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

**Michael Richard Meerman**

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# Record of Investigation into Death (With Inquest)

*Coroners Act 1995*  
*Coroners Rules 2006*  
*Rule 11*

I, Andrew McKee, Coroner, having investigated the death of Michael Richard Meerman with an inquest held at Hobart in Tasmania make the following findings.

## Hearing Date

17 June 2021

## Representation

Counsel Assisting the Coroner: Senior Constable A Barnes

## Introduction

Mr Meerman died between 16 February and the 26 February 2019 at Unit 2/6 Dossiter Street, Bellerive. At the time of his death Mr Meerman was the subject of a Treatment Order made pursuant to the *Mental Health Act 2013* (the MH Act) on 21 December 2018. The order expired on 20 June 2019. On 20 February 2019 the order was reviewed pursuant to Section 181 of the MH Act.

The order was in the following terms

This Treatment Order:

- (a) Is authority for the patient to be admitted and if necessary to be detained in an approved facility for the purposes of receiving treatment; and
- (b) Authorises a combination of treatment settings and for the admission or readmission of the patient to those settings, this includes treatment in the community.

## The Mental Health Tribunal:

- varies the Treatment Order

The Treatment Order is varied as follows:

*removal of mood stabilising medication*

## Mental Health Tribunal authorised treatment:

- I. The patient is to take the following medication (depending on clinical indication):
  - a. Anti-psychotic medication
  - b. Benzodiazepine medication
  - c. Anti-cholinergic medication for treatment of any extrapyramidal side effects

from taking anti-psychotic medication

All medication is to be taken either orally and/or by intra-muscular injection and/or by depot injection as prescribed by a treating psychiatrist within clinical guidelines, with dosages adjusted according to clinical response and tolerability.

2. The patient is required to undergo standard medical and/or blood tests, as well as physical and radiological examinations as clinically indicated and as directed to by the treating team.
3. When in the community, the patient is required to attend appointments at Adult Community Mental Health Services and including home visits from the Adult Community Mental Health Service team and/or Case Manager.

Mr Meerman's death is subject to the *Coroners Act 1995* (the Act). The Act provides that an inquest must be held where a death occurs in Tasmania and the deceased person immediately before their death was a person held in care (Section 24 (10) (b) of the Act.)

Section 3 of the Act defines a person held in care as follows:

**Person held in care** means –

- (a) a child, within the meaning of the [Children, Young Persons and Their Families Act 1997](#), in the custody or under the guardianship of the Secretary, within the meaning of that Act;
- (b) 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;

The treatment order provides that Mr Meerman could, if necessary, be detained in an approved facility for the purpose of receiving treatment.

An approved facility is defined at Section 3 of the MH Act in the following terms:

“Approved Facility means an approved hospital, an approved assessment centre or a secure mental health facility.”

The Treatment Order enabling detention in an approved facility means that Mr Meerman was liable to be detained in the facilities identified in the definition of a person held in care pursuant to Section 3 of the Act.

I am therefore satisfied Mr Meerman was a person held in care at the date of his death and as such an inquest into his death was mandatory. The investigation and inquest focused upon his care, treatment and supervision whilst he was subject to that order.

In making the findings below I am satisfied that this matter was comprehensively investigated and the relevant issues have been fully explored. I have taken into account and considered the evidence tendered at the Inquest namely:

- C1 - Subject Report
- C2 - Police Report of Death;
- C3 - Life Extinct, Dr Mykkanen;
- C4 - Affidavit of Identification, Constable Rennie;
- C5 - Affidavit of identification, A Cordwell;
- C6 - Post-mortem report by Forensic Pathologist, Dr C Lawrence;
- C7 – Toxicology Report, Mr Neil McLachlan-Troup;
- C8 - Medical Records – Royal Hobart Hospital;
- C9 - Affidavit of Linda Meerman;
- C10 - Affidavit of Phillip Seward;
- C11 - Affidavit of Carly Kirrane;
- C12 - Affidavit of Cindy Gallagher;
- C13 - Affidavit of Paul Borish;
- C14 - Affidavit of Sasm Shinnick;
- C15 - Affidavit of Constable Rennie;
- C16 - Affidavit of Constable Hinchin;
- C17 - Affidavit of Constable Sansom;
- C18 - Affidavit of Constable Lea;
- C19 - Affidavit and photographs, Constable Turner;
- C20 - Property Receipts;
- C21 – Guardianship Order Records;
- C22 - Treatment Order;
- C23 - Rental Inspection Photographs; and
- C24 - Medical Report, Dr Bell.

Having regard to the evidence I make the following findings pursuant to Section 28(1) of the *Coroners Act 1995*:

- a) The identity of the deceased is Michael Richard Meerman;
- b) Mr Meerman died in the circumstances set out in this finding;
- c) The cause of Mr Meerman's death was ischaemic heart disease; and
- d) Mr Meerman died between 16 February and 26 February 2019 at 2/6 Dossiter Street, Bellerive.

## **Background**

Mr Meerman was born on 7 November 1946 in Huntingdale, Victoria and was 72 years of age at the date of his death.

Mr Meerman grew up in Huntingdale, Victoria. He was the eldest child of Margaret Meerman. Mr Meerman was born prior to Mrs Meerman's marriage to Leon Meerman. Their marriage produced three children. As such Mr Meerman had three half siblings.

Mr Meerman was subjected to family violence as a child. He ceased living with his mother and step-father and began residing with his grandparents.

Mr Meerman moved to New Zealand in his twenties. He was employed as a firefighter. He returned to Australia around the age of thirty. He resided in temporary accommodation. In 1983 he ceased contact with his family and moved to Tasmania.

Mr Meerman was a recluse. He did not have any friends or associates. He resided alone in his unit. He had limited interaction with his neighbours.

### **Mr Meerman's Health**

Mr Meerman's medical records have been tendered as exhibit C8.

Mr Meerman had been diagnosed with schizophrenia. He was resistant to treatment and had been the subject of a number of treatment orders made pursuant to the Mental Health Act. Mr Meerman had also been diagnosed with diabetes.

An affidavit sworn by Ms C Kirrane, Mr Meerman's case manager who is also a mental health nurse details her interactions with Mr Meerman.

Ms Kirrane has expressed the view that Mr Meerman had no insight into his illness and did not believe he had schizophrenia. He held a belief that he did not require medication.

In late November 2018 Mr Meerman's landlord Housing Tasmania received a complaint regarding the condition of his unit. An inspection of the unit concluded that it was in an unclean state.

Officers of Housing Tasmania contacted mental health services and Ms Kirrane attended upon Mr Meerman. At that time he was not the subject of any Treatment Order.

In 2018 Mr Meerman was made subject to the order dated 21 December 2018. He was admitted to the psychiatric intensive care unit and later discharged to Tolosa Street Mental Health Facility.

A Guardianship and Administration Order was made on the 11 February 2019 appointing the Public Guardian as Mr Meerman's administrator.

Mr Meerman was discharged from that facility. He returned to his unit and was undergoing treatment with Ms Kirrane visiting him weekly to review his mental health and blood sugar levels. Ms Kirrane administered anti-psychotic medication to Mr Meerman by way of injection on the 31 January 2019. That medication was administered monthly.

Mr Meerman was last visited by Ms Kirrane on the 13 February 2019. During that visit she was satisfied as to his physical and mental health.

Pursuant to Section 28(5) of the Act I am required to report on the care and treatment of Mr Meerman.

Dr A Bell, an experienced medical practitioner has reviewed the care and treatment provided to Mr Meerman. In a report dated 14 April 2021 Dr Bell opined that the care and treatment of Mr Meerman was of a good standard. I accept Dr Bell's opinion.

### **Circumstances Leading to Mr Meerman's Death**

Mr Meerman was last seen by his neighbour on 16 February 2019. Bank records indicate Mr Meerman withdrew monies from an ATM at Salamanca Place.

Ms Kirrane attended Mr Meerman's property on 23 February 2019. She knocked on his door but he did not answer. Ms Kirrane did not view this as unusual as Mr Meerman would often go out during the day.

On 26 February Mrs Kirrane was contacted by Mr Meerman's neighbour. He indicated that he had not sighted Mr Meerman for a number of days.

Ms Kirrane attended Mr Meerman's home. When he did not answer the door she made arrangements for Housing Tasmania to grant her access to the property.

Upon entering the property Mr Meerman was located deceased in his bedroom.

Ms Kirrane contacted Tasmania Police. They attended and arranged for Mr Meerman to be transported to the morgue.

Mr Meerman was identified by Ms Kirrane.

### **Post Mortem Examination**

A post mortem examination was conducted by Forensic Pathologist, Dr C Lawrence. Dr Lawrence provided the following opinion as to Mr Meerman's cause of death:

*"This 72 year old man, Michael Richard Meerman, died as a consequence of ischaemic heart disease due to right coronary artery thrombus and unstable plaque. Other significant conditions include schizophrenia.*

*The deceased has a long history of chronic schizophrenia. He also has diabetes which is poorly controlled. He was found deceased in a decomposed state.*

*Autopsy confirms the presence of ischaemic heart disease with an unstable plaque in the right coronary artery with a thrombus. The heart is enlarged, weighing 565 grams.*

*Toxicology reveals therapeutic medications."*

I accept Dr Lawrence's opinion as to Mr Meerman's cause of death. I am satisfied Mr Meerman died of natural causes.

### **Comments and Recommendations**

The evidence at the inquest outlined an appropriate standard of care for Mr Meerman.

The care and treatment provided to him was entirely appropriate in the circumstances.

There is no need for me to make any other comments or recommendations.

I extend my condolences to the family of Mr Meerman.

**Dated:** 2021 at Hobart in the State of Tasmania.

**Andrew McKee**  
**Coroner**