CORONER'S COURT OF THE AUSTRALIAN CAPITAL TERRITORY

Case Title:	**Inquest into the death of Lena Edwards**
Citation:	**[2026] ACTCD 10**
Decision Date:	26 June 2026
Before:	Coroner K J Archer
Findings:	See [42-72]
Catchwords:	**CORONIAL LAW** – MANNER AND CAUSE OF DEATH – Psychiatric Treatment Order – death in care - hearing required
Legislation Cited:	*Coroners Act 1997* (ACT) ss 13, 3BB, 34A, 52
Cases Cited:	*Harmsworth v The State Coroner* [1989] VR 989, 997 *Inquest into the death of Catherine Broadbent* [2024] ACTCD 1 *Inquest into the death of Joshua* [2023] ACTCD 2 *Inquest into the death of Stanley McIntyre* [2025] ACTCD 5 *R v Doogan; ex-parte Lucas-Smith & Ors* [2005] ACTSC 7
Papers Cited	Cipolla S, Catapano P, D'Amico D, Monda R, Sallusto NP, Perris F, De Santis V, Catapano F, Luciano M, Fiorillo A. *Combination of Two Long-Acting Antipsychotics in Schizophrenia Spectrum Disorders: A Systematic Review*. Brain Sciences, Department of Psychiatry, University of Campania. 2024 Zhang X, Sun S, Fan X, Guo S, Li W, Wang C, Xu J, Chen C, Jin H,*Thromboembolic events with olanzapine: a systematic review integrating meta-analysis and FAERS database*. Frontiers, 2026 Manea M, Rusanu V, Patrichi BE, Puiu MG, Stoean RM, Stefanache AA. *Olanzapine and zuclopenthixol combined therapy for the treatment of refractory schizophrenia: 2 case reports*. European Psychiatry, 2011.
File Number:	CD 292 of 2021
Counsel assisting:	Ms X King

CORONER ARCHER:

INTRODUCTION

1. On 25 September 2021, the death of Lena Edwards was reported to the ACT Coroner's Court. At the time of her death, Ms Edwards was 34 years old, an inpatient at the Dhulwa Mental Health Unit ('DMHU'), and was subject to a Psychiatric Treatment Order ('PTO') made on 12 August 2021, operative for a period of 6 months. With respect, I refer to Ms Edwards as 'Lena' in these findings.

JURISDICTION

2. The Coroner's jurisdiction in relation to Lena's death arises under section 13(1)(i) of the *Coroners Act 1997* ('the Act'), which provides that a Coroner must hold an inquest into the manner and cause of death of a person who dies in care. Lena was a person subject to a PTO at the time of her death and it is therefore a 'death in care' defined in section 3BB of the Act. A hearing into Lena's death cannot be dispensed with pursuant to section 34A(2).

FINDINGS - SECTIONS 52 AND 74 OF THE ACT

3. At the conclusion of this inquest, I must make findings regarding the manner and cause of Lena's death in accordance with section 52 of the Act.

4. Section 74 of the Act requires the Coroner to make findings about any shortfalls in the care, treatment or supervision of the deceased that, in the Coroner's opinion, contributed to the cause of death. The provision does not impose a requirement to *always* make such findings in every case to which it applies. Rather, findings are only required where a deficiency in care, treatment or supervision is assessed as having 'contributed to the cause of death'. That shortfall does not need to be the only matter that caused the death[1].

SCOPE OF THE INQUEST

5. Submissions made by the family raised the issue as to what constituted an appropriate scope of the inquest.

[1] Inquest into the death of Stanley McIntyre [2025] ACTCD 5

Manner and Cause Findings

6. The requirement to make the findings required by section 52 - including the manner and cause of death - are central to defining the legitimate scope of an inquest. [2]

7. In any given case what might be considered part of the 'manner and cause' of a person's death is difficult to define, because each death occurs within its own circumstances and context. However, ultimately, the matters examined by the Coroner must be sufficiently connected to the actual cause of death.[3] Matters relating to a person's more distant past, treatment for unrelated conditions, or general living circumstances will often fall outside the scope of the inquest.

8. The assessment of what is relevant begins with the cause of death identified by the forensic pathologist and then focuses on matters that may have led to, influenced, or contributed to that cause in a sufficiently direct and meaningful way[4]. In this case, Professor Duflou determined the cause of Lena's death was pulmonary thromboembolism ('PTE'). It follows that the inquest is appropriately confined to examining, and making findings on, matters that are relevant to the development of the PTE that caused Lena's death, including Lena's physical health, her antipsychotic medication regimen, and the circumstances of her final period of clinical care at the DMHU.

9. On 12 February 2026, the Court received a detailed and deeply personal statement from Summer Edwards, Lena's eldest sister, concerning Lena's long history of mental illness and engagement with the mental health and the Public Trustee & Guardian ('PTG') systems in the ACT. Lena's mother, Lynette Gehrmann, had previously expressed similar concerns. Summer described a sustained and painful experience of attempts to support Lena through periods of significant illness. She described feeling excluded from decision making processes about Lena's treatment and care over many years. I acknowledge the care with which those concerns were expressed, and the evident distress that underlies them. The statement from Summer received on 12 February 2026 (which was read in the hearing) and emails from Lynette dated 19 July 2022 and 28 February 2023, formed part of the evidence in the inquest.

10. The history provided by Lena's family, is profoundly significant to understanding her life and illness. However, generally, Lena's broader history of long-term engagement with the ACT mental health system and the PTG arrangements, including issues relating to

[2] Harmsworth v The State Coroner [1989] VR 989, 997.
[3] R v Doogan; Ex parte Lucas Smith [2005] ACTSC 74.
[4] Ibid [20]

family involvement and consent, I find are not sufficiently connected to the cause of her death to be examined in this inquest.

11. I am conscious of my obligations under section 3BA of the Act to ensure that as far as practicable the objects of this Act must be carried out in a way that in respect of an inquest into a person's death recognises that family and friends of a deceased person have an interest in ensuring that all reasonable questions about the circumstances of the person's death are answered. However, the fulfilling of this obligation does not overcome the limitations that arise from my obligation to look at only those matters relevant to the manner and cause of Lena's death.

Public safety – section 52(4) of the Act

12. The power under section 52(4) to make comments on matters of public safety 'in connection with' a death is not boundless. An inquest is not an investigation that can investigate an 'infinite chain of causation'. The power to comment arises from the Coroner's primary obligation to make findings as to the manner and cause of death.[5]

13. I observe the family's concerns in this inquest regarding

    (a) family involvement in the care of the mentally ill; and

    (b) the availability of appropriate long-term accommodation

    are matters of continuing public importance that have been examined in other coronial inquests.[6] However, they are not matters that arise from my consideration of the manner and cause of Lena's death.

CIRCUMSTANCES OF LENA'S DEATH

Lena's life and background

14. Lena was born in 1986 and grew up in Ulladulla with her parents and four siblings. She began exhibiting symptoms of mental illness as a teenager and became a regular inpatient at mental health facilities around age 15 in New South Wales (NSW), Western Australian (WA) and the Australian Capital Territory (ACT). In 2011, Lena absconded from a WA mental health facility and moved to the ACT to be closer to her eldest sister, Summer. From then on, she remained in the ACT.

[5] R v Doogan; Ex parte Lucas Smith [2005] ACTSC 74, [27]-[28].

[6] See e.g. *Inquest into the death of Catherine Broadbent* [2024] ACTCD 1 (discussion about intermediate residential services)*; Inquest into the death of Joshua* [2023] ACTCD 2 (discussion about sharing health information with family).

15. Lena first came into contact with ACT mental health services in 2004 after a suicide attempt. She was diagnosed in 2011 with schizophrenia with visual and auditory hallucinations. The records show that at the time of her death, she had also been diagnosed with borderline personality disorder, and her schizophrenia was considered treatment resistant. Lena's mental health records, from 2018 until her death in 2021, span thousands of pages.

16. The records demonstrate Lena was a regular long-stay inpatient in ACT mental health units. During the last 5 years of her life, she was subject to PTO's and, for most of that time, was managed and treated as an inpatient in the Adult Mental Health Unit (AMHU) and by the Assertive Community Outreach Service (ACOS) team when in the community.

17. The origin of Lena's mental illness at such an early age is not clearly identifiable, although the available information suggests a genetic contribution. There is no indication that Lena had a significant history of substance use, other than a reliance on nicotine.

18. Lena's mental illness was chronic, severe, and significantly impaired her day-to-day functioning. From approximately 2005 onward, she was unable to maintain employment and, at the time of her death, was financially supported through the Disability Support Pension and the National Disability Insurance Scheme (NDIS). At the time of her death, she was under the management of the PTG.

19. Summer explained that she was actively involved in Lena's mental health care until the appointment of a guardian from the PTG. Summer had supported the appointment of a guardian because of the difficulties she had faced in advocating effectively for Lena within the mental health system. She hoped an appointed guardian would be better placed to navigate the mental health system and ensure Lena's needs were met. As Summer explains in her statement, she felt that the consequence of appointing a guardian was that she became even more excluded from Lena's care. From the records, Lena often refused to consent to the sharing of her health information with family. By the time of Lena's death, she had not seen her family for approximately four to five years, although there is some evidence of renewed family involvement in her care in the final month of her life at DMHU.

Psychiatric Treatment Order dated 12 August 2021

20. At the time of her death, Lena was on a six-month PTO that began on 12 August 2021. The relevant PTO application by her treating psychiatrist, Dr OR, noted the following in relation to her mental illness.

Ms Edwards was transferred from AMHU High Dependency Unit to Dhulwa Mental Health Unit (DMHU) on 21/07/21 for ongoing management. Ms Edwards remains inpatient since 2019 in the context of ongoing psychotic phenomena, high risk assault towards staff and guardedness surrounding her symptoms.

The symptoms which characterise her illness include auditory hallucinations, complex delusional system claiming that she has soft bones, and her body is being controlled by external forces and feels she is a zombie. She has expressed paranoid persecutory delusions relating to staff members claiming they have demons inside them. She has been known to act directly on these psychotic phenomena by being verbally and physically aggressive toward staff. Ms Edwards has history of self-harm on many occasions in past including attempt to hang herself requiring admission to ICU.

She had a history of numerous protracted admissions to the Adult Mental Health Unit in context of disorganized behaviour, agitation, and assault on both members of public and staff. She had on a number of occasions been brought into hospital by police after being found naked or inappropriately dressed in public.

Ms Edwards remain (sic) chronically in sightless and engages sporadically with the treating team.

21. The basis of making the PTO was that Lena refused to engage voluntarily treating team, including prescribed psychotropic medication. Dr OR's view was that, when receiving treatment, the severity of her symptoms of psychosis and aggression remained chronic but were less acute. Importantly, her risk of self-harm was reduced.

22. The treatment under the PTO included antipsychotic medication, regular psychiatric reviews, and ongoing mental state monitoring at the DMHU. The records show that Lena was prescribed:

- Olanzapine pamoate (300 mg IMI fortnightly) (antipsychotic)
- Zuclopenthixol Decanoate (200 mg fortnightly) (antipsychotic)
- Medroxyprogesterone acetate (150 mg IMI three monthly) (progestin hormonal medication).

The Dhulwa Mental Health Unit (DMHU)

23. At the time of her death, Lena was an involuntary inpatient at the DMHU. She had been transferred there from AMHU on 21 July 2021 for 'long term mental state stabilisation and potential rehabilitation before transitioning into the community'. Prior to the transfer, she had been an inpatient at AMHU since 2019, and before that, she had been living in supported accommodation called Greenleaf Care in the ACT.

24. The purpose and scope of services at DMHU in 2021 were set out in *The Operational Model of Care – Secure Mental Health Unit – Mental Health, Justice Health and Alcohol & Drug Services*, published in 2016 ('the 2016 Model of Care'). The DMHU was known at the time as the Secure Mental Health Unit ('SMHU'). The 2016 Model of Care states that the SMHU was established to:

> …support a person's treatment, care and recovery by responding to the needs of people with moderate to severe mental illness who are, or are likely to become, involved with the criminal justice system (forensic), and for those civilian people who cannot be treated in a less restrictive environment. As well as secure mental health care, there is also a need to provide secure and longer-term inpatient care for people who have unremitting and severe symptoms of mental illness or disorder and associated behaviour disturbance and are unable to be safely or adequately treated in less restrictive settings.

25. The DMHU was and still is the most restrictive healthcare environment in the ACT. It comprises a 25 beds facility across two wings: an acute wing, Lomandra, and a rehabilitation wing, Cassia. All beds are located in individual private rooms. Lena was accommodated in the acute unit, the Lomandra unit.

26. I note that Summer has previously expressed concerns that Lena was effectively held in a custodial environment. As stated in the 2016 Model of Care, DMHU is not, and has never been, a corrections facility. The 2016 Model of Care emphasises that:

> The DMHU is not a corrections facility and will not operate as such. It will fundamentally be a therapeutic setting, underpinned by contemporary, evidence-based multidisciplinary mental health care to ensure the highest quality of person-focused care, which enables recovery of the person's mental illness that played a functional role in the offending or difficult behaviour.

Lena's DMHU management plan

27. It is clear from the medical records that Lena could not have been safely treated in any environment less restrictive than the DMHU. The decision to place her there before her death was reasonable, given the risks she posed to herself and others.

28. As outlined above, Lena had been an inpatient of the AMHU since 2019. During that time, the records document a consistent pattern of assaults on clinicians between 2019 and 2021. This was not an isolated or new development; rather, it reflected a longstanding history of aggression and assaultive behaviour occurring both in the community and in other inpatient settings. Recognising this history is an acknowledgement of the severity of her illness and the challenges that faced clinicians in caring for her.

29. In 2020, clinicians considered transferring her from AMHU to the DMHU due to escalating behavioural concerns. At that time, they decided against doing so because they were concerned that increased restrictions might heighten her aggression. Ultimately, however, her violent and assaultive behaviour towards staff continued despite efforts to manage her safely in AMHU, and she was transferred to the DMHU in July 2021.

30. A detailed Dhulwa Management Plan ('the plan'), prepared on 23 July 2021 by her treating psychiatrist, Dr OR, provides a comprehensive account of her psychiatric history. The plan documents an extensive history of aggression towards clinicians in both inpatient and community settings, as well as repeated absconding from secure environments, including AMHU. The timeline of serious incidents, involving absconding, violence, and aggression, extends across seven pages. It also records that, between 2005 and 2020, Lena had a significant history of police interaction, including approximately 90 AFP attendances, largely relating to assaultive behaviour towards clinicians and police.

31. The plan noted the key challenges in treating her, including her extreme difficulty with engaging with psychiatrists, her tendency to avoid speaking with medical staff, and her frequent refusal to take oral medication. The plan recorded was that Lena was to be nursed in the enhanced care unit at DMHU (Lomandra) and placed on 15-minute observations. Staff were instructed to approach her in pairs and to maintain a low threshold for utilising the de-escalation unit. Security staff were directed to maintain a presence on the floor. Her medication regimen was to continue as outlined above.

Time in DMHU: 23 July 2021 to 25 September 2021

32. Lena remained in the DMHU from 23 July 2021 until her death on 25 September 2021. The records demonstrate that throughout her admission, she frequently resisted physical health observations and investigations, vital checks, and blood tests. As a result, clinicians were unable to obtain baseline bloods during her admission. Her vital signs were last taken and documented on 7 August 2021, during a period of seclusion. On that occasion, all vital signs appeared to be within normal parameters; that is, blood pressure 126/85 mmHg, oxygen saturation 96%, pulse 90 bpm and normal temperature.

33. In general, a picture of Lena's physical health is difficult to ascertain from the records. It does not appear that she was demonstrating any clear physical health symptoms, such as respiratory distress, during the DMHU admission. The records indicate that the primary physical health condition known to clinicians related to her dental health.

34. In terms of her mental state, Lena continued to experience psychotic symptoms throughout her time in the DMHU. Her presentation was described by her treating psychiatrist as settled, yet unpredictable. She continued to exhibit episodes of aggression, which at times resulted in periods of seclusion. Clinicians consistently documented the difficulty in engaging with her in a meaningful way.

35. Despite these challenges, Lena did participate in some therapeutic activities during her admission, including music group sessions and use of the walking track. She appeared to derive particular enjoyment from the music group, often observed dancing and smiling while listening to music. The records from these sessions reflect aspects of her personality and creativity. She enjoyed expressing herself through colourful outfits, often wearing decorative headpieces made from leaves and other features, bright makeup, and styling her hair in distinctive ways. Lena also had leave to use the walking track on site two times a day, which the records indicate she used.

36. Regular multidisciplinary team review ('MDTR') meetings were held during Lena's admission, involving her treating psychiatrist, social worker, and PTG. At those meetings, her psychiatrist noted the longstanding challenges in treating Lena's mental illness. Over the course of her history, numerous antipsychotic medications had been trialled, and she had also undergone electroconvulsive therapy ('ECT'). Despite these interventions and her current medication regimen, she remained persistently psychotic at baseline. While her medication was considered during the DMHU admission, it was not altered. It appears the focus was to attempt to build rapport and engagement with her and address her significant health (including dental) problems.

25 September 2021 - Immediate events leading up to death

37. The last recorded observation of Lena on the observation sheet was at 0400 hrs on 25 September 2021, noting she was 'asleep in her bed'. The observation sheet records that from about 1800 hrs on 24 September 2021 until 0400 hrs on 25 September 2021, Lena was observed to be asleep in her room, with a few entries noting her awake. Nursing notes record that on several occasions throughout the night, she yelled at staff for waking her with a torch during observations.

38. The DMHU does not have CCTV in patient rooms but does have CCTV in the common areas. Following Lena's death, police reviewed the relevant CCTV footage. The footage shows that the last observation of Lena in her room, likely corresponding with the recorded 0400 hrs observation, occurred at 0402 hrs. At about 0426 hrs, Lena is seen leaving her room carrying an empty coffee cup. She sat on a green chair in the Lomandra common area, a chair which she was known to use regularly for sleeping. The footage shows Lena appearing to experience respiratory distress and slumping in the chair.

39. At about 0431 hrs, DMHU security observed Lena on CCTV in respiratory distress and issued the duress alarm. At 0432 hrs, several nurses attended, attempted to rouse Lena, and commenced CPR. CPR efforts from clinicians continued until ACTAS arrived at approximately 0450 hrs. Despite ACTAS's efforts, Lena could not be revived and died at the scene.

40. Given that Lena was on 15-minute observations, she would ordinarily have been due for another visual observation check shortly after 0415 hrs. There is no record of that observation occurring. However, security incident reports prepared after the incident (by security staff) indicate that security staff observed Lena leave her room at approximately 0426 and alerted other staff on the floor of her whereabouts. It appears, at that time, other staff (presumably clinicians) were conducting welfare checks in the bedrooms of other patients along the Lomandra corridor.

41. Notwithstanding a potential missed observation at around 0415, it appears the Lena developed acute respiratory distress (consistent with a PTE) in the common area shortly after 0426 hrs, which was identified by security staff and responded to by clinicians and emergency services. I am satisfied that the acute onset of respiratory distress was not foreshadowed in other observable symptoms such as shortness of breath, sharp chest pain, coughing, fainting, or rapid heartbeat noting Lena was being periodically viewed on CCTV in the period immediately before her death.

Cause of death

Post-mortem examination

42. Forensic Pathologist, Professor Duflou, conducted a post-mortem examination and provided a written report dated 28 October 2021. The post-mortem examination included an internal examination, a medical records review, and toxicology testing. Professor Duflou opined that the direct cause of Lena's death was 'pulmonary thromboembolism'. He said:

> The cause of death was found to be a pulmonary embolism. On microscopy, the pulmonary embolisms identified were of different ages, with the major abnormality having appearances suggesting it had become lodged immediately prior to death, while smaller pulmonary emboli were identified in the more peripheral lung tissue which had appearance suggesting they may have commenced lodging in the lungs many days to possibly weeks prior to death.

43. Toxicological testing revealed a high level of olanzapine (Zyprexa) in her blood – at this level sedation can be expected as a common side-effect, and this in turn could predispose to venous thrombosis and pulmonary embolism due to resultant decreased mobilisation. A therapeutic level of zuclopenthixol was detected, and there was evidence of recent administration of haloperidol.

44. At the time of the post-mortem examination, Lena was 78 kg, and her Body Mass Index (BMI) was 26.4 kg/m2, which is considered just above the 'normal weight range', which is 18.5 to less than 25 kg/m2

45. I accept Professor Duflou's opinion that the direct cause of Lena's death was PTE.

46. The link between PTE and antipsychotic medications occurs when a blood clot, usually forming in the deep veins of the leg, travels to the lungs and obstructs blood flow. It is a condition associated with a wide range of risk factors, including genetic clotting disorders, recent surgery, immobility, obesity, smoking, infection, and various chronic medical illnesses.

47. Professor Duflou described a possible *indirect* causal link between Lena's antipsychotic medication, olanzapine, and PTE. He noted that olanzapine can have a sedative effect, which can in turn increase the risk of PTE by contributing to a more sedentary lifestyle.

48. The available research is consistent with Professor Duflou's opinion. Antipsychotic medications, including olanzapine and zuclopenthixol (the other antipsychotic medication Lena was prescribed), have been associated in the medical literature with

an increased risk of PTE. The underlying mechanism, however, remains unclear. The most consistently identified explanation is an indirect one, as noted by Professor Duflou - antipsychotic medications can be sedating and subsequently reduce mobility. Some studies have proposed a more direct effect, such as changes in platelet activity or inflammatory markers, but these remain uncertain and are not well established.[7]

49. The current understanding of the relationship between antipsychotic medication and PTE in the available medical literature may be best characterised as a statistical or empirical association, rather than one supported by established evidence of a direct causal mechanism.

50. More broadly, psychiatric patients appear to have a higher baseline risk of PTE compared with the general population. Certain psychiatric illnesses may themselves increase the risks of thrombosis, although the precise reasons are not fully understood. Some research suggests that severe psychiatric episodes, such as acute psychosis or mania, may lead to significant elevations in stress hormones, including cortisol, which can strain blood vessels and increase the likelihood of clot formation.

51. It is also well established that people living with long-term mental illness have higher rates of comorbid conditions such as obesity, diabetes, and hyperlipidaemia, all of which are known PTE risk factors.

Lena's medication

52. At the time of her death, Lena was prescribed olanzapine 300 mg depot fortnightly and zuclopenthixol 200mg depot fortnightly. Clinicians described this as a 'double depot' regimen.

53. The medical literature indicates that antipsychotic monotherapy is considered the first-line strategy for schizophrenia. However, where monotherapy fails, and the illness is assessed as treatment-resistant, dual or combination antipsychotic therapy is a recognised approach, including the specific combination of olanzapine and zuclopenthixol. While dual antipsychotic therapy may increase the side effects already associated with individual antipsychotics (for example, increased sedation), it does not appear in the available literature to be associated with any new or distinct adverse

[7] Olanzapine and zuclopenthixol combined therapy for the treatment of refractory schizophrenia: 2 case reports, European Psychiatry, 2011. Thromboembolic events with olanzapine: a systematic review integrating meta-analysis and FAERS database, Frontiers, 2026.

effects, including any direct association with PTE or clotting disorders.[8]It is clear from the clinical records that Lena's schizophrenia was severe and treatment resistant.

54. The records show that Lena had previously been prescribed zuclopenthixol and olanzapine individually without significant adverse effects. She commenced a double depot regime in mid-2019, initially olanzapine and haloperidol, because her treating psychiatrist considered that olanzapine on its own did not sufficiently 'sustain a reasonable quality of life and safety'. In December 2020, the regimen was changed to the combination of olanzapine and zuclopenthixol. There is no indication in the records that Lena suffered from any adverse effects, including blood clots, associated with either the olanzapine or the double-depot combinations.

55. It is difficult to determine the extent to which Lena's antipsychotic regimen may have contributed to a more sedentary lifestyle and thereby increased her risk of PTE. Lena's family recall her as previously being highly active. The records show that she maintained a reasonable level of mobility while at the DMHU unit, including regular use of the walking track. Her BMI at the time of her death was only slightly above the normal range. However, it remains reasonable to accept that her antipsychotic regimen may have contributed at times to increased sedation and may not have been conducive to a highly active lifestyle. The extent of any medication related reduction in mobility cannot be determined based on the information available.

56. Given the circumstances of this case and the available evidence regarding the association between antipsychotic medications and PTE (including the expert opinion of Professor Duflou), there is insufficient evidence to support a finding of a causal or contributory link between Lena's antipsychotic medication and the PTE(s) that caused her death.

Other risk factors

57. It is relevant to note that Lena was also prescribed medroxyprogesterone acetate ('medroxyprogesterone') 150 mg injection every three months. Medroxyprogesterone is a progestin hormonal medication used for birth control, hormone therapy, and other conditions. It is recognised as a medication that can also increase the risk of developing blood clots, including PTEs. Hormonal contraceptive therapies, in general, are associated with increased thromboembolic risk. Progestin-only preparations (such as medroxyprogesterone) are considered lower risk than estrogen and/or combined

[8] Combination of Two Long-Acting Antipsychotics in Schizophrenia Spectrum Disorders: A Systematic Review, University of Campania, 2024. Olanzapine and zuclopenthixol combined therapy for the treatment of refractory schizophrenia: 2 case reports, European Psychiatry, 2011.

estrogen/progestin formulations. Again, the causal link between the PTE(s) identified at post-mortem and this medication is unclear. Lena had been on medroxyprogesterone for a significant period, at least from 2018, with no documented side effects. It is not apparent from the medical records that she had a blood clotting disorder that should have prompted consideration of anticoagulant therapy.

58. As to other recognised risk factors for PTE, there is no evidence in Lena's medical records of any significant additional risk factors for PTE. She had no recent surgery and no significant physical health comorbidities that might otherwise explain the occurrence of a PTE.

Further investigation into the olanzapine levels

59. Notwithstanding the above, further enquiries in respect of the olanzapine level in Lena's blood were made, including whether it was consistent with what she had been prescribed. The level of olanzapine detected in Lena's post-mortem blood was 0.21mg/L. Professor Duflou, in his report dated 28 October 2021, described the level as 'high'. With reference to the ACTGAL information sheet on olanzapine, the level detected falls within the toxic range of 0.11 to 1mg/l. Lena's prescribed dose of olanzapine,300mg fortnightly depot, falls within the upper end of the therapeutic range for the treatment of schizophrenia. Given that she was receiving a high therapeutic dose, a correspondingly elevated olanzapine concentration in her post-mortem toxicology would be expected.

60. The medical records confirm Lena received her olanzapine injection on the following dates in the lead up to her death (and did not receive any additional doses she should not have). The last injection, on 21 September 2021, was four days prior to her death.

Date	Amount
13/07/21	300 mg injection
27/07/21	300 mg injection
10/08/21	Refused injection
24/08/21	300 mg injection
07/09/21	300 mg injection
21/09/21	300 mg injection

61. The records show that, following the administration of the injection, Lena was monitored for a two-hour post-administration period, as required by the *CHS Treatment for Initiation, Administration and Monitoring of People on Long-Acting Injection* procedure issued on 16 September 2020. The olanzapine long-acting injection observation chart relevant to the last injection Lena received on 21 September 2021 indicates that there

were no signs or symptoms of overdose, nor any other complications, during the two-hour monitoring period.

62. Professor Duflou was asked whether the dose of olanzapine that Lena was receiving, 300 mg every two weeks, was consistent with the elevated level detected in her post-mortem blood sample. He explained that after death, the concentration of olanzapine in the blood can rise significantly due to process called *post-mortem redistribution*. This process can result in post-mortem olanzapine levels measuring anywhere from approximately 0.4 to 23 times higher than the levels that would have been present ante-mortem (that is, during life).

63. Taking post-mortem redistribution into account, Professor Duflou confirmed that the level of olanzapine detected in Lena's toxicology could well be consistent with Lena's being administered her prescribed therapeutic dose of olanzapine. In the circumstances where there is no evidence of additional, unprescribed olanzapine doses and taking into consideration post-mortem redistribution factors, I do not find that the post-mortem toxicological result reflects administration of olanzapine in excess of the prescribed therapeutic amount.

64. There are no matters of public safety that arise in relation to the treatment and management of Lena's mental health with antipsychotic medication.

SECTION 3BA CONCERNS

65. As noted above, both Summer and Lynette have expressed concerns that they were excluded from decision making regarding Lena's mental health care and were not informed of key treatment decisions. An example is her placement in the DMHU and instances when she was discharged from hospital.

66. The medical records show that Lena frequently declined to consent to her family being involved in, or informed about, her care. As noted in other coronial matters, family involvement is contingent upon the patient's consent. A patient's right to privacy is legislated under the *Health Records (Privacy and Access) Act 1997* ('Health Records Act') and the *Mental Health Act 2015*. Principle 10 of Schedule 1 to the Health Records Act establishes that a patient's health information is confidential and may only be disclosed to persons authorised under the legislation. Limited and exceptional circumstances permit clinicians or other record keepers (such as the PTG) to involve family or disclose health information without the patient's consent. Those circumstances are addressed in previous coronial findings I have made (see, for example, the *Inquest into the death of Joshua [2023] ACTCD 2).*

67. In Lena's case, the situation was further complicated by the involvement of the PTG. The medical records indicate that Lena's appointed guardian was involved in key decisions and was informed of aspects of Lena's care by Lena's treating team. However, the PTG was subject to the same legislative restrictions as clinicians regarding disclosure to family members. Lena had to consent to such disclosure, and in the absence of Lena's consent, may have further limited family access to information.

68. The medical records do indicate there was some attempts by Lena's treating team to renew contact with Lena's family in August 2021. A family meeting involving the treating psychiatrist, a social worker and Lynette was held on 25 August 2021 (approx. 1 month before Lena's death). At that meeting, Lynette raised concerns about not being informed of Lena's mental health care arrangement. It was agreed that a family meeting involving Lynette, the treating team and the PTG would occur every three months going forward. Unfortunately, Lena died before any further meetings took place.

CONCLUSION

69. On the basis of the available evidence, the following findings required by section 52 are appropriate in this case:

- Lena Edwards died on 25 September 2021 at the Dhulwa Mental Health Unit, 30 Mugga Way, Symonston in the Australian Capital Territory.
- The cause of Lena's death was pulmonary thromboembolism.
- The manner of Lena's death was natural causes.
- There are no matters of public safety that arise in respect of her death.

70. In respect of section 74 of the Act, I am of the opinion that there were no aspects of the quality of care, treatment and supervision of Lena whilst in the care of clinicians at Dhulwa that contributed to the cause of her death.

71. At the hearing for the inquest, I expressed my condolences directly to Lena's family. My thoughts are with them. Lena was a an important and loved presence in their life. The pain of their loss was very apparent to me. I wish them well for the future and thank them for their engaged and thoughtful contributions to the coronial process.

72. I have chosen to publish detailed findings in respect of the inquest I have conducted. It is consistent with Lena's family's expressed wishes. They wanted Lena's experiences in the mental health system to be known to others. The terms of sections 52 and 74 of the Act and the fact that death in care cases demand public hearing evidence a clear

legislative intent of ensuring that a light is cast on how our community, through the compulsory aspects of our health system, care for our community's most vulnerable members. It is important that their story is given expression.

I certify that the preceding seventy-two [72] numbered paragraphs are a true copy of the Reasons for Decision of his Honour Coroner Archer.

Associate: Ella Mansfield

Date: 26 June 2026