**CORONER'S COURT OF THE AUSTRALIAN CAPITAL TERRITORY**

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| **Case Title:** | **Inquest into the death of Peter Wallace** |
| **Citation:** | **[2026] ACTCD 8** |
| **Hearing Date:** | 2 July 2025 |
| **Decision Date:** | 11 June 2026 |
| **Before:** | Coroner Archer |
| **Findings:** | See [13]-[49] |
| **Catchwords:** | **CORONIAL LAW** – death in care – manner and cause of death congestive cardiac failure – whether matter of public safety arises from the inquest - whether issues arise as to with quality of care, treatment, and supervision when subject to a psychiatric treatment order |
| **Legislation Cited:** | *Coroners Act 1997* (ACT) ss 13, 21, 3BA, 3BB, 34A, 52, 74<br>*Mental Health Act 2015* (ACT) ss 58-65 |
| **Representation:** | **Counsel Assisting the Coroner**<br>Xiao Lin King |
| **File Number:** | CD 124 of 2023 |

**CORONER ARCHER:**

**Introduction**

1. On 29 May 2023, the death of Mr Peter Vernon Wallace was reported to the Australian Capital Territory (**ACT**) Coroner's Court. I will, with respect, refer to Mr Wallace as Peter in these findings.

2. At the time of his death, Peter was 76 years old and was subject to a Psychiatric Treatment Order (**PTO**), which was made by the ACT Civil and Administrative Tribunal (**ACAT**) on 22 December 2022 for a period of 6 months.

3. On 1 June 2023 pursuant to section 21 of the *Coroners Act 1997* I directed that the post-mortem examination be dispensed with, being of the view that medical records and other information provided by investigating police sufficiently disclosed the manner and cause of Peter's death.

4. By report dated 29 June 2023, Professor Duflou, forensic pathologist, having reviewed Peter's medical records and the information provided by investigating police, opined that Peter died on 29 May 2023 of congestive cardiac failure complicated by type 2 respiratory failure. Professor Duflou also found that other significant conditions contributing to the death but not relating to the disease or condition causing it were morbid obesity and type 2 diabetes mellitus.

5. I accept Professor Duflou's opinions as to the cause of Peter's death.

**Jurisdiction**

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

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

7. Under s 3BB of the Act, "in care" extends to a person subject to an order under the *Mental Health Act 2015* (ACT). Given Peter was subject to a PTO (*Under the Mental Health Act* ss 58 to 65) at the time of his death, his death was within the coroner's jurisdiction, and as a result of the application of s 34A(2) of the Act, a hearing into Peter's death could not be dispensed with.

8. At the conclusion of the inquest, including the hearing for the inquest, I am required to make the findings by s 52 of *the Act*, which provides:

(1) A coroner holding an inquest must find, if possible—

(a) the identity of the deceased; and

(b) when and where the death happened; and

(c) the manner and cause of death; and

(d) in the case of the suspected death of a person—that the person has died.

(4) The coroner, in the coroner's findings—

(a) must –

(i) state whether a matter of public safety is found to arise in connection with the inquest or inquiry; and

(ii) if a matter of public safety is found to arise—comment on the matter;

9. To find a "cause" of death in any given case, a coroner is required to consider what physiologically produced that result. Separately, a finding as to the "manner" of death involves a consideration of the circumstances in which the death took place. If a matter of public safety arises, I can comment on it.

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

**Evidence**

11. At the conclusion of the coronial investigation, I had the following sources of information:

- The investigating police report;
- Mental Health, Justice Health and Alcohol & Drug services (**MHJHADS**) records;
- Canberra Health Service records
- Southern Cross Care records; and
- Coronial brief of evidence consisting of witness statements, scene photographs, ACAT records, GP records and some material arising from previous PTO proceedings.

12. A hearing for the inquest that was conducted on 2 July 2025. On that date the above information was tendered and received as an exhibit. Submissions were received from Counsel Assisting, Ms Xiao Lin King, who had been appointed as Counsel Assisting by me pursuant to section 72 of the Act. No other party or person sought leave to appear.

**FINDINGS**

*Background*

13. Peter was born in Newcastle (NSW) on 26 January 1947. He was 76 years old at the time of his death. Little is known about his early childhood and personal background. Since 2016, he was in the care of the Public Trustee and Guardian (**PTG**). Investigating police were unable to identify any surviving immediate family members.

14. The police report noted that Peter studied at Monash University where he obtained a Bachelor of Laws and Bachelor of Arts before working briefly as a solicitor. His mental health records confirm he reported to clinicians that he worked as a solicitor until his late 20's when his mental health began to deteriorate.

15. At the time of his death, Peter was a long-term resident at Southern Cross Aged Care Facility (**SCC**), 7 Boake Place, Garran in the ACT. As noted, Peter was under a PTO. He was also the subject of guardianship order made in November 2016. The PTG was named as his guardian.

*Mental Health and PTOs*

16. Peter's ACT mental health records date back to 1997 and consist of 2227 documents. His mental health started to deteriorate in his early 20's in the 1960's and he was diagnosed with schizophrenia soon after. It is likely Peter's early mental health treatment took place interstate in Victoria. Records were not obtained from Victoria.

17. Peter's schizophrenia was characterised by severe delusions and aggressive behaviour. It is not apparent from the records that alcohol or illicit substances played a role in his mental health struggles.

18. Peter first became subject to a PTO in the ACT in 1998. He was subject to more than 30 PTO's between then and his death. Under each of the PTOs, he was treated with antipsychotic medication. Historically it appears that Peters condition tended to stabilise with a consistent medication regime, supervised through the PTO process.

19. At the time of his death, Peter was managed by the Older Person Mental Health Team (**OPMH**) within Canberra Health Services. OPMH is described in publicly available on-line sources as a multidisciplinary team of psychiatrists, nurses and allied health staff offering services to older people experiencing moderate to severe symptoms of, or impacts from, their mental illness or suspected mental illness. His treatment plan involved fortnightly home visits (at SCC) from his case manager, with review by a psychiatrist every three months. In the period preceding his death, Peter's medication regime included Zuclopenthixol 150 mg fortnightly injections and olanzapine 7.5 mg daily.

20. His medical records indicate that in the period proximate to his death, Peter was compliant with his mental health medication and as a result, his mental health was generally stable.

*Physical Health*

21. Peter also suffered from significant physical health morbidities, including;

    - congestive cardiac failure (CCF) with an implanted pacemaker (2018),
    - type 2 respiratory failure,
    - morbid obesity,
    - osteoarthritis, hypertension,
    - type 2 diabetes,
    - recurrent leg ulcers; and
    - obstructive sleep apnoea.

22. In 2013, Peter moved to SCC due to 'decreasing mobility' caused by 'severe osteoarthritis degeneration in both knees. He remained a resident there until his death.

23. The medical records reflect a history of irregular heart rhythm and high blood pressure dating back to 2013. Over the course of his treatment, he was prescribed beta-blockers, anticoagulants and blood-pressure medication. He would often refuse to take these medications.

24. The records show that clinicians tried to monitor his cardiac function while on antipsychotic medication. It is known that antipsychotic medications can negatively affect heart function by increasing the risk of dangerous and potentially fatal heart rhythm disorders. Those medications can also contribute to heart failure, myocarditis,

and cardiomyopathy. Again, this monitoring (ECGs and blood pressure measurement) was often met with resistance from Peter.

25. In 2018, Peter had a pacemaker inserted to treat a 'complete heart block', (the electrical signals responsible for making his heartbeat became completely blocked.)

26. A diagnosis of congestive cardiac failure (CCF) appears in Peter's record from 2018 onwards. CCF is a progressive and often terminal disease. In general terms it occurs when the heart muscle becomes too weak or stiff to pump blood efficiently, leading to fluid and blood backing up in the body. The life expectancy of someone with this condition is generally 5 to 10 years from diagnosis.

27. In the period proximate to his death, Peter's physical health conditions were managed at SCC primarily by his long-term GP, and a consultant geriatrician at SCC.

28. Peter's medical records suggest that Peter's mental health and physical health condition contributed to him having a largely inactive lifestyle and severely limited his capacity for self-care. Peter communicated clearly to SCC staff that he did not want to socialise with anyone and preferred to stay in his room and order unhealthy foods for lunch. He would react aggressively if his food choices were not respected.

29. The records indicate Peter was about 120 kg at the time of his death.

*Palliative Care Path and Peter's Health Decline*

30. In March 2020, Peter was assessed by a Consultant Geriatrician who recommended (to his GP and PTG) a palliative approach to his ongoing care: He noted Peter:

    - was very resistant to receiving any personal care;
    - was not complaint with some of his medication including metoprolol (beta blocker);
    - had significantly declined in physical mobility and had been bed bound for months and was unlikely to walk again due to the level of his obesity;
    - was suffering from significant liver dysfunction but was strongly against further investigations or intervention.

31. The opinion of the geriatrician was that without further investigations or intervention Peter was very likely to further deteriorate and die. In his view, subjecting Peter to further investigation and intervention would likely cause him more distress.

32. In forming a view as to what directions should be given as to the future course of Peter's care PTG sought the input of his treating clinicians, including mental health team and palliative care clinicians. Peter's on-going refusal of treatment was considered. Peter's mental health team opined that they did not consider his decisions to refuse medical treatment to be driven by psychosis or delusion.

33. By 2022, Peter's health was so poor that he was 'bed bound' and hence required 'maximum assistance' from SCC staff for daily care tasks. He had recurrent hospital admissions for exacerbation of his CCF and respiratory type 2 failure.

34. On a number of occasions between 2020 and 2023, Peter was referred to the Palliative Aged Care Specialist team (**PEACE**) by SCC clinicians for 'goals of care' discussions.

35. On 16 May 2022, following a 'goals of care' conference involve PEACE clinicians, the GP, the SCC care coordinator and a PTG representative, an 'Advance Care Plan' in respect of Peter was developed. The plan recorded:

    - the current state of Peter's health was 'recurrent hospital transfer for exacb (sic) CCF, leg oedema, non-complaint with personal care/hygiene';

    - treatment wanted – management in SCC only by GP. Symptom management. Palliative approach to care; and

    - treatment not wanted – Not for CPR, not for hospital transfer.

36. An Advanced Care Plan was signed on 16 May 2022 by a nurse from PEACE on behalf of Peter as a non-competent person. Peter's GP reviewed and signed the plan on 9 June 2022. Anticipatory end of life (EOL) medications where prescribed by PEACE clinicians[1].

37. I find the decision made to formally move Peter to palliative care on 16 May 2022 to have been reasonable.

*Days preceding death*

38. On 2 February 2023, Peter was admitted to hospital for 'pneumonia and type 2 respiratory failure'. He was discharged to SCC on 6 February 2023. In hospital, clinicians provided comfort care (pain medication) and supplemental oxygen. At times during this admission, Peter was not expected to survive.

[1] Anticipatory medications are prescribed to patients nearing the end of life to ensure there is no delay in managing their symptoms e.g. pain, nausea and breathlessness.

39. Following discharge on 6 February 2023, Peter was continued on supplemental oxygen via nasal prongs at SCC. He continued to have episodes of low oxygen saturation.

40. On 5 May 2023, Peter's psychiatrist reviewed him at SCC for the purpose of an upcoming PTO extension hearing. This was the last psychiatrist review before his death. The reviewing psychiatrist noted:

    - Peter still does not believe he had schizophrenia and needed psychiatrist mental illness;
    - Mental state appears good. No evidence of ongoing positive psychiatrist symptoms currently;
    - Clear risk of physical and mental deterioration if Peter was to be a 'voluntary';
    - The plan was to apply for another PTO as it is necessary to preserve his health and wellbeing.

41. Peter continued to decline over the period before his death. The evidence suggests that his condition was adequately monitored and he was administered medication to alleviate his pain and distress. On the day of his death the Geriatric Rapid Acute Care Evaluation (**GRACE**) team attended at about 1030 hrs and assessed Peter for end-of-life care. His GP and PEACE clinicians where also involved in his care on that day. Peter died in the evening of 28 May 2023 at SCC.

**Findings pursuant to Section 52**

42. I find that Peter Vernon Wallace died on 29 May 2023 at Southern Cross Aged Care Facility.

43. The cause of Peter's death was congestive cardiac failure complicated by type 2 respiratory failure. Morbid obesity and type 2 diabetes were significant contributors to his death.

44. The manner of death was natural causes. Peter died from a combination of longstanding medical conditions, which were well known to his treating clinicians and had been subject to ongoing treatment and management throughout that time.

45. The treatment and management of Peter's multiple comorbidities was clinically and psychosocially complex. Clinicians took reasonable steps to assess, diagnosis and manage his conditions in light of the circumstances.

46. There are no matters of public safety that arises from the circumstances of Peter's death.

**Findings pursuant to Section 74**

47. In the course of my investigation, I caused the PTG to be asked as to whether the PTG held concerns about the standard of care Peter received when subject to guardianship order. PTG advised that Peter's unwellness and decline was well known to them. PTG was complimentary in respect of Peter's care providers including SCC . The opinion of PTG was that Peter was able to make informed choices about his medical care. His GP communicated those choices to PTG.

48. The direct cause of Peter's death is not associated with the treatment of his mental health condition which justified the making of the PTO. I do not find that any aspect of the care, treatment and supervision of Peter while subject to a PTO contributed to the cause of his death.

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

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

Associate: Ella Mansfield

Date: 11 June 2026