

CORONER'S COURT OF THE AUSTRALIAN CAPITAL TERRITORY

Case Title: Inquest into the death of Mr EN

Citation: [2026] ACTCD 16

Decision Date: 14 October 2026

Before: Coroner K J Archer

Findings: See [46]-[48]

Catchwords: **CORONIAL LAW** – MANNER AND CAUSE OF DEATH – pulmonary thromboembolism – poor mental health – natural causes death – “death in care” hearing required – no public safety issues – association between poor mental health and general health outcomes.

Legislation Cited: *Coroners Act 1997* (ACT) ss 13, 34A, 52 and 74
Mental Health Act 2015 (ACT) s58(2)

Texts Cited: Kisely, S, et al, “Participation in the National Bowel Cancer Screening Program by people with severe mental illness, Australia, 2006–2019: a national data linkage study”, (2025) 221(11) *Medical Journal of Australia* 617

File Number: CD 223 of 2023

Counsel Assisting: Ms C Pilley

CORONER ARCHER:

Introduction

1. Mr EN died on 3 October 2023 at 76 Federal Highway, Watson, in the Australian Capital Territory.
2. Mr EN was subject to a Psychiatric Treatment Order (PTO), made under section 58(2) of the Mental Health Act 2015, by the ACT Civil and Administrative Tribunal (ACAT) on 13 June 2023 for a period of 6 months.

Jurisdiction

3. The Coroner's jurisdiction in relation to Mr EN's passing arises under section 13(1)(i) of the Coroners Act 1997 (the Act), which requires the Coroner to hold an inquest into the manner and cause of a person who dies in care.
4. Mr EN's death is considered a "death in care" due to the PTO in place at the time of his passing. In an inquest into a death in care, a hearing cannot be dispensed with under s34A(2) of the Act. A hearing was held in the ACT Coroners Court, on 18 June 2026. I heard from both Mr EN's father and his ex-wife at the hearing. They made valuable contributions to the coronial process which have assisted me in making my findings.

Required findings

5. At the conclusion of the inquest and hearing, the Coroner must make findings regarding the manner and cause of Mr EN's death in accordance with section 52 of the Act. Section 74 of the Act also requires the Coroner to make findings about any shortfalls in the quality of care, treatment and supervision of the deceased person that, in the opinion of the Coroner, contributed to the death.
6. The section has previously been interpreted as not requiring a coroner in cases to which the section applies to always make findings about the quality of care, treatment and supervision of the deceased. What the section calls for is 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.

Biographical Detail

7. Mr EN was 45 years old at the time of his death. Mr EN is survived by his parents, his ex-wife and his two children. The evidence suggests that this separation from his family weighed heavily upon him. The behavioural symptoms of his mental health challenges,

including being delusional, paranoid and sometimes aggressive, created barriers to a fuller integration into the life of his children.

8. Mr EN had a brother who passed away from an overdose in 2009, who had been diagnosed with schizophrenia and bipolar disorder.
9. Mr EN was a chef by trade. He was unemployed at the time of his death and was living at Youth with a Mission (YWAM) in Watson. Mr EN had lived there since July 2022.

Circumstances of Mr EN's death

10. On 3 October 2023 at about 3:30pm, a resident of YWAM accessed the men's communal bathrooms to clean the cubicles. The resident saw that the door of the middle cubicle was closed and entered an adjacent cubicle. The resident saw Mr EN's arm from below the neighbouring cubicles sidewall. The resident called for help from another resident. They saw Mr EN was slumped against the floor, and an ambulance was called.
11. ACT Fire & Rescue were first on the scene. They were able to open the cubicle door and moved Mr EN onto the floor. Mr EN did not have a pulse and was not breathing, and CPR was commenced. An ambulance arrived at 3:54pm. CPR was ceased at 4:18pm. There were no obvious signs of trauma.
12. From discussions that police had with residents of YWAM, Mr EN was last seen at about 12:15am on 3 October 2023, walking the hallways of the building, appearing quite ill. Residents reported that it was usual to not see him until later in the mornings, as he often slept late. Residents commented that Mr EN appeared to be heavily medicated in the days prior to his death, was unable to eat any food without throwing up, and had significant weight loss. Residents said that he had not looked well from a long time and had refused to see a doctor.
13. Medication was found in Mr EN's room, including boxes of escitalopram and a small bottle of Benztrop. Escitalopram is a prescription anti-depression medication, that Mr EN was prescribed by his treating clinicians. Benztrop is a brand name for the medication benztropine, which is a prescription medication that is used to restore the balance of certain brain chemicals involved in muscle control. It is often prescribed for drug-induced movement disorders. Mr EN was prescribed benztropine by his treating clinicians because of tremors.
14. All of the medications which were found in Mr EN's room had been prescribed to him by his treating clinicians. There is no evidence to suggest that Mr EN may have overdosed on the medication that he had been prescribed.

The Post - Mortem Examination

15. On 5 October 2023, Forensic Pathologist, Dr Fronczek, performed a post-mortem examination, which included an internal and external examination, toxicology and microscopic examination of tissues. Dr Fronczek identified indicia of pulmonary thromboembolism and metastatic neuro-endocrine carcinoma (cancer) of the stomach, with wide-spread intra-abdominal metastases. Dr Fronczek indicated that cancer is a known risk factor for pulmonary thromboembolism.
16. Dr Fronczek's opinion was that Mr EN died as a result of pulmonary thromboembolism, with cancer of the stomach as a significant condition contributing to death.

MENTAL HEALTH HISTORY

17. Mr EN's mental health history included schizoaffective disorder, bipolar II disorder, depression, and narcissistic personality disorder. His first contact with ACT Mental Health was in 2003, and he reportedly had a mental health admission in Goulburn in his late teens because of a psychotic episode.
18. On 18 August 2022, Mr EN's private psychologist informed his GP that she felt that the primary issue for Mr EN was Adjustment Disorder, and that over time he had exhibited increased anxiety, disorganisation, was quite paranoid, and had poor emotional capacity to cope well. However given Mr EN's presentation during that year, it is likely he had an underlying psychotic illness.
19. In 2022, Mr EN had a psychiatric admission at Bloomfield Hospital in Orange from 17-21 March 2022. Following that, he was admitted to the Adult Mental Health Unit (AMHU) of The Canberra Hospital (TCH) between 20 to 28 April 2022, and between 15 June 2022 and 5 July 2022.

Admission at the AMHU: 15 June 2022 and 5 July 2022

20. Mr EN was apprehended by police on 15 June 2022 at 3:43pm after he threw a bottle at a shopfront and threatened to stab members of the public. He was rambling and said that his electronics were being hacked. He was transported to TCH by police on Emergency Action (EA), where it was noted that he had paranoia, delusions and chronic back pain. He was admitted to the AMHU.
21. The Discharge Summary from Mr EN's AMHU admission describes the primary discharge diagnosis as "[l]ikely exacerbation of a primary psychotic illness". He was under an Emergency Detention 3 day order (ED3), followed by an ED11 order. From the application form for the ED11 order completed by his treating psychiatrist, it seems that

Mr EN was refusing to take psychotropic medication for his mental health and refusing to engage in any follow up, and accordingly, involuntary treatment was considered the least restrictive form of care.

22. During Mr EN's admission at the AMHU, the PTO was made by the ACAT on 27 June 2022 for a period of 6 months.

PTO Made on 13 June 2023

23. A PTO Treatment Plan and Location Determination, dated 19 May 2023, which accompanied the application for PTO which Mr EN was on at the time of his death, describes Mr EN's treatment plan as follows:

Clinical management with regular meetings for review of wellbeing, development and progression of recovery goals, treatment adherence and mental state with clinical manager. Regular reviews as clinically required with treating medical practitioner, usually at least three monthly or more. Psychotropic medication in the form of oral medication / long acting injectable preparation.

24. A PTO hearing occurred on 27 June 2023. Mr EN was advised of the hearing date but did not attend.
25. As a condition of the PTO, Mr EN was required to have fortnightly face-to-face reviews with his case manager from the City Mental Health Team (CMHT) and a paliperidone depot injection every three months.

Mental Health Treatment Received in the Community

26. At the time of his passing, Mr EN was still being treated and supported by the CMHT of MHJHADS.
27. Mr EN's last contact with CMHT was on 28 September 2023, 6 days prior to his passing, when he attended a review with his treating psychiatrist and case manager. The consultation note from that review describes Mr EN as having schizoaffective disorder (psychosis remains in remission on treatment), anxiety and depression (in remission on treatment), extrapyramidal and sexual side effects relating to depot, and alcohol use disorder (in remission).
28. The note records that Mr EN was taking the following medications:
 - (a) naproxen 250 mg tablet (take 250mg three times a day);

- (b) paliperidone palmitate (INVEGA TRINZA) 263 mg modified release injection, 1.315 mL syringe (injected every 3 months);
 - (c) benztropine 2 mg tablet (take one tablet every 12 hours if needed for tremors);
and
 - (d) escitalopram 30mg mane.
29. At the review, Mr EN said that he was doing well, said his mood was “fine” and denied having any persecutory concerns, thought interference, grandiose beliefs or any perceptual abnormalities. He said that he was spending a lot of time looking for a job. Mr EN reported that he saw his daughters every second weekend and was looking for a job so that he could apply for a rental property and have his daughters stay overnight.
30. Mr EN reported that he was having some sleep disturbance due to sore shoulders and anxious ruminations at times. Mr EN said that he felt socially isolated, had given up smoking and drinking alcohol and was taking naproxen for chronic pain. He remained insistent on not applying for the Disability Support Pension (DSP) or NDIS, as that would involve a concession that he had a mental illness.
31. At the review, Mr EN's akathisia (inability to stay still) was noted, and he was observed to be restless and stamping his feet during the review. It was noted that there was “little improvement [to akathisia] with the decrease in dose of depot in the last review”. Mr EN said that he had not been taking the benztropine, which he had been prescribed for the akathisia.
32. Mr EN denied any suicidal thoughts or ideations and identified his children as a strong protective factor. The plan for Mr EN's ongoing mental health care and treatment from the review was documented follows:
- Psychoeducation provided.
 - **Agreed to review depot.** Next due on 30.11.23. Primeej to please arrange an MO review prior to the next depot.
 - Encouraged to take Benztropine for EPSEs.
 - Discussed adding Mirtazapine to help with initial insomnia + Akathisia. Mr EN not keen. Will try Benztropine first and if no improvement in Akathisia will let Primeej know and may consider Mirtazapine. Discussed other Mx options too.
 - Continue Escitalopram 30mg mane.
 - Primeej to see every 2 weekly. Working on social inclusion + activities + supports as Mr EN agreed. Mr EN to consider DSP application + help with housing and let Primeej know, thanks.

- Fasting bloods + prolactin + ECG requested.
- Ongoing psychology.
- Case management by Primeej; monitoring of MS, risk, side effects of medications, thanks.
- Physical health review by GP with thanks.
- Mr EN has emergency contact details in case needed
- Letter to GP.

PHYSICAL HEALTH HISTORY

33. Mr EN's physical health history included injury of meniscus of the right knee (2019), and lower back pain and right shoulder pain (11 October 2022).
34. From the medical records, it seems that Mr EN's physical health contributed to the social, psychological and financial stress he was experiencing.
35. The GP records show that Mr EN last attended his GP on 7 February 2023. Mr EN attended his GP on that date for a mental health care plan and for bilateral rotator cuff syndrome. A note by the GP from that appointment records the following about Mr EN mental health:

[d]epression/Anxiety with features of adjustment disorder, chronic disorganisation. No formal diagnosis – past proposed BPAD and personality disorder

[Mr EN] does not accord with past labels of Narcissistic personality and BPAD

Possible Neurodiversity characteristics...
36. The plan arising from the GP appointment on 7 February 2023 was that Mr EN was given a mental health plan for further visits with his private psychologist, and for his rotator cuff syndrome, he was advised to continue with gentle mobilisation and exercises. No complaint was made to his doctor of symptoms that may have created in the mind of his GP a suspicion of stomach cancer.
37. The evidence reflects that Mr EN's cancer was not known to him or his doctors at the time of his passing. There is no reference in any of the medical records, including in the GP records, to Mr EN having cancer.
38. Symptoms of stomach cancer generally include;
 - Nausea or vomiting
 - Difficulty swallowing

- Stomach pain
 - Fatigue
39. As noted, those living with Mr EN at YWAM were interviewed soon after his death. A housemate Mr EN had lived with for approximately a year had described Mr EN as looking as though he was “coming off a bender”, “hungover” or “in a bad way” for as long as he had known Mr EN. Whether his appearance was indicative of underlying illness cannot be known. Mr EN’s housemates reported that in the period close to his death Mr EN had been struggling to keep food down, often vomiting within minutes of eating.
 40. One housemate, who was particularly close with Mr EN, had been urging him to go to the hospital with him for approximately three weeks prior to his death. Mr EN was reportedly resistant to this idea.
 41. Even if the cancer had been identified at this stage Mr EN’s prognosis may have been poor. Publicly available sources suggest metastatic stomach cancer generally has a very low survival rate.
 42. It is well established that those who suffer significant mental illness have generally poorer health outcomes. Those suffering from mental illness and psychotic illnesses in particular, suffer physical illness at a disproportionate rate significant enough to reduce life expectancy.
 43. The records do not suggest that Mr EN had been subject to any bowel cancer screens. A recently published study suggests that Participation in the National Bowel Cancer Screening Program was significantly lower among people with severe mental illness than other Australians during the period 2006–2019. Their proportion of positive faecal occult blood test results was larger (12.3% v 6.6%), but the proportion who subsequently underwent colonoscopy was smaller (71.7% v 82.6%)¹. Although not investigated in this inquest, and not the subject of any recommendation, there may be a need for mental health services generally to identify barriers that may exist in the stomach cancer care pathway given the poor outcomes that are evident in this cohort.
 44. In Mr EN’s case, there were general challenges that his carers and health providers faced in persuading him to engage with care services.

¹ Steve Kisely, et al, “Participation in the National Bowel Cancer Screening Program by people with severe mental illness, Australia, 2006–2019: a national data linkage study”, (2025) 221(11) *Medical Journal of Australia* 617.

Findings as to Section 52 and Section 74

45. Pursuant to section 52(1) of the Act, the Coroner is required to find, if possible, the following matters in this inquest:
 - (a) the identity of the deceased;
 - (b) when and where the death happened; and
 - (c) the manner and cause of death.
46. Mr EN passed away on 3 October 2023 at 76 Federal Highway, Watson, in the ACT. Mr EN's cause of death was pulmonary thromboembolism and metastatic neuro-endocrine carcinoma of the stomach.
47. There is nothing to suggest that the mental health treatment that Mr EN was received from the CMHT while under the PTO contributed to his death. The Forensic Pathologist found that the cause of Mr EN's death was natural causes. No matters of public safety arise in connection with his passing.
48. Those living with Mr EN described him as a father to two beautiful girls, who, despite seeing them regularly, missed them terribly.
49. I extend my condolences to Mr EN's family.

I certify that the preceding forty-nine [49] numbered paragraphs are a true copy of the Reasons for Findings of His Honour Coroner Archer.

Associate: Miguel Kanissery

Date: 14 October 2026