MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Simon Cooper, Coroner, having investigated the death of Mervyn Roy Menzies

Find, pursuant to Section 28(1) of the *Coroners Act* 1995, that

a) The identity of the deceased is Mervyn Roy Menzies;
b) Mr Menzies died in the circumstances set out further in this finding;
c) The cause of Mr Menzies' death was aspiration pneumonia; and
d) Mr Menzies died on 12 July 2020 at the Royal Hobart Hospital, Hobart, Tasmania.

In making the above findings I have had regard to the evidence gained in the investigation into Mr Menzies' death. The evidence includes:

- Police Report of Death for the Coroner;
- Tasmanian Health Service – Death Report to Coroner;
- The Tasmanian Health Service – Medical Certification of Cause of Death;
- Comments on Passing Sentence – Evans J – 23 April 2008;
- Comments on Passing Sentence – Evans J – 5 November 2010;
- Affidavit of Victor Menzies, sworn 31 January 2021;
- Report – Dr Anthony J Bell, Medical Advisor to the Coronial Division;
- Records – Lifestyle Solutions; and
- Records – Tasmanian Health Service.

Mr Menzies was born with intellectual and physical disabilities. He spent most of his life living in institutions. At the time of his death he was living in a care home.

Mr Menzies' legal status

Mr Menzies' legal status was that he was the subject of a supervision order made by Evans J on 5 November 2010 pursuant to the *Criminal Justice (Mental Impairment) Act* 1995. The terms of that order were as follows:

1. *That Mr Menzies reside at a place of residence or supervised accommodation as directed by the Chief Forensic Psychiatrist (or delegate) and not change that place of residence without the prior permission of the Chief Forensic Psychiatrist (or delegate), and comply with any plan for his support put in place by the Chief Forensic Psychiatrist (or delegate).*
2. *That Mr Menzies comply with all house rules at the place of residence or supervised accommodation.*
3. *That Mr Menzies engage in structured activities as per his support plan and comply with all reasonable directions made by staff and others involved in supervising that support plan.*
4. *That at all times when Mr Menzies is not engaged in structured activities he remain with and comply with reasonable directions of the person responsible for his direct supervision at that time.*
5. *That he attend all appointments with medical and other health staff and allow medial [sic] and health staff to visit him in the community.*
6. *That he abstain from alcohol unless prior permission is given by the Chief Forensic Psychiatrist (or delegate).*
7. *That he not take substances of abuse.*
8. *That he take medication and drugs as directed by the Chief Forensic Psychiatrist (or delegate).*
9. *That he not approach young children and other vulnerable people unless directly supervised and with prior consent of his supervisors.*
10. *That the Chief Forensic Psychiatrist (or delegate) can grant permission for the provision of personal information about the applicant and such other information as is necessary to third parties for the purposes of enabling his supervision and care and to minimise the risk to the public.*

The *Coroners Act* 1995 (section 3) defines a 'person held in care' as meaning, relevantly:

> "*A person detained or liable to be detained in an approved hospital within the meaning of the Mental Health Act 2013 or in a secure mental health unit or another place while in the custody of the controlling authority of a secure mental health unit, within the meaning of that Act*".

I do not consider that Mr Menzies was a person held in care within the meaning of the *Coroners Act* 1995. He was not detained in an approved hospital or secure mental health unit at the time of his death.

He was not, as a matter of law, liable to be detained in such a place at the time of his death.

Under the terms of the *Criminal Justice (Mental Impairment) Act* 1999, Mr Menzies was several steps away from being detained. Section 31 of that *Act* deals with the circumstances in which a person under a supervision order may be apprehended and dealt with in accordance with the law. That section provides that a prescribed person (which includes the Chief Forensic Psychiatrist, mental health officers and police officers amongst others) may apprehend a defendant who is the subject of a supervision order if the prescribed person "believes on reasonable grounds" that contravention or likely contravention of the supervision order has or is likely to occur or that there has been a serious deterioration in a defendant's mental health.

Only after a person the subject of a supervision order has been apprehended (and that may only occur in the circumstances set out immediately above) is the defendant lawfully able to be taken and held in an approved hospital or secure mental health unit.

In my view, it is not until a person the subject of a supervision order is apprehended, lawfully, pursuant to section 31 of the *Criminal Justice (Mental Impairment) Act* 1999 that she or he becomes a 'person held in care' in terms of the *Coroners Act* 1995.

Mr Menzies therefore was not 'held in care' at the time of his death. It follows by reason of the operation of section 24 of the *Coroners Act* 1995 that there is no obligation on my part to hold an inquest in relation to Mr Menzies' death. In addition, I do not consider there would be any benefit in holding an inquest in the circumstances. No additional witnesses are likely to come forward if an inquest is held and the circumstances of Mr Menzies' death are clear.

Nonetheless, it is necessary to examine the circumstances in which he died.

Circumstances of death

On 6 July 2020 Mr Menzies awoke feeling unwell and was taken to the Royal Hobart Hospital. The history given at the hospital by a carer was that he had become unwell approximately two days earlier with fever and had experienced difficulty swallowing. He was assessed and dehydration, acute on chronic renal failure and bacterial infection were identified. A COVID 19 test was negative.

A CT scan of Mr Menzies' chest showed multifocal opacity in the left lung more prominent in the left lower lobe.

It was apparent that he was suffering from pneumonia. His condition continued to deteriorate over the next few days.

By 9 July 2020 Mr Menzies was critically ill and in obvious distress. A decision was made to change his care to palliative. He settled and died a few days later.

Investigation

The fact of Mr Menzies' death was reported to me by the Royal Hobart Hospital. I had his treatment and care reviewed by Dr Anthony J Bell (MB BS MD FRACP FCICM), the Medical Advisor to the Coronial Division. Dr Bell provided a report in which he expressed the opinion that the cause of Mr Menzies' death was severe pneumonia. This was consistent with the information received from the Tasmanian Health Service in both its report of death and the Medical Certification of Cause of Death. I am satisfied that Mr Menzies died because of pneumonia.

Dr Bell reviewed Mr Menzies' treatment at both Lifestyle Solutions and the Royal Hobart Hospital. He said, and I also accept, that "the care provided to [Mr Menzies] was a good standard for many years".

Comments and Recommendations

The circumstances of Mr Menzies' death are not such as to require me to make any comments or recommendations pursuant to Section 28 of the *Coroners Act* 1995.

Dated 27 July 2021 at Hobart in the State of Tasmania.

Simon Cooper
Coroner