IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 006881

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

*Section 67 of the **Coroners Act 2008***

Findings of:	Coroner David Ryan
Deceased:	Matthew James Howarth
Date of birth:	19 June 1996
Date of death:	1 December 2022
Cause of death:	Coronary artery atherosclerosis in the setting of schizoaffective disorder
Place of death:	Sovereign House, 1 Drummond Street North, Ballarat Central, Victoria
Keywords:	In care – Natural causes

INTRODUCTION

1. On 1 December 2022, Matthew James Howarth was 26 years old when he was located deceased at an inpatient mental health facility in Ballarat.

BACKGROUND

2. Matthew's medical history included schizoaffective disorder and a history of polysubstance abuse for which he had participated in suboxone and methadone programs in the past. He also had a long history of receiving treatment in the community from Grampians Health. Over the years, the treatment of Matthew's mental health required a number of hospital admissions and he also had periods of homelessness. He was in receipt of a Disability Support Pension which was managed by the State Trustees and he was supported through the National Disability Insurance Scheme.

3. On 16 November 2022, Matthew was involuntarily admitted to the Grampians Mental Health Adult Acute Unit in Ballarat because he was displaying psychotic symptoms and behaviours. His management and care were subject to treatment orders made under the *Mental Health Act 2014* (**the MH Act**). He was regularly reviewed by health clinicians during his stay and was prescribed medication including zuclopenthixol, olanzapine, sodium valproate and diazepam.

4. On 25 November 2022, after his condition had stabilised, Matthew was transferred to Sovereign House, a Secure Extended Care Unit in Ballarat. On 29 November 2022, his olanzapine was replaced with quetiapine. He was also commenced on suboxone which required close supervision as it appeared to affect his oxygen saturation.

5. On 27 November 2022, Matthew commenced daily periods of supervised leave. There were no issues of concern that were reported during these periods of leave.

THE CORONIAL INVESTIGATION

6. Matthew's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

7. The death of a person in care or custody is a mandatory report to the coroner, even if the death appears to have been from natural causes. Matthew was a person in care at the time of her death as he was a person detained in a designated mental health service within the meaning of the *Mental Health Act 2014* pursuant to the relevant definition in section 3(1) of the Act.

However, an inquest was not required to be held pursuant to section 52(3A) of the Act given that Matthew's death was from natural causes.

8. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

9. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

10. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Matthew's death. The Coronial Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

11. This finding draws on the totality of the coronial investigation into the death of Matthew James Howarth including evidence contained in the coronial brief. While I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[1]

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

12. On 1 December 2022 at 6.00am, Matthew was observed in bed by staff and was noted to be asleep with audible respiratory sounds. Similar observations were made by staff at around 7.15am.

13. At 8.20am, Matthew was observed by staff to be unresponsive in bed. Emergency services were contacted and cardiopulmonary resuscitation (**CPR**) was commenced and he was

[1] Subject to the principles enunciated in Briginshaw v Briginshaw (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

administered naloxone. Despite the best efforts of first responders, Matthew could not be revived and he was pronounced deceased at 9.45am.

Identity of the deceased

14. On 8 December 2022, Matthew James Howarth, born 19 June 1996, was identified via fingerprint identification.

15. Identity is not in dispute and requires no further investigation.

Medical cause of death

16. Forensic Pathologist Dr Victoria Francis from the Victorian Institute of Forensic Medicine performed an autopsy on 9 December 2022 and provided a written report of her findings dated 7 August 2023.

17. The autopsy revealed severe coronary artery atherosclerosis which can lead to sudden death. Dr Francis also noted that people with schizoaffective disorder have an increased risk of death.

18. Toxicological analysis of post-mortem samples identified the presence of diazepam (and its metabolite),[2] valproic acid,[3] quetiapine,[4] zuclopenthixol,[5] olanzapine[6] and naloxone.[7]

19. Dr Francis provided an opinion that the medical cause of death was *1(a) Coronary artery atherosclerosis in the setting of schizoaffective disorder*. She also expressed the opinion that the death was due to natural causes.

20. I accept Dr Francis' opinion.

[2] Diazepam is a benzodiazepine derivative indicated for anxiety, muscle relaxation and seizures.
[3] Valproic acid is indicated for epilepsy, and as an adjunct in mania and schizophrenia where other therapy is inadequate.
[4] Quetiapine is an antipsychotic drug.
[5] Zuclopenthixol is indicated for schizophrenia.
[6] Olanzapine is an antipsychotic drug.
[7] Naloxone is a synthetic opioid antagonist that is used for the treatment of opioid dependency by preventing or reversing the adverse effects including respiratory depression, sedation and hypotension.

FINDINGS AND CONCLUSION

21. Pursuant to section 67(1) of the Act, I make the following findings:

    a) the identity of the deceased was Matthew James Howarth, born 19 June 1996;

    b) the death occurred on 1 December 2022 at Sovereign House, 1 Drummond Street North, Ballarat Central, Victoria, from coronary artery atherosclerosis in the setting of schizoaffective disorder; and

    c) the death occurred in the circumstances described above.

22. As noted above, Matthew's death was reportable by virtue of section 4(2)(c) of the Act because, immediately before her death, he was a person placed in care as defined in section 3 of the Act. Section 52 of the Act requires an inquest to be held, except in circumstances where someone is deemed to have died from natural causes. In the circumstances, I am satisfied that Matthew died from natural causes and that no further investigation is required. Accordingly, I exercise my discretion under section 52(3A) of the Act not to hold an inquest into his death.

I convey my sincere condolences to Matthew's family for their loss.

Pursuant to section 73(1B) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

I direct that a copy of this finding be provided to the following:

Michael Howarth, Senior Next of Kin

Melinda Joyce, Senior Next of Kin

WorkSafe Victoria

Ballarat Health Services

Grampians Health

Ryan Craig

Senior Constable Mitchell Kohn, Coronial Investigator

Signature:

Coroner David Ryan

Date: 23 January 2025

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.