CORONER'S COURT OF THE AUSTRALIAN CAPITAL TERRITORY

Case Title:	**Inquest into the death of Ms UT**
Citation:	**[2026] ACTCD 14**
Decision Date:	12 August 2026
Before:	Coroner K J Archer
Findings:	See [3-5], [69-70]
Catchwords:	**CORONIAL LAW** – MANNER AND CAUSE OF DEATH – Psychiatric Treatment Order – death in care – appropriate administration and monitoring of clozapine - hearing required
Legislation Cited:	*Coroners Act 1997* (ACT) ss 3BB, 13,34A, 52, 74
Cases Cited:	*Inquest into the death of Stanley McIntyre* [2025] ACTCD 5
Texts Cited:	Australian Prescriber, *Therapeutic Guidelines, Clozapine in Primary Care,* (December 2017) Canberra Health Services, *Clozapine Therapy Guideline*, (CHS25/196, May 2025) Alawami, M, Wasywich, C, Ciovic, A, Kenedu, C. *A systematic review of clozapine induced cardiomyopathy,* International Journal of Cardiology, 2014. What is Heart Failure? The Heart Foundation, (web page): https://www.heartfoundation.org.au/your-heart/heart-failure
Counsel Assisting:	Ms X King Ms C Pilley
File Number:	CD 113 of 2023

CORONER ARCHER:

Introduction

1. On 21 May 2023, the death of Ms UT was reported to me as a Coroner in the ACT.

2. At the time of her death, Ms UT was 37 years old and was subject to a Psychiatric Treatment Order ('PTO') that was made on 19 December 2022, for a period of six months.

3. Forensic Pathologist, Professor Duflou, performed a post-mortem examination and concluded the direct cause of Ms UT's death was morbid obesity with dilated cardiomyopathy and obstructive sleep apnoea.

4. These findings explore the possible relationship between that cause of death and the medication regime that was necessarily in place to treat the severe mental health condition that presented such a challenge in Ms UT's life. Dilated cardiomyopathy is a condition in which the heart's main pumping chamber becomes weakened. It is generally chronic and can result from a variety of factors that place strain on the heart, including obesity and certain medications. At the time of her death, Ms UT's prescribed regimen included clozapine, an antipsychotic associated with cardiomyopathy.

5. Ultimately, it is my finding that there is insufficient evidence to establish a causal link between clozapine and the cause of death, although such a link is possible. In the alternative, even if a connection was established, it would not provide evidence of a shortfall in her care.

Ms UT

6. Ms UT was born in Canberra on 7 February 1986. She was a beloved daughter and younger sister. Ms UT was raised in Canberra and studied childcare at the Canberra Institute of Technology. When well, she worked in that area. Those who knew her described her as creative, with a love of art, drama and cooking, and as someone who deeply cared for her family.

Jurisdiction and required findings

7. The Coroner's jurisdiction in relation to Ms UT'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. As Ms UT was a person subject to a PTO at the time of her death, her death was a 'death in care' as defined in section 3BB of the Act.

8. The Act provides that at the conclusion of the inquest and hearing, the Coroner must make findings regarding the manner and cause of Ms UT's death in accordance with section 52 of the Act. If a matter of public safety is found to arise in connection with the inquest, the Coroner must comment on the matter: section 52(4) of the Act.

9. Section 74 of the Act requires the Coroner in cases involving a death in care 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 the care, treatment or supervision of the deceased 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].

Hearing

10. As Ms UT's death was a 'death in care' for the purposes of the Act it is not possible for a Coroner to dispense with a hearing: section 34A of the Act.

11. A hearing was conducted on 30 June 2026. Both of Ms UT's parents were in attendance. They had been provided with detailed submissions prepared by Counsel Assisting. They were invited to give their perspective in respect of Ms UT 's treatment within the Canberra Health Service over many years and specifically in the last several years of her life. Their contributions to the hearing were important and they inform aspects of my findings.

12. I acknowledge the role of both Ms King and Ms Pilley as Counsel Assisting in, respectively, developing written submissions upon which these findings are based and in appearing at the hearing.

The investigation

13. The AFP conducted an investigation on behalf of the Court. This included interviewing Ms UT's parents and those present at the scene of her death. Medical records were obtained from the ACT Ambulance Service, the Canberra Hospital, Calvary Public Hospital Bruce, Mental Health, Justice Health, Alcohol and Drug Services and Ms UT's GP. Research publications and Therapeutic Goods Administration advisories were referenced in respect of the prescription, use and monitoring of clozapine.

The post-mortem examination

14. Professor Duflou conducted a post-mortem examination on 24 May 2023 and provided a written report dated 5 July 2023. In light of the range of physical comorbidities and

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

symptoms present in the period proximate to her death, the examination included an internal examination, CT imaging, a review of medical records, and toxicological testing. Professor Duflou opined that the cause of death was morbid obesity, with dilated cardiomyopathy and obstructive sleep apnoea. In summary, he observed:

- Morbid obesity, weight 117 kg and BMI 40.5 g/m2.
- Medication detected at levels expected from typical therapy. No unexpected or illicit substances were detected.
- A CT scan revealed no obvious causes of death, including no visible brain or heart abnormalities.
- Internal examination revealed no discernible abnormalities in the brain or heart. There were some indications of a respiratory tract infection in the lungs. A viral swab confirmed the presence of rhino/enterovirus, an upper respiratory tract infection.
- Microscopic examination of the heart tissue revealed an area of fibrosis within the left ventricular free wall and a focal increase in fibrous tissue within the right ventricle. Right ventricular hypertrophy was noted. No significant fat infiltration, inflammation or ischaemic damage was identified.

15. In respect of the heart, Professor Duflou said:

> Overall, the features are most likely those of dilated cardiomyopathy of unascertained causes – causes in this case can include post-viral pathology, obesity-related cardiopathy and medication related post-myocarditis cardiomyopathy.

16. Professor Duflou concluded:

> Overall, a definite cause of death has not been identified, but there are no indications of injuries causing death, or of there having been an accidental or intentional drug intoxication. The death appears to be due to natural processes, and in the absence of other causes, it appears likely that the deceased obesity with associated heart disease (dilated cardiomyopathy) and obstructive sleep apnoea resulted in the death.

17. I accept Professor Duflou's opinion subject to what follows. The post-mortem findings demonstrate that Ms UT's death was multifactorial rather than attributable to a single pathological process. Although dilated cardiomyopathy was identified as a contributing factor, the associated pathology was relatively subtle and detectable only on microscopic

examination. The absence of evidence of infarction or inflammation at post-mortem suggests a chronic, progressive cardiac condition rather than an acute cardiac event.

18. The cause of the cardiomyopathy was not determined at post-mortem, although Professor Duflou expressed the view that it was likely obesity related. There is insufficient evidence to establish a direct causal connection between clozapine and the cardiomyopathy identified at post-mortem. However, it is reasonable to observe that her long-term psychiatric treatment formed part of the overall clinical picture. The records show weight gain over the course of her prolonged inpatient admission and while on clozapine and other sedative antipsychotic medications. A holistic view of the evidence suggests an indirect link between her mental health treatment and the development of obesity, which likely contributed to, or exacerbated, other conditions, including cardiomyopathy and sleep apnoea. The extent to which any individual medication including clozapine, directly contributed to Ms UT's death, might be suspected but cannot be determined with certainty.

19. How that risk was managed during her life is addressed below.

Ms UT's mental health history

20. The available medical records indicate that Ms UT was diagnosed with schizophrenia in 2009, at age 23, during an admission to Bloomfield Hospital in NSW. She came into contact with ACT mental health services in 2011 and was first placed on a PTO in 2014. Despite this, between 2014 and 2020, her mental state was relatively stable on the antipsychotic, zuclopenthixol. For most of this period, she was a voluntary patient in the community under the care of the Tuggeranong Mental Health Team. When unwell, Ms UT presented with psychotic delusions and disorganised behaviour.

21. The records demonstrate that throughout her mental health care and treatment decisions, Ms UT's family, particularly her mother, were closely involved in her care. Ms UT's mother was also appointed as her guardian in 2020.

Overview of Mental Health Care Between 2020 and 2023

Inpatient Care: June 2020 to February 2023

22. Ms UT died approximately four months after returning to community-based living, following a period of nearly three years in involuntary inpatient care in the Canberra Health Service ('CHS'), Adult Mental Rehabilitation Unit ('AMHRU') and the Adult Mental Health Unit ('AMHU').

23. An overview of the inpatient mental health care in the years prior to her death is relevant to understanding the severity of her mental illness, the antipsychotic medication she came to be on and her overall physical health.

24. In June 2020, following a prolonged period of relative stability in the community, Ms UT experienced a psychotic relapse and was admitted to the AMHU. She was placed on a PTO and remained an involuntary inpatient until January 2021. The relapse was attributed to a prescribed reduction in her antipsychotic medication at the time, zuclopenthixol.

25. While in the AMHU, despite reinstatement of a higher dose of zuclopenthixol, Ms UT did not stabilise. Another antipsychotic medication, clozapine was commenced in October 2020. The records suggest she had been briefly prescribed clozapine in 2014, but it had been ceased due to her non-compliance with the medication. The potential cardiac risks associated with clozapine and the impact it may have had on Ms UT's heart is addressed in detail later.

26. Ms UT's mental state improved significantly on clozapine. The PTO was revoked in December 2020 and she was discharged from the AMHU in January 2021. She was able to re-enter the workforce.

27. In May 2021, Ms UT travelled to Darwin for a holiday with her partner at the time. Unfortunately, she experienced another psychotic relapse which resulted in a lengthy admission to a mental health unit in Darwin from 10 May 2021 to 15 July 2021. That relapse was attributed to a combination of non-adherence to her medication and other life stressors she was experiencing.

28. Ms UT was placed back on a PTO and transferred to the AMHU on 19 July 2021. She remained an inpatient (moving between AMHU and AMHRU) until 11 February 2023 (with the exception of 10 days in the community in September 2022.)

29. On 1 October 2021, approximately one year after commencing clozapine, a routine echocardiogram was performed. The scan was interpreted as showing cardiomyopathy, which clinicians suspected was clozapine induced. Accordingly, clozapine was ceased.

30. Following the cessation of clozapine, Ms UT's mental state deteriorated markedly. The records indicate that between October 2021 and December 2022, a range of antipsychotic medications and other treatments were trialled. A PTO application dated 15 December 2022 summarised these treatments, which included various combinations of aripiprazole, amisulpride, haloperidol, zuclopenthixol, lithium and ECT. Despite these interventions, Ms UT remained significantly unwell, frequently described by clinicians as floridly psychotic and acting on her delusional beliefs.

31. On 19 December 2022, clozapine was recommenced. Clinicians described it as a treatment of 'last resort' due to its possible adverse effects and the previously identified cardiomyopathy.

32. On clozapine, Ms UT again demonstrated significant improvement. On 11 February 2023, her mental state had stabilised enough for her to be discharged from the AMHU. A comprehensive discharge plan was in place, including weekly clozapine clinic reviews (discussed below), supported independent living accommodation at what became known to Ms UT, her treating team and her family as 'Evatt House' and contact with the Assertive Community Outreach Service ('ACOS')[2] three times a week. At discharge and until her death, her medication regimen included:

    - Zuclopenthixol depot injections, 600 mg every 10 days (antipsychotic)
    - Clozapine oral tablets, 250 mg daily (antipsychotic)
    - Lorazepam oral tablets, as per needed (benzodiazepine)
    - Atorvastatin oral tablets, 40 mg daily (statin to reduce cholesterol)
    - Metformin oral tablets, 1000 mg daily (to control blood sugar)

Care in the Community

33. The medical records demonstrate that Ms UT was gradually reintegrating into the community and becoming increasingly independent. Evatt House was a supported independent living service provided by a NDIS provider, Livability Care Australia. At Evatt House, Ms UT resided with two other NDIS participants and had access to full time and 24 hour a day on site support from carers.

34. Following her discharge, Ms UT had frequent contact with various healthcare providers. She commenced seeing a regular GP and had significant contact with mental health clinicians from ACOS. In the initial months following discharge, she was reviewed by a psychiatrist weekly. Ms UT's mother remained closely involved in her care. The impression gained from the records is that Ms UT was compliant with her medication and her mental state remained stable, with no clear signs of psychosis, although she occasionally reported hearing voices.

[2] The ACOS team provides long-term clinical management, treatment and care in the community for adults who have severe and long-lasting sign of psychosis and complex needs.

35. Ms UT reported being happy at Evatt House. She was observed by ACOS clinicians to be functioning well in that environment, learning how to prepare her own meals and seeking out activities to keep herself busy, including aqua aerobics and volunteering.

Clozapine therapy and Ms UT s physical health

Clozapine in general

36. Clozapine is an antipsychotic medication primarily used to treat schizophrenia. It is reserved for people with schizophrenia that:

    (a) is considered severe and treatment resistant; and

    (b) has not responded adequately to at least two other antipsychotic medications.[3]

37. Clozapine is widely regarded as the most effective treatment for schizophrenia.[4] However, its use is restricted due to the significant adverse effects that can be associated with it. These include:

    (a) serious haematological risks, particularly neutropenia and agranulocytosis (low white blood cell counts)[5]; and

    (b) cardiac complications such as myocarditis (acute inflammation of the heart muscle) and cardiomyopathy (chronic impairment/weakening of cardiac function).

38. Other recognised adverse effects include weight gain, obstructive sleep apnoea, seizures and hypotension[6].

39. Due to these risks, clozapine treatment in Australia is strictly regulated by the Therapeutic Goods Administration ('TGA'). The TGA requires mandatory patient monitoring protocols that must be followed by prescribers and patients. Clozapine products are therefore supplied with brand specific mandatory monitoring systems, which require baseline health assessments prior to commencement and ongoing monitoring throughout treatment.

40. In the ACT, these requirements are (and were at the time of Ms UT's death), operationalised though the CHS *Clozapine Therapy Guidelines*. The current guidelines,

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[3] See Australian Prescriber, Therapeutic Guidelines, Clozapine in Primary Care, 1 December 2017.
[4] See Australian Prescriber, Therapeutic Guidelines, Clozapine in Primary Care, 1 December 2017.
[5] See Australian Prescriber, Therapeutic Guidelines, Clozapine in Primary Care, 1 December 2017 p231: '*Clozapine was introduced in the 1960s but was withdrawn in the 1970s because it caused agranulocytosis. As better drugs for treatment-resistant schizophrenia did not emerge, clozapine was reintroduced with a strict scheme for neutrophil monitoring. Since clozapine was reintroduced in Australia in 1993, its use has steadily increased'*
[6] Canberra Health Services, Clozapine Therapy Guideline, CHS25/196, 22 May 2025

reflecting the national monitoring requirements, require, among other things, that a patient:

(a) has treatment resistant schizophrenia;

(b) undergoes pre-treatment assessments to determine suitability, including baseline blood tests and cardiac screening (such as an echocardiogram and ECG);

(c) undertakes a routine annual echocardiogram while on treatment; and

(d) undertakes ongoing monitoring following commencement of treatment, including regular blood tests. The blood tests monitor, in particular, white blood cell counts, as well as cardiac enzymes and inflammatory markers (including troponin, C reactive protein ('CRP'), and creatine kinase). The testing schedule is:

i. Weekly blood monitoring for the first 18 weeks of treatment; and

ii. Monthly blood monitoring thereafter for the duration of treatment.

41. The guidelines also identify known adverse effects and recommended responses. Relevant to this case, the guidelines say: [7]

(a) **Myocarditis -** Rare side effect. If it occurs, it is usually within 1 to 6 weeks of commencement. Signs include tachycardia and chest pain. Withold clozapine, check troponin and CRP levels, repeat ECG and echocardiogram. Contact cardiologist at Clozapine monitoring centre.

(b) **Cardiomyopathy -** Rare side effect. May occur anytime (other studies suggest that the onset of cardiomyopathy is normally later than myocarditis, on average 6 to 9 months after commencing)[8]. Signs include any evidence of heart failure, including tachycardia and shortness of breath. Withold clozapine, check troponin and CRP levels, repeat ECG and echocardiogram. If confirmed, contact cardiologist at Clozapine monitoring centre.

(c) **Postural hypotension** - A sudden drop of blood pressure that occurs when standing up or sitting down. Can cause dizziness and fainting. Occurs particularly during the initial weeks of treatment. Best managed with slow

[7] See Canberra Health Services, Clozapine Therapy Guideline, CHS25/196, 22 May 2025, p 44 -54, table 4.

[8] See A systematic review of clozapine induced cardiomyopathy, International Journal of Cardiology, 2014.

titration of clozapine and advice on strategies to manage postural dizziness e.g. take time standing up.

(d) **Weight gain -** Common side effect. Management includes dietary counselling and regular weight monitoring at the clozapine clinic.

(e) **Obstructive sleep apnoea -** Patients may be at increased risk due to clozapine associated weight gain. Consider referral to a sleep clinic.

Suspected Clozapine Induced Cardiomyopathy in 2021

42. Prior to commencing clozapine in October 2020, Ms UT underwent a baseline echocardiogram which demonstrated she did not have any significant cardiac impairment. The reported ejection fraction ('EF'), a measure of the heart's ability to pump blood[9], was approximately 50–55%, which is considered borderline low or mildly reduced. In a healthy heart, the EF is considered to be 50% or higher.[10]

43. A routine echocardiogram performed on 1 October 2021, approximately one year after commencing clozapine, demonstrated a reduction in Ms UT's EF to 44%, which is considered mild to moderate dysfunction. The report also noted mild left ventricular hypertrophy (thickening of the heart muscle) and raised the possibility of an infiltrative process affecting the hearts capacity to contract, such as fibrosis or other abnormal tissue deposits. Notably, cardiac enzymes and inflammatory markers at that time were within normal limits. It appears, primarily based on the reduced EF shown on the echocardiogram, clinicians suspected clozapine induced cardiomyopathy and clozapine was ceased.

Decision to recommence Clozapine in December 2022 and the cardiac investigations

44. In December 2022, there was no doubt that Ms UT had treatment resistant schizophrenia. As outlined above, following cessation of clozapine in October 2021, multiple antipsychotic medications were trialled without achieving an adequate response.

45. Treating clinicians from CHS were acutely aware of the prior suspected clozapine induced cardiomyopathy. Prior to recommencing clozapine, cardiac investigations were undertaken and specialist advice obtained in accordance with the Clozapine Patient Monitoring System ('CPMS')—the monitoring framework associated with Clozaril (the brand of clozapine ultimately prescribed). The investigations included:

[9] Specifically, the proportion of blood ejected from the left ventricle with each heartbeat.
[10] What is heart failure? | Heart Foundation

(a) **August 2022** – Echocardiogram performed. Report stated an EF reading of 60% (an improvement from the October 2021 reading of 44%.)

(b) **5 December 2022** – Echocardiogram performed. Report stated an EF reading of 48 % (similar to the reading from October 2021.)

(c) **26 December 2022** – CPMS protocol blood approval obtained. That is, Ms UT's blood results, including cardiac enzymes, were considered within safe range to commence clozapine.

(d) **8 December 2022** – CPMS Cardiologist advice obtained. The cardiologist said:

As you describe, your patient has been stable on clozapine for many years, but an echocardiogram last year suggested that her LV function was impaired, and clozapine was discontinued on the basis of this result.

Apparently, her echocardiograms have been reviewed by your cardiology team who feel they are technically difficult and that the reported decrease in LV systolic function was not accurate. A repeat echo more recently again has proved difficult due to the inability to image her walls accurately, and I note that an echocardiogram in August of this year was said to have an ejection fraction of 60%, whereas one in December of this year which again was suboptimal said there was perhaps mild LV dysfunction and a Definity study was recommended.

Echocardiography is always challenging in people who are overweight, and as you know there can be +/- 5% variation in serial echocardiography on the same patient as the ejection fraction varies according to the pulse rate, ambient temperature, state of hydration, blood pressure and concomitant medications.

In her case I think it would be quite reasonable to rechallenge her with clozapine, and as soon as she is stable from a psychiatric perspective, either perform a cardiac MRI or a gated blood pool scan to get an accurate measure of her LV function as it is unlikely that she would get an acute deterioration with recommencement of clozapine. If her LV function is normal or near normal on this estimate, I would continue clozapine and up titrate accordingly with a view to repeating her study perhaps 3-6 months after starting clozapine again to assess her function to ensure there has been no further deterioration.

Given her psychiatric instability off clozapine, I think this is a reasonable action plan as if she does develop cardiomyopathy it is likely to occur over months rather than weeks and once she becomes psychiatrically stable you may be able to do a more definitive test to assess her LV function more precisely.

46. On 16 December 2022, following the CPMS cardiologist approval and consultation with her family, Ms UT was commenced on clozapine.

47. The above cardiac investigations indicate ongoing clinical uncertainty as to whether Ms UT had previously developed, or continued to have, cardiomyopathy. The records suggest clinicians questioned the reliability of the echocardiogram findings due to Ms UT's large body size, which may have affected imaging quality and accuracy. A cardiac MRI, suggested by the CPMS cardiologist, is generally considered a more sensitive modality for assessing cardiac structure and function.

48. The records demonstrate that, in these circumstances, clinicians sought to balance the potential cardiac risks against the need to improve Ms UT's quality of life. This decision-making process involved both treating clinicians and Ms UT's family. Ultimately, in light of the uncertainty regarding the extent of any cardiomyopathy at the time, recommencing clozapine was considered an acceptable, albeit 'last resort' option, that could be managed with close and ongoing cardiac monitoring.

Cardiac monitoring after recommencement

49. A cardiac MRI was performed on 18 January 2023. The findings were reassuring, particularly given that, by that stage, Ms UT had been on clozapine for several weeks. The MRI report noted there was no structural or functional abnormalities of the heart. Both the left and right ventricles were of normal size and exhibited normal systolic function. There was no evidence of impaired contractility (as had been suggested on prior echocardiograms), and all cardiac valves appeared normal. Importantly, there were no features suggestive of inflammation or myocardial damage.

50. In addition to the cardiac MRI, in accordance with the CPMS protocol and CHS guidelines, Ms UT had her weekly then monthly clozapine clinic reviews. The clozapine clinic review records demonstrate that the biochemical markers in her blood, including cardiac enzymes (troponin and creatine kinase) and inflammatory markers (CRP), remained within acceptable limits.

51. The last clozapine clinic review occurred on 24 April 2023, with the next review scheduled for 22 May 2023 (the day following Ms UT's death). At the 24 April review, there were no reported cardiac symptoms. Vital signs, including respiratory function, were within normal limits.

Other physical health conditions

52. It is difficult to determine from the records the overall state of Ms UT's physical health prior to commencing clozapine in December 2022. The records indicate that, as her

mental state stabilised in the community, her treating mental health team worked with her GP, NDIS supports, and her mother to assess and manage a range of physical health issues. There was some uncertainty as to the extent to which her various conditions were attributable to her medication. In summary, the principal comorbidities investigated and management undertaken in the period proximate to her death, included:

(a) **Obesity:** At the time of her death, Ms UT weighed approximately 117 kg. The records indicate that being overweight was a longstanding issue, which clinicians partly attributed to the range of sedative antipsychotic medications prescribed over the course of her mental health treatment, including but not limited to clozapine. Her weight at the commencement of clozapine in October 2020 was around 112 kg and it did increase while on clozapine, during the lengthy inpatient admission. In the months prior to her death, while in the community, she received dietary advice, was more active than during her admission, and reportedly lost about 2 kg.

(b) **Suspected obstructive sleep apnoea:** Ms UT reported a long history of poor sleep, which reportedly worsened following recommencement of clozapine, including excessive daytime sleepiness and fragmented sleep. On 3 May 2023 (18 days before her death), she was reviewed by a sleep and respiratory physician, who opined there was a 'high likelihood of severe sleep apnoea'. The physician said that cause was likely polyfactorial, a combination of untreated sleep apnoea and medication side effects. Further investigations, including a sleep study and treatment with positive airway pressure therapy were recommended, along with weight management strategies.

(c) **Myoclonic jerks (involuntary muscle movements):** Ms UT reported experiencing muscle jerks following recommencement of clozapine in December 2022. This was treated with sodium valproate (anti-epileptic) from March 2023, with some reported improvement.

(d) **Blood pressure variability:** In the months preceding her death, vital sign monitoring recorded episodes of both hypertension and postural hypotension, which were linked to dizziness and falls. At the time of her death, clinicians were actively continuing to assess and investigate her blood pressure.

53. It is apparent that Ms UT's treating team recognised that the above conditions may have been caused or exacerbated by her medication, particularly clozapine, as they are known adverse effects. The records show that the possible adverse effects were weighed

against the demonstrated improvement in the quality of her life on clozapine. At a psychiatric review on 27 April 2023, the psychiatrist noted:

> (2) Sleep disorder, daytime sedation and myoclonic jerking are the main issues to effectively investigate, work out and manage. The contributions of OSA and various medications to sedation, effective treatment of OSA, detection of epileptiform activity and effect use of anticonvulsant need to be worked through systemically.
>
> (3) As highlighted before, clozapine and high dose of zuclopenthixol combined will be contributing to sedation but there is little room to manoeuvre with dose reductions as this stage as [Ms UT] has been so unwell and the consequence of destabilization may take some time [sic] manage.

Days leading up to death

54. Ms UT last saw her GP on 15 May 2023, about a week before her death. At that appointment, she was noted to have a longstanding cough, wheeze, and reduced air entry, but no respiratory distress. She was commenced on budesonide and was advised to use Ventolin regularly.

55. On 19 May 2023, Ms UT collapsed after having a regular zuclopenthixol depot shot at the Belconnen Mental Health Clinic. She described having a 'brain jerking feeling' after the shot was administered and before her fall. She was subsequently transferred to the Calvary Hospital emergency department ('ED') for further investigation.

56. At the ED, her vitals were checked. They appeared within normal ranges except for an observed drop in her blood pressure when going from lying down to standing. Bloods were taken which confirmed white blood cells and CRP levels were not raised. An ECG was done which showed normal sinus rhythm. Ms UT was discharged later that day with a diagnosis of postural hypotension. The discharge plan included following up with her GP within three to five days or call 000 if further syncope (dizziness) was experienced.

57. On 20 May 2023, at about 1552 hrs, a clinician from ACOS conducted a welfare check via phone. Ms UT reported she felt the same since discharge from the hospital. She was reminded to follow up with her GP and of her clozapine clinic review on 22 May 2023.

58. Ms UT was last seen alive on 20 May 2023 between 2200 and 2300 hrs, when she was observed by a carer at Evatt House to be asleep in her bed. The carer's room was next door to Ms UT's and as such the carer reported hearing Ms UT snoring at about 0100 hrs on 21 May 2023.

59. On 21 May 2023, at about 0745 hrs, during morning medication wakeup, that carer observed Ms UT was unresponsive and cold to the touch in bed. ACTAS attended but it was clear she was deceased.

60. Ms UT likely died in the early hours of 21 May 2023.

Public safety issues and analysis of Ms UT's treatment and care

Clozapine Use

61. Even if an indirect or global contributory link is established between clozapine use and Ms UT 's death, there is no identified shortfall in care or matter of public safety associated with that contribution that would warrant findings under s 74 and s 52(4) of the Act. The medical records indicate that the decision to re-commence Ms UT on clozapine was in line with relevant guidelines and protocols. Clinicians were aware of the potential adverse effects and, as her mental state stabilised, appropriately monitored, investigated, and managed her physical health.

62. The evidence suggests there was limited scope to significantly alter her antipsychotic regimen, given her severe treatment-resistant schizophrenia and the risks associated with psychiatric destabilisation. My findings are that her mental health treatment, care, and supervision whilst subject to various PTO's, reflected a considered and appropriate attempt to balance physical health risks against psychiatric stability and overall quality of life.

63. Both her parents indicated at the hearing that they and Ms UT were very aware of the risks that clozapine use carried. However, its use made very significant and positive contributions to her mental health. Ms UT and her parents were aware of the physical effects of her treatment and medication regime, and they were looking forward to addressing them in the context of her improved health.

64. The PTO was due to expire on 19 June 2023 and Ms UT and her parents were anticipating that she could live in the community without the PTO such was the improvement in her mental health. A touching reflection of her mother at the hearing was that Ms UT was conscious that her health challenges had led her to miss out on significant life experiences. Ms UT grieved that reality. She was looking forward to getting her physical health right and doing simple things that gave her pleasure such as cooking and exercise.

General Care Issues

65. In published findings of this Court the care experiences of a range of people who have died whilst subject to a PTO have been assessed. It is a fair summary to say those

experiences have varied somewhat in respect of the ability of the person to secure care and accommodation suitable to their needs. At the hearing Ms UT's parents spoke highly of the care arrangements that were in place at the time of Ms UT's passing not only in respect of her medical care but also in respect of the supported independent accommodation that was her home. The staff were supportive and caring and her housemates suitably matched. It was a happy house.

66. I note that a positive feature of Ms UT's care arrangements was that there was clearly good communication between Ms UT's clinicians and carers and her parents. Communication may have been facilitated in this case by the fact that Ms UT's mother had been appointed as her guardian and was actively consulted in relation to the decisions that had to be made under the formal care arrangements that existed under the PTO.

Publication of findings

67. At the hearing I canvassed with Ms UT's parents whether I should publish these findings. I indicated that there were issues that arose in respect of Ms UT's medication regime that warranted public agitation. Similarly, the positive aspects of Ms UT's home life in her supported accommodation should be publicly acknowledged. The opportunity for those suffering mental illness to live in suitable supported accommodation are rarer than they should be.

68. Ms UT's parents agreed that my findings should be published but requested that Ms UT's name be redacted to protect her privacy and the privacy of her family. Consistent with their wishes and being satisfied that it is in the public interest to do so I have anonymised Ms UT's name: section 40(2) of the Act.

Formal findings

69. On the basis of the available evidence, I make the following findings for the purpose of section 52 of the Act:

    (a) Ms UT died on 21 May 2023 at 48 Kellway Street, Evatt in the Australian Capital Territory.

    (b) The cause of Ms UT's death was morbid obesity with dilated cardiomyopathy and obstructive sleep apnoea.

    (c) The manner of Ms UT's death was natural causes.

    (d) There are no matters of public safety that arise in respect of her death.

70. I make no adverse findings in respect of section 74 of the Act.

Condolences

71. I reiterate the condolences I offered at the hearing to Ms UT's parents. I acknowledge the enormous contribution they made to her care. I am grateful for the kind, thoughtful and patient way they engaged in the coronial process.

72. I apologise again for the unforgivably long time my investigation has taken and acknowledge publicly that this has compounded their distress. I am sorry.

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: 12 August 2026