FINDINGS of Coroner Olivia McTaggart following the holding of an inquest under the *Coroners Act* 1995 into the death of:

MATHEW LESLIE McCOY

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Record of Investigation into Death (With Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Olivia McTaggart, Coroner, having investigated the death of Mathew Leslie McCoy, with an inquest held at Hobart in Tasmania, make the following findings:

Hearing Dates

3 December 2021

Representation

Assisting the Coroner: Sergeant D Orr

Introduction

1. Mathew Leslie McCoy, aged 27 years, died on 30 December 2018.

2. At the time of his death, Mr McCoy was the subject of a Treatment Order under the *Mental Health Act* 2013 as a result of suffering schizophrenia. The Treatment Order was made on 23 October 2018 and was due to expire 22 April 2019. The order authorised that Mr McCoy was liable to be admitted and, if necessary, detained in an approved facility for the purpose of receiving treatment; to take prescribed medication; to submit to standard regular medical review, urine and/or blood tests as directed; and attend appointments (including home visits) from Adult Community Mental Health Services staff and his case manager.

3. Section 24(1)(b) of the *Coroners Act* 1995 (the Act) makes an inquest mandatory where a deceased person is a 'person held in care.' A person who is 'held in care' is defined as a "person detained or liable to be detained in an approved hospital within the meaning of the *Mental Health Act* 2013." At the time of his death, the Treatment Order authorised Mr McCoy's admission and detention within an approved facility for the purpose of treatment. At the time of his death, there had not been an actual decision made to detain him in an approved hospital and he was being monitored and treated whilst living at home.

4. Whether there is a requirement to hold a mandatory inquest in cases where a deceased person is living in the community but purportedly complying with the terms of a Treatment Order, is not without difficulty and presents as a matter for future

consideration. I have determined that, in this case, it was appropriate to proceed on the basis that Mr McCoy was liable to be detained in an approved facility and therefore was a 'person held in care.'

Evidence tendered at Inquest

5. I have had regard to evidence obtained in the investigation into the death of Mr McCoy. The evidence comprises the following.

- Police Report of Death;
- Affidavits confirming life extinct and identification;
- Post-mortem report of Dr Donald Ritchey, State Forensic Pathologist;
- Toxicology report of Mr Neil McLachlan-Troup, forensic scientist;
- Review of Mr McCoy's treatment by Dr Anthony Bell, coronial medical consultant;
- Affidavit of Constable Toby Skeels, investigating officer;
- Affidavit (with photographs) of Constable Matthew Streat, forensic services officer;
- Affidavit of the President of the Mental Health Tribunal;
- Current Treatment Order;
- Affidavit of Jacquelynn Doble, mother of Mr McCoy;
- Affidavit of Stephen Harwood, Valern Hotel manager;
- Affidavit of Jayson Reeve, cleaner at the Valern Hotel who found Mr McCoy deceased;
- Interim Administration Order – Guardianship and Administration Board;
- Phone records;
- Medical records and reports; and
- Photographic and video evidence.

Background

6. Mathew Leslie McCoy was born on 12 March 1991 and was 27 years of age at the time of his death. Mr McCoy lived alone in a unit in Glenorchy. He was not married and did not have any children. He is the youngest child of Ms Jacquelynn Doble.

7. He suffered from schizophrenia from his early teenage years up to his death. Ms Doble, his mother considered that his use of cannabis at that time contributed to the severity of his illness. Further, Ms Doble believed that he was significantly affected by the death of his brother who died by suicide when Mr McCoy was sixteen years of age. She said that, before he became ill, her son was an active and hard-working person.

8. Mr McCoy was hospitalised several times in his early twenties as he sought treatment for his condition.

9. In her affidavit for the investigation, Ms Doble described the difficulties she experienced in caring for her son and the progress of his illness. She said that she would see him responding to voices which were in his head and, whilst in such a delusional state, would often become aggressive and violent. She said that she previously had Mr McCoy living with her but as his violent behaviour increased she was unable to have him living at home. She described episodes of Mr McCoy punching holes in walls and windows and exhibiting violence towards their pet dog in response to delusional ideas. She said that he did not ever speak of harming himself. She described her son's periods of hospitalisation, which assisted his condition, although when he was not in hospital he was inconsistent in taking his medication. She noticed that his delusions would dissipate when he took his medication as prescribed.

10. Ms Doble described Mr McCoy's deterioration in his mental health before his death. She said that he was not capable of properly looking after himself. He became forgetful, his unit was filthy and he often had no food in the fridge. He was unable to work and was in receipt of a disability support pension. He still had uncontrollable outbursts. Ms Doble would check on him regularly, particularly as he was isolated and did not have friends. She said that, several weeks before his death, she saw him experience an episode of seizures, after which he asked Ms Doble to remember his name and to remember *him*. This caused her to wonder if he could feel that his health was failing as it was strange behaviour, even for him.

Treatment and care before death

11. Mr McCoy was on a Treatment Order under the *Mental Health Act* 2013 to manage his severe mental health issues. He was also subject to an Administration Order by the Guardianship and Administration Tribunal for management of his finances.

12. On 9 October 2018, a community mental health nurse attended Mr McCoy's home and noted that he was not taking his antipsychotic medication, clozapine, as he should

have been. The evidence in the coronial investigation indicates that he had not taken his prescription medication at all or as prescribed for some months before his death.

13. On 17 October 2018, Mr McCoy was taken by police to the Royal Hobart Hospital for assessment. Neighbours had notified police with concerns regarding his behaviour and there was concern about his non-compliance with medication. Upon admission, he also tested positive for THC (cannabis).

14. Mr McCoy was an inpatient for 16 days. Whilst in hospital, he was provided with a safe and supportive environment and was regularly administered clozapine, paliperidone (by depot injection), and olanzapine to treat his illness. He was discharged home on 2 November 2018, subject to the Treatment Order, with prescriptions for his medication and arrangements for monitoring and treating him, and transporting him to necessary appointments.

15. By 19 November 2018 it was apparent that Mr McCoy was avoiding contact with his mental health professionals, was missing appointments, and refusing treatment. It was recorded by his reviewing psychiatrist on that date that he was in breach of the Treatment Order and would need to be taken back to the Department of Psychiatry at the Royal Hobart Hospital for admission. Arrangements for this to occur were commenced. However, over the next several days, Mr McCoy told health professionals visiting him at home that he would agree to have his bloods taken as required and to have his depot antipsychotic medication administered. Mr McCoy did attend for administration of his depot medication but his treating health professionals continued to have concerns regarding his condition and reluctance to be treated. At a Multidisciplinary Team Clinical Review on 27 November 2018, his treating team expressed the view that his risks would not be mitigated by a further hospital admission and they would await his psychiatrist's review. In late November, Mr McCoy improved his level of engagement and compliance with depot injections and blood-taking. His psychiatrist assessed him on 14 December as having an improved mental state, being much less paranoid and suspicious. After this review, Mr McCoy continued to comply with his requirement for weekly blood tests and transportation to his depot injections.

16. On 28 December 2018, Mr McCoy was transported by a clinical nurse consultant to the clozapine clinic where his medications were administered. He also underwent his routine blood test. On that day he presented as pleasant, easily engaged and with minimal irritability. On one occasion during the day he was observed to be talking to himself and laughing, apparently responding to internal stimuli. A plan was made for

Mr McCoy to have his bloods taken on 2 January 2019 and medications administered at the clozapine clinic on 3 January 2019.

17. The evidence does not allow me to determine Mr McCoy's movements between 28 December and early in the morning of 30 December 2018 when he was seen alive just before his death in the surrounds of the Valern Hotel.

Circumstances of death

18. On 30 December 2018 Mr Jayson Reeve arrived at the Valern Hotel at 5.40am to begin his work day as a cleaner at the hotel. Upon arriving, he discovered a male person lying on his back in the carpark of the hotel. He was unresponsive and appeared to be deceased. Mr Reeve notified police and officers attended a short time later.

19. The attending officers observed the deceased male laying at an awkward angle with some fluid dried around his head area. There was a phone next to him, but no other property or forms of identification. The police were able to identify the man as Mr Mathew McCoy by using the phone. Mr McCoy was later formally identified by his mother at the Royal Hobart Hospital. A thorough coronial investigation into Mr McCoy's death followed.

20. Mr Stephen Harwood, manager of the Valern Hotel, stated in his affidavit for the investigation that he saw Mr McCoy at 3.00am when he was leaving work. He observed Mr McCoy sitting against a wall, then getting up and walking towards Station Street. There was no indication that Mr McCoy was unwell or having any difficulty at that stage.

21. A review of CCTV footage from the Valern Hotel revealed Mr McCoy's action prior to his death. He was filmed in the carpark walking around and appearing to collect items from the ground. He is then seen to sit down and subsequently to lay down. He is seen to remain lying in that position until he is found by Mr Reeve. He does not appear to be in distress. I note that Mr McCoy lived one kilometre away from the hotel, within easy walking distance.

22. At the scene police identified no signs of violence to the body of Mr McCoy or anything to indicate that another person was involved in his death.

Evidence from autopsy and toxicology testing

23. Experienced forensic pathologist, Dr Donald Ritchey, performed an autopsy upon Mr McCoy. At autopsy, Dr Ritchey was unable to detect any anatomical cause of death. Mr McCoy did not have any significant cardiac disease or pulmonary embolism (blood clot) that would account for his sudden death. There was no sign of injuries to suggest any violence had occurred to Mr McCoy that would account for death.

24. Toxicological analysis of samples taken from Mr McCoy indicate that he had significant blood alcohol level (0.095 g/100mL) and therapeutic levels of his prescribed medication (clozapine, risperidone, and olanzapine) in his system. However, these substances, either alone or in combination, would not account for death. Although Dr Ritchey was unable to positively determine the cause of death, he indicated that the most likely cause was cardiac arrhythmia in the setting of schizophrenia and antipsychotic medications interacting with alcohol.

25. Dr Ritchey stated that a less likely possibility to account for death is that Mr McCoy had ingested an illicit drug that could not be identified by routine testing at Forensic Science Service Tasmania. At inquest, Ms Doble told the court that she had not known Mr McCoy to use illicit drugs (apart from cannabis) and she believed it was unlikely that any other substance was present in his system at the time of his death.

26. I agree that it is much more likely that Mr McCoy suffered a cardiac arrhythmia than toxicity caused by an unidentified drug. Nevertheless, I cannot rule out the latter as a possible cause of death. I am satisfied that there are no suspicious circumstances associated with his death, that he did not die due to trauma, and that he did not die as a result of suicide.

Comment upon Mr McCoy's care, supervision and treatment pursuant to section 28(5) of the Act

27. Dr Anthony Bell, coronial medical consultant, reviewed Mr McCoy's treatment and care as part of the coronial investigation. In his report, he commented that Mr McCoy had appropriate follow-up appointments for patients taking clozapine, including regular electrocardiograms (ECG) and echocardiograms. I accept the opinion of Dr Bell in this regard.

28. The medical records also indicate that Mr McCoy was monitored appropriately in the community while he was subject to the Treatment Order. He was visited at home on a regular basis by his case manager and others and encouraged to comply with all

aspects of his treatment regime. His treating team were aware of the risk posed by Mr McCoy if he did not take his medication. His non-compliance and lack of engagement with his treatment and with his health professionals following his discharge from hospital prompted discussion concerning preparations to return him to hospital. It was, however, considered that a hospital admission may not resolve the ongoing issues associated with Mr McCoy's serious illness. Mr McCoy subsequently engaged in his treatment and appointments sufficiently to remain in the community, albeit with close monitoring. I am of the view that the approach adopted by Mr McCoy's mental health team was sound and reasonable in the circumstances, and showed a willingness to return him to hospital if his illness became significantly worse. I do not consider that any more could have been reasonably done by his health professionals to improve his condition.

Formal findings required by section 28(1) of the *Coroners Act* 1995:

a) The identity of the deceased is Mathew Leslie McCoy;

b) Mathew Leslie McCoy died in the circumstances set out in this finding;

c) The cause of Mathew Leslie McCoy's death cannot be determined; and

d) Mathew Leslie McCoy died on 30 December 2018 at Hobart in Tasmania.

Acknowledgements

I extend my appreciation to Sergeant Darren Orr who completed the investigation in this matter and appeared to assist me at inquest.

I particularly acknowledge the efforts by Ms Doble to care for her son over many years despite the difficulties presented by his severe illness.

I convey my sincere condolences to the family and loved ones of Mathew Leslie McCoy.

Dated: 10 December 2021 at Hobart in the State of Tasmania

Olivia McTaggart
Coroner