

CORONER'S COURT OF THE AUSTRALIAN CAPITAL TERRITORY

Case Title: Inquest into the death of Russell James Longmore

Citation: [2026] ACTCD 18

Decision Date: 15 October 2026

Before: Coroner K J Archer

Findings: See [73] - [74]

Catchwords: **CORONIAL LAW** – manner and cause of death – brain cancer – refusal to undergo diagnostic procedure – concern about capacity to consent to treatment – subject to psychiatric treatment order – hearing required – no shortfall in treatment, care and supervision

Legislation Cited: *Coroners Act 1997* (ACT) ss 13, 34A, 52, 55 and 74
Guardianship and Management of Property Act 1991 (ACT) ss 7 and 8
Mental Health Act 2015 (ACT) ss 58, 80 and 88

Cases Cited: *Inquest into the death of Stanley McIntyre* [2025] ACTCD 5

Texts Cited: Brown, N F, et al., 'Survival Outcomes and Prognostic Factors in Glioblastoma' (2022) 14(13) *Cancers* 3161
Cancer Council Victoria and Department of Health Victoria, *Optimal care pathway for people with high-grade glioma*, (2 ed., June 2021)
Cleveland Clinic, *Glioblastoma (GBM)*, (webpage, 23 April 2025): <https://my.clevelandclinic.org/health/diseases/17032-glioblastoma>
Hays, E M, Duan, Wei, Shigdar, S, 'Aptamers and Glioblastoma: Their Potential Use for Imaging and Therapeutic Applications' (2017), 18(12) *International Journal of Molecular Sciences* 2576
Mayo Clinic, *Glioblastoma*, (webpage): <https://www.mayoclinic.org/diseases-conditions/glioblastoma/symptoms-causes/syc-20569077>

File Number: CD 154 of 2025

CORONER ARCHER:

Introduction

1. On 3 June 2025, the death of Mr Russell James Longmore was reported to me as a Coroner in the ACT. With respect, I refer to Mr Longmore as “Russell” in these submissions. Russell identified as an Aboriginal man. At the time of his death, he was 67 years old and subject to a Psychiatric Treatment Order (PTO).
2. Russell was found deceased at his home residence on 3 June 2025 by Woden Mental Health Team (WMHT) Case Manager (CM) during a monthly home visit. He had last been seen alive on 6 May 2025. A couple months earlier, Russell had absconded from The Canberra Hospital (TCH), where investigations had identified a brain lesion considered likely to be malignant. He subsequently remained in the community without undergoing the proposed diagnostic work-up and receiving treatment for the lesion.
3. As part of the inquest process, a pathologist performed a post-mortem examination and concluded the direct cause of Russell’s death was glioblastoma in the central brain, a malignant brain tumour.
4. These submissions discuss the evidence in relation to the development and identification of the tumour and the difficulties faced by those involved in Russell’s care in facilitating further investigation and treatment.

Jurisdiction and required findings

5. Russell was subject to a PTO made under section 58(2) of the *Mental Health Act 2015* (ACT) (the Mental Health Act) at the time of his death. That order was made by the ACT Civil and Administrative Tribunal (ACAT) on 29 January 2025 for a period of 6 months. It was due to expire on 29 July 2025.
6. The Coroner’s jurisdiction in relation to Russell’s death arises under section 13(1)(i) of the Coroners Act 1997 (the Act), which provides that the Coroner must hold an inquest into the manner and cause of a person who dies in care. As Russell was subject to a PTO at the time of his death, his death is a “death in care”, pursuant to the meaning of that term in section 3BB of the Act. As Russell’s death was a “death in care”, a hearing cannot be dispensed with as pursuant to section 34A (2) of the Act.
7. At the conclusion of the inquest and hearing, the Coroner must make findings regarding the manner and cause of Russell’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 as pursuant to section 52(4) of the Act.

8. 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

Russell James Longmore

9. Russell was born on 12 October 1957. He spent his early life in Narrabundah. He was the second youngest of four siblings, and is survived by his eldest brother, Rodney. At the time of his death, Russell was estranged from his family. Rodney informed police that he had not seen Russell since around 2000. It is understood Russell may have a son, although little information about this was available.
10. During the inquest and at the hearing, Rodney shared with the Court memories and reflections about Russell. He recalled that he and Russell grew up together until Rodney left the family home when he was about 14 or 15 years old, at which time Russell was age 10 or younger. Their contact thereafter was intermittent. Rodney described the family environment as difficult and marked by violence between their parents. Their mother, who was Aboriginal and from South Australia, died in 1977. The available records indicate that Russell identified with his Aboriginal heritage.
11. Further aspects of Russell's life and Rodney's reflections are discussed below.

The investigation

Sources of information

12. The Australian Federal Police (AFP) conducted an investigation on behalf of the Coroner. This included speaking with Rodney and those present at the scene of Russell's death. Medical records were obtained from Mental Health, Justice Health, Alcohol and Drug Services (MHJHADS), The Canberra Hospital (TCH) and from Winnunga Nimmityjah Aboriginal Health Service (Winnunga). Records were also obtained from the ACAT and from the National Disability Insurance Agency to assist the Court to understand the supports that Russell received under the National Disability Insurance Scheme (NDIS).

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

The post-mortem and cause of death

13. On 30 September 2025, pathologist Dr Sanjiv Jain, performed a post-mortem examination and found that the cause of Russell's death was "glioblastoma of the central brain", a malignant brain tumour. The examination included an internal examination, histological examination of the brain, and supplemented by a review of the medical records.
14. Dr Jain observed post-mortem decomposition of the brain and "foci of increased vascularity and altered coloration in the paraventricular region". Histological examination of tissue from that area showed glioblastoma. No other significant abnormalities were identified in the heart, lungs or abdomen. Toxicological analysis detected paliperidone (an antipsychotic) at a concentration of approximately 0.001 mg/L. The level of paliperidone was not related to Russell's death. Dr Jain said:

the cause of death can be established as being due to the involvement of the brain by glioblastoma, which is a malignant brain tumour, and as it was centrally placed, would have caused intracranial pressure and death.
15. In my submission, Dr Jain's opinion as to the cause of Russell's death can be accepted.

About glioblastoma

16. It is useful to briefly describe the nature of the glioblastoma to provide context for the treatment options available to Russell and the consideration of his care.
17. Glioblastoma is an aggressive form of primary brain cancer that begins in glial cells, cells within the brain and central nervous system. It is classified as a Grade 4 glioma,² the highest grade of glioma, and is characterised by rapid growth and infiltration of surrounding brain tissue. The infiltrative growth can make complete surgical removal difficult and often impossible.³ Glioblastomas can arise spontaneously from glial cells or can develop from the progression of lower grade glioma.⁴
18. Research indicates that the precise cause of glioblastoma is unknown. It is more commonly diagnosed in older adults and occurs more frequently in men than women. The literature identifies previous exposure to ionising radiation involving the head or neck

² The World Health Organization grading system classifies gliomas according to their biological behaviour. Glioblastoma is, by definition, a Grade 4 glioma.

³ See e.g; Mayo Clinic, *Glioblastoma*, (webpage): <https://www.mayoclinic.org/diseases-conditions/glioblastoma/symptoms-causes/syc-20569077>; Cleveland Clinic, *Glioblastoma (GBM)*, (webpage, 23 April 2025): <https://my.clevelandclinic.org/health/diseases/17032-glioblastoma>.

⁴ Hays, E M, Duan, Wei, Shigdar, S, 'Aptamers and Glioblastoma: Their Potential Use for Imaging and Therapeutic Applications' (2017), 18(12) *International Journal of Molecular Sciences* 2576 .

as the only established environmental risk factor, and accounts for only a small minority of cases.⁵

19. The *Optimal Care Pathway for People with High-Grade Glioma* (the Pathway)⁶ published in June 2021 and endorsed by *Cancer Australia*, notes that there is no clear prevention strategy for high-grade glioma. Unlike some other cancers, there are no established lifestyle changes known to reduce the risk of developing glioblastoma. Screening before symptoms develop has not been shown to be beneficial in detecting high-grade glioma. Symptoms vary according to the location of the tumour within the brain and may include seizures and changes in cognition, speech, vision, strength, sensation, personality, behaviour, balance or coordination.
20. As recognised in the Pathway, maximal safe surgical resection is commonly the first therapeutic intervention where feasible, usually followed by radiotherapy and chemotherapy. However, high-grade gliomas are generally regarded as incurable, with treatment directed towards slowing tumour progression, prolonging survival and alleviating symptoms. Published studies report a median survival of approximately 12 to 18 months for patients receiving treatment, compared with approximately three months for patients without treatment. Long-term survival is uncommon, with reported five-year survival rates of approximately 5% to 7%.⁷

Background circumstances

21. At the time of his death, Russell was living alone in ACT Housing accommodation at 12/7 Yambina Crescent, Waramanga and was receiving a Disability Support Pension. He was estranged from family and had few known friends. The records describe him as socially isolated. He was receiving involuntary mental health treatment pursuant to his PTO and was supported through the NDIS. On 21 March 2025, after a brain lesion was identified during a hospital admission, ACAT made an order appointing the Public Trustee and Guardian (PTG) as guardian for Russell, with powers to make decisions in relation to his health and welfare.

Mental health history and care under the PTO

22. The records indicate that Russell first came into contact with ACT mental health services in early 2019, when he presented to the Adult Mental Health Unit with symptoms of

⁵ See e.g. Cancer Council Victoria and Department of Health Victoria, *Optimal care pathway for people with high-grade glioma*, (2 ed., June 2021).

⁶ Ibid.

⁷ Brown, N F, et al., 'Survival Outcomes and Prognostic Factors in Glioblastoma' (2022) 14(13) *Cancers* 3161.

psychosis, including paranoid beliefs. It appears he was diagnosed with schizophrenia soon after and was placed on his first PTO on 15 April 2019.

23. The PTO application dated 24 January 2025, relating to the order in force at the time of his death, described his schizophrenia as:

characterised by disorganisation, grandiose and persecutory delusions. In the past, he has acted on those thoughts and been charged for property damage. He has threatened a member of the public and assaulted a police officer when unwell, resulting in his arrest. He has poor self-care in the context of his mental illness and substance abuse issues.

24. The PTO application recorded a history of substance use, including cannabis, tobacco, alcohol, intravenous drugs and opioids, although his more recent use (at the time of the application) appeared limited to cannabis and tobacco. Police records also documented a longstanding history of antisocial and aggressive behaviour including disorderly conduct, property damage and intoxication. He had a lengthy criminal history spanning over 50 years from 1973 (age 16) until 2023.
25. The medical records indicate that with antipsychotic medication, Russell's mental state was generally regarded as stable and his level of functioning improved. However, even during periods of stability, he had limited insight into his illness and he did not accept that he had a mental health condition. He continued to have difficulties caring for himself and frequently declined medical appointments and assistance with daily living tasks.
26. In the period proximate to his death, Russell's treatment under the PTO included paliperidone depot injections and psychiatric reviews every three months, and monthly contact with a case manager. The records suggest clinicians sought to maintain a level of contact that Russell would tolerate, recognising that attempts at more intensive intervention often resulted in further disengagement.

NDIS support

27. Russell was also receiving support through the NDIS in years prior to his death. His NDIS plan included funding for assistance with meal preparation, household cleaning and transport. He was supported by a support coordinator and a support worker who attempted to see him either weekly or fortnightly.⁸
28. Over time, Russell appears to have developed a degree of trust in his NDIS workers, particularly his support worker, Harshan⁹. Harshan would take him for drives to get food, often McDonald's, which Russell appeared to enjoy.

⁸ The records are inconsistent in respect of whether the NDIS plan involved weekly or fortnightly contact.

⁹ His name has been de-identified to protect his privacy

29. However, even within that relationship there were limits to the assistance Russell would accept. He continued to decline support for matters such as cleaning his house and attending medical appointments. Russell's engagement with Harshan appears to have been motivated by the companionship and social connection that relationship provided, rather than the practical supports NDIS was offering.
30. An email from Russell's support coordinator to ACAT dated 16 May 2025, approximately two weeks before he was found deceased, described Russell's personality and the ongoing challenges involved in supporting him:

Russell is a friendly man in his late 60's. He just wants to be safe to be able to live his life his way and pretty much be left alone. When we were first contacted and asked to work with Russell he was very anti supports. I went out to meet him and he agreed to take me on as his coordinator but was not keen to engage. It has been difficult- Russell has no Phone, No internet and is not prepared to use any of these things even if he did have one. So all my visits are face to face and often he is not home or will not answer the door. As Russell got to know me he has become happy to see me and if he opens the door he always welcomes me inside and has a chat, sometimes agreeing to come to lunch in the community with me. After enquiring about things he is happy to discuss, I always remind him that his lone support worker can assist him with tasks such as Cleaning, cooking, shopping, community participation and can take him to any appointments etc. Russell always refuses and its often at this point in the conversation that Russell requests I leave.

...

Russell was really difficult to place a support with but he clicked with Harshan from Empower Living and he is the only support Russell will accept. Russell will not allow Harshan to assist or do any cleaning, washing, housework, cooking etc. He will not allow Harshan to take him to appointments (even medical) because quite simply Russell has no intention of attending. He will let Harshan take him out in the community for Lunch and often to the airport to watch the planes. He will also let him take him shopping when required and if there are major issues with Russell's Centrelink or electricity/heating/housing he will let/ask Harshan to assist with going to see them to sort this out. Russell is only funded for 2 hours per week of support so Harshan is rostered 2 hours every Friday (Russell's choice).

...

Anytime we have seen any signs of Russell being forced or feeling like people are not listening to him, he cancels all services.

Physical health prior to the hospital admission on 25 February 2025

31. In respect of his physical health, Russell had sporadic engagement with Winnunga between 2013 and 2023. He last engaged with Winnunga in April 2023 when routine bloods were taken. Despite subsequent attempts to follow him up, including liaison with his mental health team, he did not re-engage.
32. The routine bloods identified iron deficiency, which was a longstanding issue but otherwise did not identify anything of significant concern.

33. The mental health records show that in the years and months prior to the hospital admission in February 2025 (discussed below), Russell's mental health team were concerned about his general physical health. He was repeatedly encouraged to attend medical appointments and various health investigations, including blood and stool testing. He persistently refused to engage with these recommendations.
34. Although concerns about self-neglect and physical health were longstanding, the records suggest Russell's clinicians observed a marked deterioration in his physical health in November 2024.
35. From November 2024 onwards, the mental health treating team noted Russell had lost significant weight and appeared unsteady on his feet. His treating team encouraged him to attend a GP and undergo some health investigations. While he occasionally expressed some willingness to do so, he ultimately did not engage with the recommended care.
36. By late January 2025, the mental health treating team noted further weight loss and that Russell appeared "confused". By this stage, the records indicate that the treating team were concerned enough about his physical health that they were considering seeking a guardianship order.

Rodney's reflections on Russell

37. Rodney also shared with the Court some insights into Russell's behaviour. Rodney recalled that from a young age, Russell preferred to do things on his own terms and was resistant to accepting help from others. In relation to his reluctance to engage with healthcare and other services, Rodney said Russell had "always been like that".
38. Rodney also recalled that Russell had always been "cranky" and had begun using substances, including cannabis, at a young age. He thought that Russell became increasingly reclusive and prone to aggression following his drug use.
39. These observations were consistent with aspects of Russell's behaviour documented throughout the records. However, Rodney had not known Russell to suffer from serious mental illnesses such as schizophrenia. He said the extent of Russell's refusal of care in the years preceding his death came as a surprise to him and was, understandably, a source of considerable sadness.

The hospital admission: 25 February to 26 March 2025

40. It is against this background that Russell became a voluntary inpatient at TCH between 25 February and 26 March 2025.

41. On 25 February 2025, Russell was transported by ACTAS to TCH after a fall while walking back home from the shops. The ambulance was called by a bystander who found Russell lying on the ground.
42. Russell was voluntary admitted to TCH under the general medicine team. During the admission, several health issues were managed, including investigating the fall, self-neglect leading to malnutrition, and COVID-19.
43. In relation to the fall, it was considered likely to have been caused by a postural drop in blood pressure.
44. On 26 February 2025, an MRI of his brain was undertaken. The MRI was reported to show “multi-lobulated, heterogeneously enhancing lesion crossing the midline with differentials for midline crossing lesions include meningioma, glioblastoma, lymphoma or metastatic disease”. That is, a lesion was identified in his brain which had multiple lobes and irregular contours, and which extended across the midline of the brain into both hemispheres.
45. The neurosurgery team considered the lesion was likely malignant and explained to Russell that a brain biopsy was needed to confirm this. He was informed of the consequences of not investigating and treating the lesion, including the possibility of death within a few months. Russell declined the biopsy but agreed to a lumbar puncture to investigate the possibility of lymphoma.
46. However, concerns were raised about Russell’s capacity to make decisions about his medical care. He had been observed to have difficulty remembering conversations with treating clinicians and was very slow in his responses.
47. As psychiatric review on 3 March 2025 found Russell had deficits in memory and that he was “not able to meaningfully explain to [the psychiatrist] his medical predicament and the consequences of not investing or treating the tumour, despite these having been explained to him by the neurosurgeon”. The psychiatric team recommended a guardianship application be made to assist with decisions concerning his health.

The guardianship application and order

48. On 13 March 2025, a Canberra Health Service (CHS) social worker applied to ACAT for the appointment of guardian under section 7 and a financial manager under section 8 of the *Guardianship and Management of Property Act 1991* (ACT) (the Guardianship Act).
49. The guardianship application was accompanied by a letter from a general physician from TCH which stated:

Mr Longmore presented to hospital on the 25th February following an unwitnessed collapse on a footpath. Work-up for causes of collapse revealed a lesion in the brain that is suspicious for a brain tumour. He has not been delirious through his admission. For a formal diagnosis to be made, he would need either to have a brain biopsy (under anaesthetic) and/or a lumbar puncture (under local anaesthetic). Further treatment of the brain lesion would be dependent on the pathology but may include surgery, chemotherapy and radiation therapy as appropriate. Palliation may also be an option depending on prognosis and appropriateness of therapy.

This information has been relayed to Mr Longmore on multiple occasions. He is unable to recall or process this information, however. He shows very limited insight into his medical issues. He is unable also to explain how he manages his affairs at home - ie how to shop, cook, obtain money to buy goods or pay bills.

In hospital, Mr Longmore has been reviewed by the mental health team, allied health and medical teams. The consensus assessment has been that Mr Longmore lacks capacity to make decisions regarding his medical, financial and accommodation affairs given his very limited ability to retain or process information. There does not appear to be an acute reversible cause for his cognitive impairment.

For these reasons, I strongly advocate for a temporary (up to 12 months) guardian be appointed to assist Mr Longmore make medical, financial and accommodation decisions to assist with the diagnostic, medical treatment and discharge process and to ensure he can manage out of hospital in the community should he be discharged.

50. The guardianship application was heard by ACAT on 21 March 2025. ACAT appointed the PTG as Russell's guardian with powers pursuant to section 7 of the Guardianship Act, including:

- (a) To give any consent required for a medical procedure or other treatment (other than a prescribed medical procedure), including treatment to support the protected person's mental health;
- (b) To make other personal decision needed to ensure the protected person's health and welfare are met and to protect them from unreasonable risks to their health and welfare, including regarding services under NDIS and My Aged Care;
- (c) To do things necessary to give effect to decisions about the matters set out above, including (but not limited to):
 - (i) Giving or receiving information; or
 - (ii) Giving consent to investigations and assessment; or
 - (iii) Participating in negotiations; or
 - (iv) Signing documents.

51. The application for the appointment of a financial manager was adjourned. On 16 March 2025, that application was dismissed and the guardianship order were reviewed and re-issued in materially the same terms as the 21 March 2025.

Abscondments from TCH

52. During the TCH admission, Russell absconded twice. On 9 March 2025, before any guardianship order had been made, Russell left the ward. He returned voluntarily by ambulance the following day.
53. On re-admission, Russell remained confused and did not recall the reason for his previous hospital admission. He was willing to be re-admitted to the ward. Thereafter, nursing staff were allocated to observe him because of the risk of further abscondment.
54. Russell absconded again from the ward on 26 March 2025. The TCH records document discussion between his treating clinicians, including psychiatrist and general physician, as to how to get him back to hospital. The documented view at the time was that there was no legal basis to compel his return under the Mental Health Act. It was noted that as there were “no immediate threats to himself”, he could not be held under a “duty of care” and he was not in breach of his PTO. By that time, the PTG had been appointed Russell’s guardian. The extent of their power to facilitate Russell’s return and further physical health investigation or treatment is considered below.

Events after leaving hospital

55. The medical records demonstrate that Russell’s mental health team and NDIS supports were aware of the TCH admission and possible malignant brain tumour, and made ongoing attempts to maintain contact, monitor his welfare and encourage engagement with physical health care in community. A hospital discharge summary was sent to Winnunga.
56. The following chronology summarises Russell’s care, contact with services and other relevant events in the community before his death.
 - (a) **28 March 2025:** Russell’s recent hospital admission was discussed at a multidisciplinary review involving the mental health treating team. It was noted that he was at “risk of physical deterioration”. The plan was for Russell’s CM to follow up with him and support Russell to attend a GP for physical health screening.
 - (b) **31 March 2025:** Russell’s CM attended his home. Russell answered the door but declined entry. He appeared “superficially engaged” and “unsteady”. He stated he did not want to talk with mental health team, would not attend the clinic and proceeded to close the door. The plan was recorded as attempting another home visit in a month and that he was due for a depot injection and psychiatric review on 22 April 2025.

- (c) **4 April 2025:** The NDIS team attempted a home visit. Russell did not answer the door.¹⁰
- (d) **22 April 2025:** Russell did not attend his depot and psychiatric review appointment. His CM called him the next day, but he did not answer.
- (e) **25 April 2025:** ACT police advised the mental health team that Russell had found his “housemate” deceased at home. Although Russell generally lived alone, the records indicate that a friend had been staying with him intermittently for about six months. The Access Mental Health Team contacted Russell, and he confirmed he was okay and denied suicidal ideation.
- (f) **29 April 2025:** Russell’s psychologist and CM conducted a home visit. He was described as pleasant, polite and well engaged. His overdue depot was administered. Russell reported he was eating well and sleeping well. He declined additional NDIS support and declined an offer to present to hospital. A plan was made for the CM to liaise with the guardian.
- (g) **6 May 2025:** Mental health clinicians attended his home to drop off a copy of the ACAT hearing notice and application for guardianship. Russell was pleasant and polite. The clinicians observed the house to be “in squalor”. This was the last time that Russell was seen alive prior to his passing. The clinicians reported to police after Russell’s passing that he looked the same as usual on this home visit and they did not hold any concerns for him at the time.
- (h) **15 May 2025:** Russell did not attend a scheduled NDIS appointment.
- (i) **16 May 2025:** Mental health clinicians attended Russell’s home to transport him to the ACAT guardianship hearing. Russell did not answer the door.
- (j) **27 May 2025:** The NDIS team attended Russell’s home. Russell did not answer the door. A card was left on his door advising of a further appointment on 12 June 2025.

Discovery of Russell’s death

57. On 3 June 2025, Russell’s CM attended his home for a routine monthly home visit. Russell did not respond to knocking on the door. The door was unlocked. On entering, the CM found Russell clearly deceased on the couch.

¹⁰ Russell’s NDIS support coordinator informed police that it was not uncommon for Russell to avoid people for weeks at a time.

58. Police who attended described the scene as in disarray and dirty. They did not document any drug paraphernalia in the immediate vicinity of Russell.
59. The Forensic Medical Officer (FMO) who attended observed a level of decomposition and considered that Russell had died sometime between when he was last seen alive on 6 May 2025 and the end of May.
60. On the available evidence, I am satisfied that Russell died sometime between 6 May and 31 May 2025.

Nature and course of the cancer

61. Russell died from glioblastoma, an aggressive brain cancer which was not formally diagnosed during his lifetime and for which he refused to receive treatment for.
62. It is not possible on the available evidence to determine when the tumour first developed or began causing symptoms. There was, however, a marked deterioration in Russell's physical condition from about November 2024. In retrospect, aspects of that deterioration, including unsteadiness, lethargy and confusion, appear consistent with the progression of a glioblastoma.
63. Glioblastoma is an aggressive and incurable cancer. The evidence indicates that, even with timely diagnosis and optimal treatment, the disease would not have been cured, and Russell's death would not have been prevented. At best, treatment may have prolonged his life for a few months. Such treatment would likely have been significant and invasive, involving biopsy, brain surgery and then ongoing radiotherapy and chemotherapy. There is a real question whether such treatment would ultimately have been considered clinically appropriate or in Russell's interests.

Powers to compel physical health treatment

64. Notwithstanding the above submissions, the circumstances of Russell's death raise difficult questions about what can, and should, be done where a person receiving involuntary mental health treatment also suffers from a serious physical illness which they lack capacity to understand and for which they resist treatment. This is a situation which arises with some frequency in the Coroner's Court. In Russell's case, his impaired understanding of the brain lesion may have reflected both his pre-existing mental illness and the cognitive effects of the lesion itself.
65. A PTO under the Mental Health Act authorises involuntary treatment in respect of a person's mental illness but does not provide authority for involuntary treatment for a physical illness. In practice, that distinction can be difficult to maintain. Impaired insight

and decision-making capacity do not necessarily operate differently according to whether the condition requiring treatment is characterised as mental or physical.

66. The Mental Health Act also contains powers of apprehension, detention and treatment in respect of persons with mental illness or mental disorders (ss 80–88). Those provisions appear directed to urgent circumstances involving immediate risk and the need for immediate assessment and treatment. They do not provide a general mechanism by which a person may be apprehended or detained solely for the purpose of investigating or treating a serious physical illness.¹¹
67. In Russell's case, clinicians did not consider the PTO to provide authority to return him to hospital for further brain lesion investigation or treatment. Nor did they consider his condition, although serious and recognised to be likely terminal, to present the level of immediacy or acute risk required to invoke the emergency powers under the Mental Health Act.
68. Russell's circumstances had an additional feature. As discussed above, a guardian had been appointed with powers under section 7 of the Guardianship Act to make decisions about his health and welfare, including consent to medical procedures or treatment.
69. Had Russell remained in hospital, the guardian could have provided consent to the proposed biopsy. However, Russell absconded before a decision to consent had been made and the available records do not disclose any subsequent consideration of what further steps, if any, might have been available to the guardian to facilitate investigation and treatment.
70. In practical terms, pursuing a biopsy or subsequent treatment would likely have required Russell to be returned to hospital against his wishes and, if he continued to resist, the use of restraint or force. This raises the separate question of whether the guardianship powers conferred under section 7 extended beyond consent to medical treatment to permit a guardian to consent to the use of restraint or force necessary to overcome resistance to medical treatment.
71. That question, and the tribunal decisions relevant to it, were not comprehensively examined in this inquest. For the reasons discussed above, in my view, it is unnecessary to resolve the issue in this matter. Even had further mechanisms been available to

¹¹ See e.g. s 80(4) of the *Mental Health Act*, which requires a doctor or mental health officer to believe that the person has a mental disorder or mental illness and that either (a) the person requires immediate treatment, or (b) the person's condition is likely to deteriorate within three days to the extent that immediate treatment will be required. See also section 88, which limits treatment during detention to the minimum necessary to prevent any immediate or substantial risk of the detained person causing harm to themselves or another person.

facilitate investigation and treatment, there remains substantial doubt that the ultimate outcome in this case would have been materially different. It is, for example, unclear:

- (a) how Russell may have responded to compulsion in bringing him to hospital;
- (b) whether he would have submitted to treatment even if at hospital;
- (c) whether he would have consented to further treatment being administered to him;
- (d) whether any treatment would have had any therapeutic effect; and
- (e) whether the treatment of the condition was likely to be in Russell's best interest .

Time taken to investigate his wellbeing

72. It is noted that there was almost a month between Russell being last seen alive and when entry to his unit was effected on 3 June 2025. Given his physical vulnerabilities, the fact he was subject to a PTO, his known social isolation and the observed condition of his unit that period of time may be considered long. No finding is made that the failure to make contact with him contributed to his death.

Final findings

73. For the purposes of section 52 of the Act, I make the following findings;
- (a) That Russell James Longmore died between 6 to 31 May 2025 at 12/7 Yambina Crescent, Waramanga ACT.
 - (b) That the cause of Russell James Longmore's death was glioblastoma of the central brain.
 - (c) That the manner of Russell James Longmore's death was natural.
 - (d) That there are no matters of public safety that arise in respect of Russell James Longmore's death.
74. For the purposes of section 74 of the Act, I find that there were no shortfalls in the quality of care, treatment or supervision which contributed to his death.

Postscript and condolences

75. I express my deepest condolences to Russell's family.

I certify that the preceding seventy-five [75] numbered paragraphs are a true copy of the findings of Coroner Archer.

Associate: Miguel Kanissery

Date: 15 October 2026