civil and Administrative Tribunal (**ACAT**) on 1 February 2021 for a period of 6 months. Forensic pathologist, Professor Johan Duflou, performed a post-mortem examination and opined that the cause of Stanley's death was pulmonary emphysema.

Jurisdiction

3. The coroner's jurisdiction in relation to Stanley's death arises under s 13(1)(i) of the *Coroners Act 1997* (ACT) ('***the Act'***), which provides:

> (1) A coroner must hold an inquest into the manner and cause of death of a person who—
>
> (i) dies in care or custody.

4. Under s 3BB of the Act, a "in care" means a person subject to an order under the *Mental Health Act 2015* (ACT) ('***MH Act'***). Given Stanley was subject to a PTO (*MH Act* ss 58 to 65) at the time of his death, his death is within the coroner's jurisdiction. As required by s 34A(2) of the Act, a hearing into Stanley's death must not be dispensed with.

5. At the conclusion of the inquest, including the hearing for the inquest, I must make the findings that are required by s 52 of *the Act*, which provides:

> (1) A coroner holding an inquest must find, if possible—
>
> (a) the identity of the deceased; and
>
> (b) when and where the death happened; and
>
> (c) the manner and cause of death; and
>
> (d) in the case of the suspected death of a person—that the person has died.
>
> (4) The coroner, in the coroner's findings—
>
> (a) must –
>
> (i) state whether a matter of public safety is found to arise in connection with the inquest or inquiry; and
>
> (ii) if a matter of public safety is found to arise—comment on the matter;

6. To find a "cause" of death in any given case, a coroner is required to consider what physiologically produced that result. Separately, a finding as to the "manner" of death

involves a consideration of the circumstances in which the death took place. If a matter of public safety arises, I can comment on it.

7. Pursuant to s 74 of *the Act*, where applicable, I must also make findings as to the quality of care, treatment, and supervision of the deceased person that, in my opinion, contributed to the cause of their death. Section 74 of *the Act* does not require a coroner in cases to which this section applies to always make findings about the quality of care, treatment and supervision of the deceased. What the section calls for is for findings to be made when shortfalls in the quality of care, treatment and supervision of the deceased "contributed to the cause of death". That shortfall does not need to be the only matter that caused the death.

Course of the Inquest / Hearing

8. Coroner Jane Campbell had carriage of Stanley's matter after it was referred to the Court. As no findings had been made by the time of my appointment as the Territory's dedicated coroner in March 2022, I assumed carriage of the matter to complete the investigation of Stanley's death.

9. A brief of evidence was completed by the Australian Federal Police (**AFP**) at the direction of the court. It contained interviews with Stanley's younger brother ('Stanley's brother') and Stanley's mental health case manager Mr Steven Keed. It also contained extensive records subpoenaed from Canberra Health Services (**CHS**) and ACT Housing.

10. A hearing into Stanley's death was conducted on 13 December 2024. Ms King appeared as counsel assisting. The brief of evidence was tendered and marked as an exhibit. I was also provided with a copy of Ms King's written submissions.

11. No other person sought leave to appear. Stanley's brother who advocated tirelessly for Stanley throughout the coronial process, was unable to attend the hearing. He had a point of view in respect of the circumstances of Stanley's death which is referred to below.

Stanley Mcintyre – His Life and Mental Health History

12. Stanley was born on 28 May 1958 in New South Wales (**NSW**). Stanley's medical records contain little information about his early childhood. The records indicate that Stanley reported to clinicians that he and his family moved to Canberra around 1970.

13. A review of Stanley's medical records also disclosed that Stanley had a lengthy history of severe and treatment resistant schizophrenia. Stanley was first diagnosed with schizophrenia in 1979, when he was 21 years old. Stanley's brother recalled that Stanley began to develop a psychiatric illness after he left high school in year 10 and returned

from an overseas trip to Europe with his friends. From early on in his treatment history, clinicians considered Stanley's schizophrenia to be severe and chronic. Beginning in the 1980s, Stanley had had frequent psychiatric hospital admissions, including in-patient stays at the now closed *Brian Hennessy House* in 1999 and 2003. Despite treatment with anti-psychotic medication, he was often profoundly thought-disordered, experienced psychosis, and lacked insight into his condition. His illness was further complicated by alcohol abuse and illicit drug use dating back to the 1980s.

14. Consistent with the severity of his illness, Stanley had a history of treatment whilst subject to PTOs involving a mixture of in-patient care and treatment within the community. At the time of his death, Stanley was subject to a PTO and was being managed in the community by the City Mental Health (**CMH**) team. Stanley's treatment plan involved attending CMH every three weeks for a Haloperidol 75 mg depot injection (anti-psychotic), every six weeks for a psychiatric review with Dr Bree Wyeth, and weekly welfare visits from his case manager, Mr Steven Keed.

15. Mr Keed had been Stanley's case manager for three years prior to his death. He described Stanley as the most complex patient he had ever worked with, as his illness had meant that he was forgetful, delusional, and at times threatening and aggressive towards clinicians and support workers. Stanley was poor at engaging with the community mental health team. He would often miss appointments and depot injections, which, according to Mr Keed, had made it very difficult to maintain consistent support services for Stanley. It is evident from the medical records that Mr Keed was one of the few people Stanley trusted.

16. Stanley's mental health prior to his death was described in the application for a PTO, dated 27 January 2021, by psychiatrist Dr EK Rodrigo, in the following terms:

> Mr McIntyre has demonstrated a poor baseline functioning, usually with some form of psychotic symptoms, both as an in-patient and in the community. Mr McIntyre suffers from a co-morbid alcohol use disorder.
>
> Stanley is orientated and alert, but has no insight into his condition, initially he seemed to have little to no understanding of his situation including the fact that he is facing charges.
>
> In the community he has been passively accepting his depot injection, but his recent presentation suggests a relapse despite this, he currently lacks the capacity to make a choice regarding his treatment.
>
> In general Stanley presents as malodorous and profoundly thought disordered, and incontinence of urine. The consumer is tangential, with loose associations and flight of ideas. Stanley suffers from grandiose delusions, for example, he believes he is one of the psychiatrists working here or he is a Police officer.

17. Stanley's last in-patient admission was between 24 February and 11 March 2021 (**'the February 2021 admission'**). At the time, he was facing criminal charges relating to failing to appear in court, trespass, and indecent exposure. He had been transported to the Adult Mental Health Unit (**AMHU**) at The Canberra Hospital (**TCH**) under an order made pursuant to s 309 of the *Crimes Act 1900* (ACT). That section empowers the Magistrates Court to order an accused person to be taken involuntarily to a mental health facility for the purpose of deciding whether the accused needs immediate treatment or care because of mental impairment.

18. Prior to discharge, Stanley was reviewed by psychiatrist Dr Vinod Chopra, who noted that he was calm and co-operative, but still had ongoing delusions about being a doctor and lacked insight into his mental illness. Dr Chopra prepared a final discharge report, which described Stanley's schizophrenia as treatment resistant. Dr Chopra opined that due to his mental illness, Stanley was unfit to stand trial in court and incapable of independent living.

19. On 11 March 2021, Stanley was discharged from AMHU back to his ACT Housing unit, where he lived alone. The discharge plan indicated that at the time of discharge, the CMH treating team was working on arranging suitable supported accommodation for Stanley.

20. Stanley's medical records also indicate that in the period following his last hospital admission until his death, Stanley was up to date with his depot medication, and his mental state was considered by clinicians to be at his baseline.

Stanley's Physical Health

21. A complete picture of Stanley's physical health before his death is difficult to ascertain from his medical records. This may reflect the fact that Stanley resisted attending medical appointments and participating in physical examinations. He lacked insight into not only his mental health, but also his physical health. He was an unreliable historian regarding his health.

22. It is clear that the CMH clinicians recognised and were concerned about the risks Stanley's mental illness and lifestyle posed to his physical health. Stanley's medical records demonstrate that the CMH team made efforts to engage Stanley with a General Practitioner (**GP**). Between 2019 and his death, Stanley saw GP Dr Paul Appleton on four occasions.

23. On 11 May 2021, about a month before Stanley passed, he was diagnosed with Chronic Obstructive Airways Disease (**COAD**) by Dr Appleton. COAD refers to a broad category of progressive lung diseases involving restricted breathing. One significant cause of

COAD is smoking. Stanley's medical records indicate that he had a long history of being a moderate to heavy smoker, and that over his many years of engagement with community mental health services, clinicians had made efforts to encourage him to quit smoking. Those efforts were unsuccessful, and Stanley was still a smoker at the time of his death.

24. Whilst Stanley's COAD was not diagnosed until 11 May 2021, his medical records indicate that he had been suffering from some form of lung disease for many years prior:

    (a) In January 1986, Stanley presented to the hospital with sudden chest pain and was diagnosed with pneumothorax (a collapsed lung). A left upper lobectomy (removal of the left upper lobe of the lung) was performed. Stanley had a normal recovery post-surgery and had good "air entry".

    (b) In May 1998, a chest X-ray report stated that "the lungs show marked changes of obstructive airways disease but are otherwise clear". Subsequent chest X-ray reports in July 1999 stated the "chest was clear".

    (c) In June 2019 and March 2020, Dr Appleton examined Stanley's chest and noted, on both occasions, "poor AE (air entry) but okay".

    (d) In November 2020, Stanley presented to the then Calvary Hospital following a sudden collapse in public. A chest CT-scan showed:

        > Either massive bullous (air pocket) or there is complete collapse of the right upper lobe, with a bullous favoured, there is a very large gas containing structure at the right lung apex and no normal lung is seen there.

    (e) A subsequent chest X-ray conducted during that presentation showed:

        > No pneumothorax. Marked bullous change within the right upper lobe and a few presumed peripheral paraseptal emphysematous lesions of the left lung and also within the right mid to lower zone. Increased bronchovesicular markings in the mid and lower zones consistent with COPD.

    (f) On 11 May 2021, Dr Appleton diagnosed Stanley with COAD and prescribed Stanley Anora Ellipta inhaler medication. Dr Appleton noted "chest poor AE and wheeze".

25. A review of Stanley's medical records in the year prior to his death revealed that Stanley did not report breathing difficulties to his treating clinicians. During the February 2021 admission, Stanley reported to clinicians that he was in peak physical health and had a "white brain, white lung, and white heart". He denied having any chest pain, palpitations, or shortness of breath. Surprisingly, his vitals, checked daily during his admissions, were within normal ranges. His oxygen saturation levels were between 93% and 97%, and his respiratory rate was between 14 and 17 breaths per minute.

26. Stanley's consultation with Dr Appleton on 11 May 2021 was his last GP visit before he passed. The consultation notes from that visit did not record how significant or advanced Dr Appleton considered Stanley's COAD to be. The only other physical health concerns Stanley was suffering from at the time were incontinence and a recently operated-on fractured elbow.

Housing and Other Support in the Community

27. In the months prior to Stanley's death, the CMH team was working on getting him more daily living support. Following his last hospital admission, Stanley was living alone in an ACT Housing unit. He was receiving a disability pension and had a basic National Disability Insurance Scheme (**NDIS**) package in place. That package included weekly frozen meal deliveries, occupational therapy, and some cleaning services. The records suggest that Stanley had lived in ACT Housing accommodation for most of his adult life.

28. The CMH team recognised that due to his mental illness, Stanley was incapable of completing many daily living tasks, including cooking, cleaning, and maintaining his physical health. As indicated in the hospital discharge plan on 11 March 2021, the CMH team, and in particular Mr Keed, were working on moving Stanley into a form of "supported accommodation". Mr Keed explained that supported accommodation would involve support workers being available on residence to provide 24/7 support to Stanley.

29. CHS and Mr Keed provided statements to the Court that addressed the nature and concept of supported accommodation. They explained that for Stanley to be moved into supported accommodation, he would have needed a supported independent living plan (**SIL**). Stanley's basic NDIS package did not include a SIL. Mr Keed explained that obtaining further NDIS support for supported accommodation would require a stable relationship between Stanley and NDIS and more consistent participation in assessments, so that Stanley's needs could be assessed. Unfortunately, due to Stanley's behavioural difficulties discussed above, that was a slow and difficult process.

30. The records demonstrate that despite apparent challenges, Mr Keed was persistent in getting Stanley a more comprehensive NDIS plan. During the last three months of Stanley's life, Mr Keed had successfully organised weekly early morning NDIS home visits and assessments for Stanley. Those visits had to occur early in the morning, as Stanley would frequently leave his unit after 8 a.m. and become unlocatable for the rest of the day. Mr Keed attended those home visits himself to assist Stanley with developing a relationship with the NDIS workers. The impression gained from the records is that due to Mr Keed's efforts, progress (albeit slow) was being made to get further daily living support for Stanley.

Stanley's Death – 2 to 22 June 2021

31. Stanley's last contact with CMH was on 2 June 2021, when he arrived at the CMH clinic mistakenly thinking he had his depot injection scheduled on that day. He was, in fact, not due for an injection until 15 June 2021. A nurse observed Stanley looked tired and took his vital signs:

    Blood Pressure 143/81 mmHG

    Heart Rate 125 beats/m

    SPo2 92 % RA

    Temperature 36.8

    Respiration rate 21 b/m

32. The nurse requested that Stanley stay and take a rest, so that some further monitoring of his vitals could be conducted. Stanley stayed for a while watching TV and then left without notifying anyone. This was the last time he was seen alive.

33. The records indicate that Mr Keed went on leave for two weeks shortly after Stanley's presentation on 2 June 2021. On 15 June 2021, Stanley did not attend CMH for his scheduled depot injection. Staff members noted his absence and decided to wait a few days to see if he would attend later. The recorded plan was to wait until 21 June 2021 before initiating breach of PTO proceedings.

34. On 18 June 2021, Stanley had still not attended CMH for his depot injection. Clinicians from CMH attended his flat to conduct a welfare check, but no one answered his door. A notification of breach of his PTO and a letter requesting him to attend CMH immediately were left at his door.

35. On 21 June 2021, when Stanley did not attend his psychiatric appointment, CMH reported him missing to police. A nurse made another home visit that day, but no one responded at the door. Enquires were made of Stanley's neighbour, who thought they had last seen him between three and seven days prior. Later that day, police attended unit 1 in Elimatta Street to conduct a welfare check. They went to Stanley's old unit. Stanley had moved into another unit in the same complex in August 2020.

36. On 22 June 2021, Mr Keed, having just returned from leave, heard about Stanley's missing person status, and decided to conduct a welfare check himself. Stanley had previously verbally consented to Mr Keed using a spare key to access his unit. Mr Keed used the spare key to access the unit at Unit and located Stanley on the lounge. It was clear that Stanley had been deceased for some time.

37. The records demonstrate that it was not unusual for Stanley to miss his depot injection and medical appointments. Mr Keed noted that it was also not unusual for Stanley not to respond to visitors knocking on his door. In these circumstances, I am satisfied that CMH had raised appropriate concerns with the relevant agencies when Stanley did not attend his appointments and took reasonable steps to locate Stanley and check on his welfare.

The Manner and Cause Of Stanley's Death

38. Following Stanley's death, Professor Johan Duflou, forensic pathologist, conducted a post-mortem examination and provided a written report, dated 16 August 2021. The post-mortem examination included an internal examination, medical records review, and toxicological analysis. The central findings made by Professor Duflou were that:

    (a) The direct cause of death was pulmonary emphysema.

    (b) Stanley's body showed signs of moderate decomposition changes, suggesting that he had been deceased for around one to two weeks prior to him being found.

    (c) Both lungs showed very advanced pulmonary emphysematous damage, with the majority of the upper lobe of the right lung replaced with bullae (large pockets of air).

    (d) Additionally, there were some naked eye changes in the lung, which would suggest a possible small tumour in the right lung and also possible pneumonia. This could not be confirmed on microscopy, given the state of the body.

    (e) Toxicological testing of the tissues revealed a modest level of alcohol, all of which might have been the result of post-mortem generation of the substance.

    (f) No other significant natural disease process of a type expected to cause sudden death was identified.

39. Professor Duflou further explained that given the state of the body, he was not able to determine whether there was a viral or bacterial infection process in the lungs. In either the infection could have exacerbated Stanley's COAD.

40. Professor Duflou also observed that persons with severe schizophrenia, like Stanley, generally have a higher death rate and that in a percentage of those cases, no anatomical or toxicological cause of death would be identified. Having said that, Professor Duflou remained of the view that the most likely cause of Stanley's death was pulmonary emphysema.

41. Emphysema is a type of COAD. It is a chronic lung condition, whereby the alveoli (tiny air sacs) in the lungs become enlarged and damaged, impeding the transportation of oxygen around the body. It is considered to be a progressive disease, occurring slowly over time. As a type of COAD, emphysema is often caused by smoking. Symptoms include shortness of breath, coughing, and fatigue, although some people may not notice any symptoms until the disease has destroyed half or more than half of their lung tissue. The damaged lung tissue caused by emphysema is not able to be reversed by treatment. The goal of treatment, therefore, is simply to manage the symptoms to provide a better quality of life and to slow down the progression of the disease. Standard treatment and management include ceasing smoking, inhaler medication, and oxygen therapy (via portable oxygen tanks). Whilst medication can be an important part of a treatment plan, ceasing smoking is the best way to slow down the progression of the disease.

42. The proximity of Stanley's diagnosis of COAD to his death suggests that his emphysema was advanced at the time of diagnosis. I note that Professor Duflou could not exclude the possibility of Stanley having suffered a viral or bacterial illness that exacerbated his COAD. Based on the available evidence, I am unable to say whether there was an unreasonable delay in the diagnosis and treatment of Stanley's lung disease. If there was any delay, the evidence suggests that it would have been due to the difficulties clinicians encountered in trying to physically examine Stanley, Stanley's unreliable reporting of symptoms, and his relatively normal oxygen saturation levels and respiratory rate in the year prior to his death.

43. Once Stanley was diagnosed with COAD, it appears that he was commenced on appropriate treatment, that is, inhaler medication. Mr Keed addressed Stanley's inhaler use in his statement. He said that he was aware that Stanley was prescribed the inhaler to take on an as-needed basis. He added that he had seen Stanley use the inhaler once or twice when he visited, but he could not make any further comment as to how reliable Stanley was in using the inhaler. In respect of Stanley's smoking, the records show that mental health clinicians had tried to encourage Stanley to stop smoking long before his diagnosis of emphysema.

44. As Mr Keed emphasised, the treatment of a patient like Stanley is a complex undertaking. A PTO made under the *MH Act* is limited to authorising the compulsory psychiatric treatment of a patient. It does not empower the Court, or anyone for that matter, to involuntarily subject the patient to treatment in respect of their physical health or substance addiction.

45. Given Stanley's long-standing smoking habit, his limited capacity to change his lifestyle (attributable to his mental illness), and the fact that emphysema is not curable, I do not

find that an earlier diagnosis would have made a material difference to his life and the cause of his death. I accept that the clinicians involved in Stanley's care had done what they could and used the powers they had to address Stanley's mental and physical health issues. At the time of his death, there were ongoing efforts to move Stanley into accommodation, in which he would likely have access to more support and services. I do not find any matter of public safety arises with respect to the diagnosis and treatment of Stanley's lung disease.

Section 3BA of the Act

46. Section 3BA(2) of *the Act* provides that as far as is practicable, the objects of *the Act* must be carried out in a way that "recognises that the family and friends of a deceased person have an interest in having all reasonable questions about the circumstances of the person's death answered". It is in that context that I address the concerns raised by Stanley's brother.

47. Throughout the inquest process, Stanley's brother raised a number of specific and general concerns regarding the care Stanley received from ACT Housing and ACT Mental Health. Those concerns arose from his experience in trying to support Stanley over a long period of time in difficult circumstances. Stanley's brother maintained that some of those institutional deficiencies might have contributed to Stanley's poor health and eventual death.

Stanley's ACT Housing unit

48. Stanley's brother described the condition of Stanley's ACT housing unit prior to and at the time of his death as "squalid" and "filthy". He believed that environment contributed to Stanley's poor health and ultimate death.

49. I accept that the unit was often very untidy and unclean. The explanation for that is set out above. I acknowledge that the records show that Stanley struggled to maintain his ACT Housing unit. Despite the efforts of CMH clinicians to teach and encourage him to clean, piles of rubbish were often found in his unit. In the years prior to his death, there were multiple occasions where his unit was found to be cockroach infested. The ACT Housing records confirm that Stanley's brother raised concerns with ACT Housing about various maintenance issues with Stanley's unit.

50. On 7 August 2020, ACT Housing moved Stanley within the Elimatta Street housing complex. Stanley had lived in his unit for at least the last 5 years. CHS advised the Court that Stanley was moved because his unit was "barely habitable due to insect infestation, fifth and rubbish'". An annual inspection of Stanley's new unit occurred on 4 May 2021 (approximately 1 month prior to his death). The inspection report noted there was a

cockroach infestation again, the kitchen benches needed cleaning and there was mould in the bathroom and toilet. The condition of other areas of the house was noted as “fine”.

51. Following the 7 August 2020 inspection, ACT Housing notified the CMH and NDIS team about the condition of Stanley's unit. Mr Keed advised that the CMH team had tried putting “cockroach bombs” in the unit, but Stanley had thrown them out. CMH was also trying to organise a forensic clean through NDIS, but Stanley was resisting engagement and assistance. The medical records suggest that in 2021, as Stanley developed a relationship with NDIS workers, he was accepting some cleaning assistance. The best accommodation for Stanley may not have been in a unit living on his own and moves were on foot to change Stanley’s housing arrangements at the time of his death. Given Stanley’s sensibilities around accepting the assistance of others it is difficult to determine how he might have adapted to different living arrangements.

52. Stanley’s experience highlights the complexities of effectively accommodating those who suffer with mental illnesses and particularly those who suffer a severe mental illness that does not always require in-patient treatment. It is well accepted that ensuring access to appropriate housing is an important aspect of community-based care of those suffering mental illnesses. The effective provision of that housing requires a close co-operation between mental health clinicians, authorities responsible for community housing and national support agencies including NDIS. It is an issue that is being pursued at a national level through the work of the National Mental Health Commission and other research and policy initiatives.

53. I do not find that the unsatisfactory aspects of Stanley’s living arrangements contributed to the cause of his death.

Hospital admission: 23 December 2020 to 19 January 2021

54. Stanley’s brother raised concerns regarding events that occurred during Stanley’s hospital admission between 23 December 2020 to 19 January 2021 (‘**the December 2020 admission’**).

<u>The Fractured Elbow</u>

55. Stanley was involuntarily admitted to AMHU for psychiatric treatment on 23 December 2020. On 4 January 2021, in AMHU, Stanley fractured his left elbow. Stanley’s brother expressed the view to me that Stanley reported to him that someone caused this fracture “bashing” him.

56. There is no evidence that an assault caused Stanley's fractured elbow. The medical records document that Stanley elbow fracture was caused by a fall at AMHU on 4

January 2021. The fall was witnessed by a clinician who recorded that Stanley had "tripped over crocs and landed on his left elbow with a head strike". The records show that Stanley required surgery but refused treatment while in hospital and following discharge into the community.

57. Stanley's elbow fracture was reviewed again by orthopaedic clinicians during the February 2021 admission discussed at [17]. It was again determined that he required surgery. On this occasion, an assessment was made that he lacked the capacity to consent to the surgery, and consent was obtained from the ACT Public Trustee and Guardianship. Stanley underwent surgery for his elbow fracture on 27 February 2021. The records indicate that surgery went well, and follow-up appointments with a fracture clinic were part of his discharge plan.

Mental State on Discharge

58. In respect to the December 2020 admission, Stanley was discharged from AMHU on 19 January 2021. A psychiatrist reviewed him prior to discharge and opined his mental state was "at baseline and as good as we have ever seen him" but that "he remains delusional and insight less and will be a challenge to manage" and that he required supported accommodation. Stanley's brother stated to me that this assessment of Stanley's mental state was inconsistent with the later commentary about the support he required in the community and he questioned whether Stanley should have been discharged.

59. As discussed at [12-20], clinicians considered Stanley's baseline mental state was poor and involved psychotic symptoms and delusion. The mental health assessment made reflects the recognition by clinicians that Stanley, even at his best, required intensive support in the community. The medical records from 19 January 2021 show that Stanley was eager for discharge and was still subject to a PTO in the community. The PTO regime would at the very least facilitate the administration of anti-psychotic medications. However, the legislative requirements for involuntary detention under the *MH Act*, suggested there were no grounds for Stanley to be involuntarily detained further.

Webster Pack Medication

60. Stanley's brother observed that Stanley had some medication in the form of webster packs and that Stanley could not read the writing on the packs. He expressed concern that Stanley did not know what medication he was taking.

61. The exact medication that was provided to Stanley in the webster packs is not apparent from the medical records. Mr Keed discussed Stanley's webster pack medication in his interview with police on 29 June 2021. He explained that the medications contained in the packs were not psychiatric medications or medication that Stanley needed to take on

a regular basis. Rather, they were medications such as pain killers or Valium, which were prescribed to Stanley on an as-needed basis. Mr Keed confirmed that Stanley would eat his medication like “smarties” if given to him all at once. To prevent this, CMH clinicians would only give Stanley one to two days of his medication at a time in webster packs.

62. In my view, CMH clinicians were appropriately monitoring and managing Stanley webster pack medication.

General Concerns Regarding ACT Mental Health

63. Stanley’s brother raised some general concerns in respect of the ACT mental health system. He stated that Stanley and the staff of ACT Mental Health had been let down by “insufficient funding, staffing and infrastructure which has clearly compromised our ability to care for the most vulnerable in our society”. He reflected on the limited availability of services like the *Brain Hennessy House*, a residential mental health unit in which Stanley was an inpatient at in 1999 and 2003. He observed that this was the best form of care for Stanley.

64. I observe that Stanley’s brother’s concerns reflect matters raised in other coronial inquests in this jurisdiction and have been the subject of ACT Audit Office review, Royal Commissions and inquires in Australia. In particular, the final report of the *Royal Commission into Victoria’s Mental Health System* (2021) discussed the value and need for more residential services for mental health consumers, including supported housing services which can provide multidisciplinary support to mental health patients on site. The extent to which this recommendation had been advanced in the ACT was not the subject of evidence in this inquest.

65. In my view, in respect of Stanley's mental health care proximate to his death, the CMH team, particularly Mr Keed, did their best, within the care structures available, to attend to Stanley's various mental, physical and social needs. The adequacy of those structures in 2020 and now is beyond the scope of this inquest.

Formal Findings

66. Pursuant to s 52 of *the Act,* I find that:

    (a) Mr Stanley McIntyre died between 2 June 2021 and 22 June 2021 at unit 3 of 44 Elimatta Street in Reid in the Australian Capital Territory.

    (b) The cause of Mr McIntyre’s death was pulmonary emphysema.

    (c) No matters of public safety arise in respect of his death.

Postscript

67. I acknowledge the role played by Stanley's brother in the inquest process. His advocacy for Stanley provided me with insights as to Stanley's life and the challenges he faced in dealing with his mental health issues.

68. I also acknowledge the role played by Mr Keed in Stanley's care. Stanley's needs were complex and addressing them was a difficult task particularly in circumstances where resources and structures may not have been sufficient or adequate to address Stanley's needs. It is clear to me that he cared.

69. I am grateful for the contributions of counsel assisting, Ms Xiao Lin King, to the inquest process. My findings reflect the outcomes of her hard work and insights.

I certify that the preceding sixty-nine [69] numbered paragraphs are a true copy of the Findings of his Honour Coroner Archer.

Associate: Lucy James

Date: 12 August 2025