

# **ACT CORONERS COURT**

## **ANNUAL REPORT 2017/18**

[Coroners Act, section 102]



Counselling Room, the ACT Forensic Medicine Centre, Phillip

**Issued at the direction of  
Chief Coroner Lorraine Walker**

**16 October 2018**

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**Coroners Act 1997 (excerpt)**

**s102      Annual report of court**

- (1) The Chief Coroner must give a report relating to the activities of the court during each financial year to the Attorney-General for presentation to the Legislative Assembly.
- (2) The report must include particulars of—
  - (a) reports prepared by coroners into deaths in custody and findings contained in the reports; and
  - (b) notices given under section 34A(3) (Decision not to conduct hearing); and
  - (c) recommendations made under section 57(3) (Report after inquest or inquiry); and
  - (d) responses of agencies under section 76 (Response to reports) including correspondence about the responses.
- (3) The Chief Coroner must give the report to the Attorney-General as soon as practicable after the end of the financial year and, in any event, within 6 months after the end of the financial year.
- (4) If the Chief Coroner considers that it will not be reasonably practicable to comply with subsection (3), the Chief Coroner may within that period apply, in writing, to the Attorney-General for an extension of the period.
- (5) The application must include a statement of reasons for the extension.
- (6) The Attorney-General may give the extension (if any) the Attorney-General considers reasonable in the circumstances.
- (7) If the Attorney-General gives an extension, the Attorney-General must present to the Legislative Assembly, within 3 sitting days after the day the extension is given—
  - (a) a copy of the application given to the Attorney-General under subsection (4); and
  - (b) a statement by the Attorney-General stating the extension given and the Attorney-General's reasons for giving the extension.
- (8) The Attorney-General must present a copy of a report under this section to the Legislative Assembly within 6 sitting days after the day the Attorney-General receives the report.
- (9) If the Chief Coroner fails to give a report to the Attorney-General in accordance with this section, the Chief Coroner must give the Attorney-General a written statement explaining why the report was not given to the Attorney-General.
- (10) The statement must be given to the Attorney-General within 14 days after the end of the period within which the report was required to be given to the Attorney-General.
- (11) The Attorney-General must present a copy of the statement to the Legislative Assembly within 3 sitting days after the day the Attorney-General receives the statement.

## **WORKLOAD STATISTICS**

### **Cases Lodged**

The number of referrals received increased again this year: see Table 1.

<b>Table 1: Cases Lodged</b>						
Type	<b>2017/18</b>	2016/17	2015/16	2014/15	2013/14	2012/13
Deaths	<b>305</b>	299	291	290	295	324
Fires	<b>3</b>	0	1	683	846	1014
Disasters	<b>0</b>	0	0	0	0	0
<i>Total Cases</i>	<b>308</b>	299	292	973	1141	1338

Of note the Court received reports of:

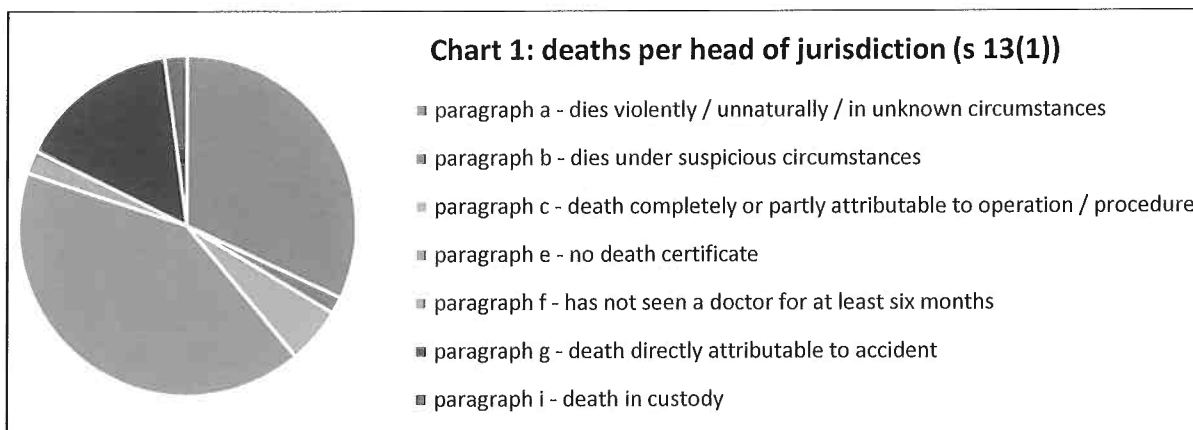
- 20 deaths of NSW residents which occurred within the ACT;
- 2 deaths that occurred within the Jervis Bay Territory;
- 1 death of an ACT resident who died in NSW but an ACT file was opened; and
- 1 death of an ACT resident who died in Kiribati but an ACT file was opened.

### **Type of Referral**

This is the second year the Court has been collecting statistics on the head of jurisdiction under which matters have been referred, which is to say, the specific paragraph or paragraphs of subsection 13(1) under which the matter has been reported to a Coroner: see Table 2 and Chart 1.

<b>Table 2: Heads of Jurisdiction</b>	<b>2017/18</b>	<b>2016/17</b>
(a) - violent/unnatural/unknown	<b>101 (32%)</b>	61 (19%)
(b) - suspicious	<b>5 (2%)</b>	10 (3%)
(c) - health-care related death	<b>17 (5%)</b>	21 (6%)
(d) - Chief Coroner own motion health-care related death	<b>0</b>	0
(e) - no certificate	<b>130 (41%)</b>	157 (48%)
(f) – hasn't seen GP in 6 months	<b>7 (2%)</b>	8 (2%)
(g) - accident	<b>49 (16%)</b>	66 (20%)
(h) - Attorney-General direction	<b>0</b>	0
(i) - death in custody	<b>7 (2%)</b>	3 (1%)

As I noted last year, these statistics need to be considered in context.



Firstly, these numbers reflect only the basis on which a matter is referred to the Coroner by Police and do not reflect the ultimate findings made by a Coroner. Secondly, matters may be referred under multiple heads of jurisdiction such as (hypothetically) a suspicious death in custody. I am pleased to note that the “no certificate” numbers have dropped, given my view last year that these numbers were artificially inflated by cases where a recent GP cannot be located. That said, given the small sample size (two years) it is probably too early to draw significant conclusions from this data.

#### Hearings / Attendances

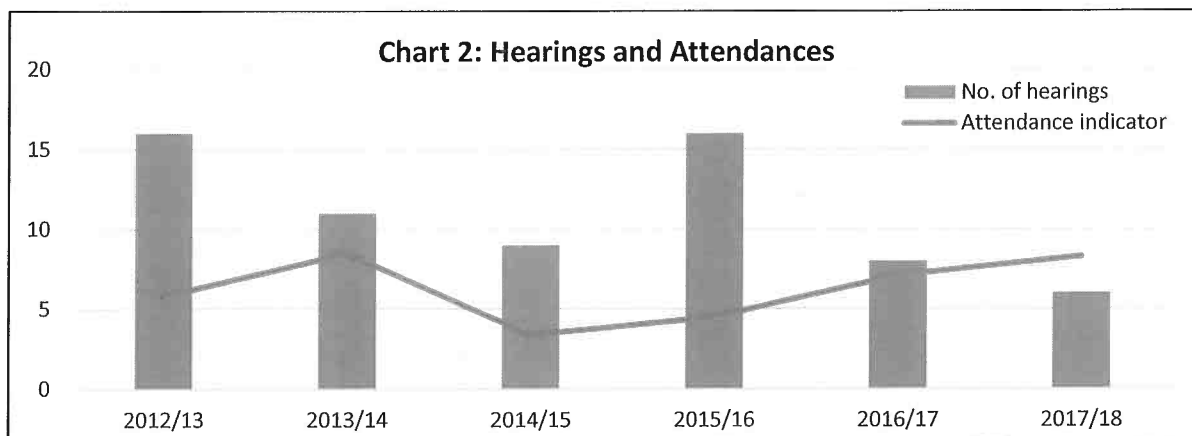
This is the second year that my annual report will include statistics as to the number of hearing days (attendances): see Table 3 and Chart 2.

<b>Table 3: Attendances</b>						
	<b>2017/18</b>	2016/17	2015/16	2014/15	2013/14	2012/13
No. of hearings	<b>6</b>	8	16	9	11	16
No. of attendances	<b>50</b>	57	72	31	93	92
Attendance indicator	<b>8.3</b>	7.1	4.5	3.4	8.5	5.8
Hearing time (days)	<b>37</b>	28	-	-	-	-

Relevantly, the number of attendances is the number of times that parties or their representatives are required to be present in court. It is a very raw number: a 15 minute directions hearing is recorded in exactly the same way as a full day of court. The ‘attendance indicator’ is defined as the average number of attendances recorded (no matter when the attendance occurred) for those cases that were finalised during the year. The increase on this number year on year reflects the fact that the hearings that are going through the court system at present are more complex and lengthier than in previous years. I expect that this number will continue to increase next as the Wood and Mental Health Deaths inquests progress through the system. [I note that the Wood inquest is presently injunction pending an appeal against my decision to continue the inquest and subpoena a

particular witness; the appeal is presently listed in the Federal Court of Australia for hearing in November 2018.]

Internal court records show that in the 2017/18 year, the Court sat for 37 days of hearing time across all Coroners (compared to 28 days last year, an increase of 32% year on year).



#### Cases Finalised

The majority of matters have again been completed by in-chambers findings without the necessity to proceed to a public hearing: see Table 4.

Table 4: Cases Finalised						
Type	2017/18	2016/17	2015/16	2014/15	2013/14	2012/13
<i>With a Hearing</i>	<b>6</b>	8	16	9	14	16
Deaths	<b>6</b>	8	16	9	12	12
Fires	<b>0</b>	0	0	0	2	4
Disasters	<b>0</b>	0	0	0	0	0
<i>By Chambers decision</i>	<b>294</b>	297	234	1007	1171	1375
Deaths	<b>294</b>	297	234	305	317	376
Fires	<b>0</b>	0	0	702	854	999
Disasters	<b>0</b>	0	0	0	0	0
<i>Total Cases</i>	<b>300</b>	305	250	1016	1185	1391

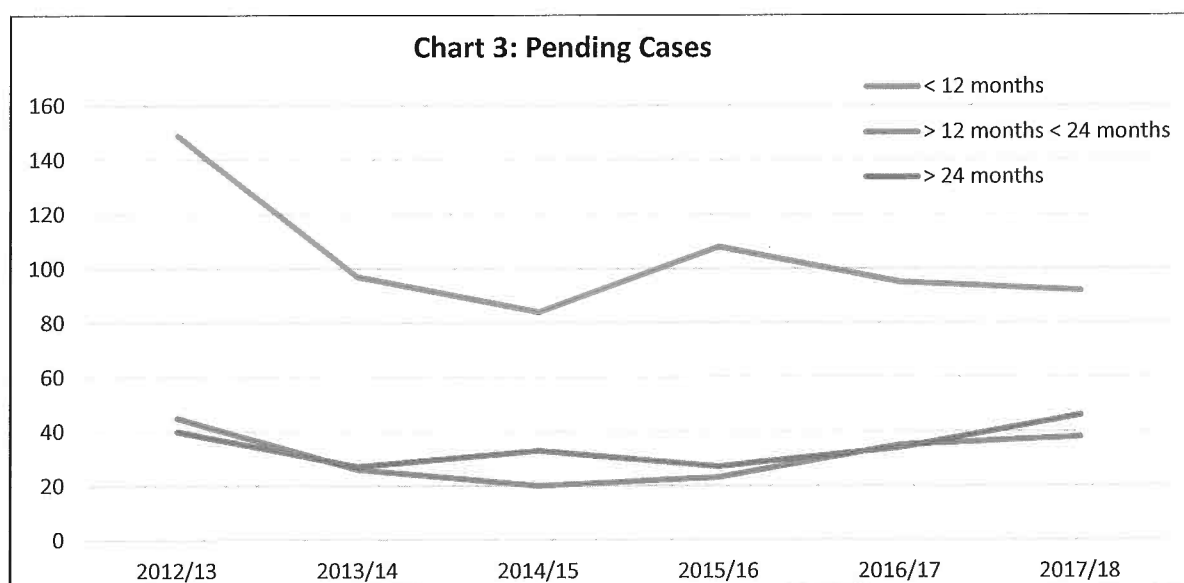
Matters resolved without hearing constitute 98% of all inquests into deaths finalised in the 2017/18 year. The Court achieved a clearance rate of 97% over 2017/18. While ideally I would like the clearance rate to equal or exceed 100% each year – whereby as many (or more) files are closed than are received, I acknowledge that this year I directed that more attention be put into resolving historic matters, and as noted above there was a year-on-year increase on hearing days.

### Timeliness / Backlog

Due most likely to an increased hearing workload, the overall number of cases pending at 30 June increased in two of the three statistical categories from 2016/17 to 2017/18: see Table 5 and Chart 3.

Table 5: Pending Cases						
Time Pending	2017/18	2016/17	2015/16	2014/15	2013/14	2012/13
< 12 months	92	95	108	84	97	149
> 12 months < 24 months	38	35	23	20	26	45
> 24 months	46	34	27	33	27	40
<i>Total Pending</i>	<b>176</b>	164	169	137	150	234

Although overall this represents an increase in the case backlog, we continue to make progress in dealing with historic matters – 28 cases were finalised which were older than 12 months old (as compared to last year, where 24 cases were similarly finalised). Put another way: of all of the 234 cases that were pending at 30 June 2013, only nine of those cases remain pending at 30 June 2018, and 225 of those cases have been closed in the four years since. Those nine pending cases had delayed progress through the coronial system for a number of reasons, such as needing to wait on the finalisation of criminal proceedings, however all are presently being worked on actively and I expect to be able to report next year that all these matters have been resolved.



It must also be remembered that pending cases figures include matters where related criminal charges are on foot or contemplated and: either the inquest is formally statutorily paused under sections 58 and 58A of the Act; or a Coroner has otherwise decided that it would be inappropriate to continue with the inquest until after the finalisation of the

criminal proceedings or investigation (either in the ACT or elsewhere) or after the finalisation of an interstate inquest. At 30 June 2018, the number of cases that fell into that category was 20, or 11.2% of the total pending cases. [This figure does not include the Wood inquest, which is presently injuncted pending an appeal against my decision to continue the inquest and subpoena a particular witness; the appeal is presently listed in the Federal Court of Australia for hearing in November 2018.]

I am pleased to report though there has been a slight decrease in the time taken to finalisation indicator: see Table 6.

Table 6: Time to Closure				
	2017/18	2016/17	2015/16	2014/15
Median days to finalisation (target)	92 (85)	94 (85)	75 (85)	83 (153)

However, the ACT Government has now changed the KPIs for the Court going forward and this statistic will no longer be collected going forward. I am pleased that the ACT Government agreed with my view expressed in last year's Report that the time to finalisation indicator was not a good KPI for the Court.

The new "strategic indicator" for the Coroners Court will be that 90% of cases are finalised within 12 months of lodgement. Although I am not entirely sure at this stage how that new statistic will be collected and reported, I can report that as at 30 June 2018, of the 300 cases finalised in 2017/18, 272 of those (90.7%) had been lodged in the last 12 months.

#### Interpretation

A long running theme in my recent Annual Reports has been that substantial and rapid improvement in dealing with the historic case backlog would require the application of additional resources both judicial and administrative. As I have directed that attention to the backlog must not detract from the processing of routine current cases, old files get finalised as and when they can within the constraints of magisterial workloads and coronial court staff ensuring smooth administration of incoming matters. Long term pending cases are old for one or more of the following reasons: contentious or complicated fact situations, voluminous materials, expert opinions to be obtained, related criminal proceedings, or issues particular to the family of a deceased person which necessitate delay in dealing with the matter. Generally also there is more family engagement on the case. Accordingly, coming back to old matters to resolve them requires substantially more time than might otherwise be thought the case merely from a 'volume of papers' perspective.

How does the ACT compare to other jurisdictions in terms of backlog? The Productivity Commission prepares an annual *Report on Government Services* (ROGS) which collect statistics on, among other things, the efficiency of coroner's courts throughout Australia. The 2018 report<sup>1</sup> for the 2016/17 year indicates that the ACT is second worst in Australia in

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<sup>1</sup> See Table 7.13, page 7.24.



terms of cases older than 24 months, which probably reflects the historic backlog of cases evident from 2012/13 which continue to work their way through the system. The ACT was also the worst jurisdiction for matters pending older than 12 months, at 42.1%, but this should be seen in context with four other jurisdictions having figures in the 30s: the Northern Territory at 37.6%, Queensland at 36.9%, South Australia at 37.0%, and Tasmania at 38.9%, all of which have dedicated coronial service beyond magistrates.

I continue to consider a number of fire referrals. In order to ensure that fires where a coronial inquiry is necessary or may add value are being appropriately drawn to the attention of the Court, in September 2018 I issued a Coronial Practice Direction which sets out the types of matters about which the Court should be notified.

While I note approvingly the small reduction in the number of matters referred to the Court due to the fact that no doctor will write a death certificate (from 157 (48%) in 2016/17 to 130 (41%) in 2017/18), I remain of the view that this number remains too high. My experience, and that of the Court generally, is that doctors remain reluctant to write certificates for cases which probably do not warrant coronial investigation, because of either a lack of understanding of the process to properly certify death, or because they consider death to be 'unexpected' notwithstanding the presence of (often multiple) morbidities very capable of causing death at any time. Sadly this is nothing that I or court staff or Police can assist with in a comprehensive way; I say again that the onus is on the appropriate medical professional bodies to provide this guidance and education.

While again overall fewer hearings were held in this year than last year, the hearings held tended to be more complex and lengthy: for example, the inquest into the death of Steven Freeman reported on later in my Report. This is reflected in the increase in the attendance indicator year on year. I should also note that as it only reports on matters finalised in the reporting year, those figures do not reflect a number of significant lengthy hearing matters which are yet to be finalised, such as the Wood and Mental Health inquests, which have each had more than three weeks of hearing so far.

## **FMC STATISTICS**

The total number of admissions<sup>2</sup> to the ACT Forensic Medicine Centre (FMC) in 2017/18 was 421 cases, made up of 360 ACT cases and 61 NSW cases, as well as one deceased person being held long term on a cost-recovery basis for The Canberra Hospital. Medical certificates were ultimately issued in 59 ACT cases and five NSW cases. Autopsies were conducted in 196 ACT cases and 42 NSW cases, with the remaining cases either being subject to an external examination or no examination if the manner and cause of death could be established from medical records.

The FMC has set a Key Performance Index (KPI) of 80% of cases having either an autopsy or medical review within five days or less from admission to the facility. In 2017/18 the facility achieved a KPI of 88.8%. This is a significant improvement in last year's result of 57.7% and meets our goal of retaining deceased persons for the minimum time necessary to conduct our enquiries and ensure their return to families and loved ones as soon as possible.

### **Length of Stay**

The median period of stay at the FMC in 2017/18 for all cases was seven days: see Table 7.

<b>Table 7: Length of Stay at FMC</b>					
Days	<b>2017/18</b>	2016/17	2015/16	2014/15	2013/14
Median stay (all cases)	<b>7</b>	6	5	5	5
Arrival » PM exam	<b>3</b>	3	3	2.4	2
PM exam » Discharge	<b>3</b>	3	2	4.1	2

These numbers are, again, a slight increase in the numbers from last year. It remains the case that deceased persons may remain at the FMC for some time if family cannot be located, for identification to be confirmed, or for public trustee procedures to be finalised. Also, as frequently occurs, there were a small number of deceased persons (10 ACT cases; 1 NSW case) held for those reasons in excess of 30 days. Additionally, the FMC has been storing a deceased person on behalf of The Canberra Hospital on a cost-recovery basis for many months while negotiations continue with family members. The FMC complies with its statutory obligations to notify the ACT Registrar of Births, Deaths and Marriages when a deceased person formerly resident in the ACT remains in the care of the FMC for more than 30 days.

### **Rate of Invasive Autopsy**

In many cases referred for coronial autopsy, an invasive autopsy is the default position in the absence of other information which can identify the person's manner and cause of

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<sup>2</sup> Note that the numbers of autopsies, examinations and admissions may differ from the number of cases lodged with the Coroner's Court due to cases which straddle the end of financial year; also where a referral is accepted without the body of the deceased person being admitted to the FMC.

death, and whether there are any issues or matters of public safety arising in connection with the death which warrant further review.

Arguments over how to balance the competing interests of families' loss of control over relatives' bodies with the public benefits of investigating causes and circumstances of deaths have evolved considerably in Australia and elsewhere. The current generally accepted position appears to be that coronial investigations, the invasiveness of autopsies and the retention of large specimens should be limited to those deaths where these procedures are justified by their utility.<sup>3</sup> Some authors have noted the following factors tending away from invasive autopsies:<sup>4</sup>

- Invasive autopsies "involve extensive mutilation of the body" and are "unethical" and "inconsistent with coroners' professed respect for the dead" unless strictly necessary;
- Invasive "autopsies are expensive";
- "Pathologists take many years to train ... and they are in short supply"; and
- "Autopsies are dangerous" due to heavy lifting, sharp instruments and infection risks.

As indicated in earlier reports, a more considered approach to invasive post-mortem examination now prevails in the ACT, with continuing regard for family concerns and a pragmatic approach to identifying cause of death by various available means, including medical reports, review of clinical notes and limited use of technology such as CT scanning. This trend has seen a significant reduction in invasive post-mortem examinations and I am pleased to note our proportion of cases subject to external examination has increased again on last year: see Table 8.

Table 8: Post-Mortem Examinations <sup>5</sup>			
Year	Total Examinations	Invasive Autopsy	External Examination (% of total)
2007	392	388	4 (1.0%)
2008	405	400	5 (1.2%)
2009	427	420	7 (1.6%)
2010	385	374	11 (2.9%)
2011	373	362	11 (2.9%)
2012	394	345	49 (12.5%)

<sup>3</sup> Dr Charles Naylor, *Review of ACT Coronial and Post Mortem Process and Practice*, 26 July 2013.

<sup>4</sup> M Barnes and B Carpenter (2011), "Reliance on internal autopsies in coronial investigations: a review of the issues", 19 JLM 88; cited in Naylor *ibid*.

<sup>5</sup> Note that the numbers of autopsies, examinations and admissions may differ from the number of cases lodged with the Coroner's Court due to cases which straddle the end of financial year.

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2013/14	295	238	57 (19.5%)
2014/15	290	215	75 (25.9%)
2015/16	279	207	72 (25.8%)
2016/17	297	215	82 (27.6%)
<b>2017/18</b>	<b>301</b>	<b>196</b>	<b>105 (34.9%)</b>

The increase in this percentage may be attributed to greater use of pathologist-led medical reviews. Professor Duflou has indicated that with greater pathologist involvement and triage of cases prior to post-mortem examination, and expanding the use of diagnostic tools in the examination process, a target of 50% of cases receiving invasive autopsies is feasible. I fear however we are reaching the limits of how many cases may be diverted out of the autopsy stream without the wider use of investigative tools pre-autopsy, such as default rapid toxicology and CT scanning.

Although not occurring in this financial year, I note that in July 2018 the ACT Government approved funding to recruit and appoint an ongoing resident forensic pathologist for the ACT. Recruitment is well underway as I write this report. I thank the Attorney-General and others within Government for seeing the necessity of this role and providing funding.

I discussed in last year's report the benefit of blanket CT scanning on admission to coronial mortuaries and that this represents best practice in autopsy service, but this capability has not been available in the ACT. In March 2018 I wrote to the Attorney-General to ask that Government explore funding the capital and ongoing costs for a CT scanner to be based at the FMC. I understand that work has commenced to explore costs and prepare a business case for the consideration of Cabinet, I am grateful for the attention this issue is now receiving.

#### Toxicology Services

Toxicology testing timeframes continue to be a concern for me, however I am happy to report that there has been an improvement in testing timeframes over the last 12 months, in which 51.8% of autopsy cases had testing performed. Toxicology testing is not required when the manner and cause of death is evident from medical records or other autopsy findings and the pathologist deems that there is no benefit in toxicology testing. The majority of testing is performed at the ACT Government Analytical Laboratory (ACTGAL), and the average days from when they receive the sample to providing the report has reduced: see Table 9.

Table 9: Toxicology Timeframes					
Type	2017/18	2016/17	2015/16	2014/15	2013/14
Average days	<b>21.7</b>	26.9	26.3	26.5	24.5

Although the improvement is pleasing, there is still room for further improvement and we will continue to monitor this. I note in this regard the toxicology results are usually the last piece of information the pathologist is waiting on before completing the autopsy report. Should toxicology results be available more speedily, this is likely to improve the time taken to complete autopsy reports.

I note also that there were 15 occasions with ACT cases where early toxicology was performed and blood was taken and sent for analysis prior to the post mortem examination. There were also two ACT cases that were sent to VIFM for analysis: one was for rapid toxicology; the other was to include the analysis of cyanide which ACTGAL are unable to perform. There was also one sample sent to the Australian Sports Drug Testing Laboratory for targeted analysis of anabolic steroids, in addition to the analysis done at ACTGAL.

As previously reported, there is benefit in getting rapid toxicology results, specifically in certain types of drug overdoses, as a confirmation result will obviate the need for an invasive autopsy. ACTGAL have a limited capability to provide this service. They are only able to provide overnight analysis on one specified drug thus excluding cases of potential multi-substance overdose and their limits of detection for some drugs are higher for ACTGAL than other providers. Agreement has been reached with the Victorian Institute of Forensic Medicine (VIFM) where they will provide a fee for service overnight toxicology screening analysis and provide indicative verbal results the following day. However actual quantitative results are not provided for another 1-2 weeks. This overnight analysis screens for 327 common drugs and poisons, and has been utilised where the pathologist deems that early results would be of benefit and toxicology samples are taken prior to autopsy. However, advice from the pathologist is that opioid overdoses (which are present in the majority of overdose deaths reported to the Coroner) do not benefit from rapid analysis as the presence of opioids and their metabolites, even in high doses, are not sufficient to obviate a full autopsy.

With the planned introduction of a triage at the FMC in the coming year, it is envisaged that toxicology samples will be taken at time of admission in all cases, rather than wait for autopsy. This will have a twofold benefit. Firstly, when appropriate the samples can be sent to VIFM for overnight screening. However more importantly it will mean that the samples will be delivered to ACTGAL prior to autopsy so that analysis will commence sooner. Assuming reporting timeframes stay constant or improve, it will reduce the actual period of time between autopsy and when the pathologist receives the toxicology report, which will see a reduction in the timeframe for the final autopsy report to be submitted.

## **STAFFING AND RESOURCES**

### **Coroners**

The ACT Coroner's Court receives no allocated resourcing for the performance of judicial coronial functions. Again the arrangements of some long standing whereby every Magistrate retains an active coronial case load continued in 2017/18, but that case load is discharged as a secondary priority with duties as a Magistrate commanding more immediate attention. This year I found the only way to manage the increasing coronial workload was to assign a significant coronial hearing matter – the inquest into four 'mental health' deaths in The Canberra Hospital – to Special Magistrate and Coroner Margaret Hunter. That matter continues with hearings in the 2018/19 year.

The appointment of the Registrar of the Coroners Court as a Deputy Coroner and delegating most of fire inquiry work to the Deputy Coroner continues to prove efficient and beneficial. However, concerns about conflicts of interest preclude the Deputy Coroner undertaking any coronial work in which the Territory has the potential to be an interested party. This, together with the Registrar's own considerable workload in respect of Magistrates' Court matters, limits the amount of work the Deputy Coroner can do in the jurisdiction. Indeed, the fires reported to the Court in 2017/18 all involved Territory instrumentalities. Noting this limitation on the work of the Deputy Coroner, I am looking to delegate some more routine death matters and work to the Deputy Coroner to better utilise the appointment.

I again note that, by agreement with the Commonwealth Government, the ACT Coroner acts also as the Coroner for the Jervis Bay Territory and the Australian Antarctic Territory, and the ACT *Coroners Act 1997* applies to deaths in those Territories. Costs in relation to these inquests are borne by the Commonwealth Government on a cost-recovery basis. In 2016/17 the ACT Coroner was notified of two deaths occurring within the Jervis Bay Territory. The inquest into the death of Captain David Wood, notified to the ACT Coroner in 2016/17 as having occurred in the Australian Antarctic Territory, was the subject of a lengthy hearing in the 2017/18 year and continues into 2018/19.

### **Administrative Staff**

The administrative needs of the ACT Coroner's Court are met from within the ACT Courts and Tribunal Administration, a business unit of the Justice and Community Safety Directorate (JACS), by way of a dedicated support section sitting under the Legal Team reporting directly to the Registrar.

The Coroners Section is headed by our Council Assisting/Legal Manager and includes legal, court support and forensic medicine staff. The Legal Manager directly manages two administrative support staff co-located with the Magistrates Court Registry, and the mortuary manager (and through them technical staff) located at the FMC in Phillip.

### Counsel Assisting

The *Coroners Act 1997* permits, and in some cases, requires, Coroners to appoint Counsel Assisting the Coroner in inquests or inquiries. While Coroners may generally do so when satisfied that it is in the interests of justice to have a lawyer assist the coroner (see section 39), in the event of a death in custody a Coroner must appoint a Counsel Assisting for the purpose of the inquest (see section 72).

Part of the rationale for appointing a Legal Manager and Legal staff to the Coroners Unit was to allow for the development of in-house advocacy capacity to provide inexpensive but specialised Counsel Assisting services to the Coroners, within operational capacities. This continues to prove beneficial and cost effective.

The ACT DPP has continued to appear in matters which were already briefed to the Office prior to our in-house practitioner assuming her role. I thank Director Jon White and his staff for their continued assistance to the Coroner's Court in this regard.

A number of cases were also briefed to the private bar in 2017/18 due to the complexity of the matter or the capacity of our in-house practitioners. In such matters our in house practitioners perform the role of instructing solicitor, which enables the costs to be kept down and has proven beneficial to the appointed lead Counsel.

This year I settled maximum rates of briefing external barristers as Counsel Assisting as follows:

- Junior (<= 5 years): \$2000 per day; \$200 per hour
- Senior Junior (>5 years): \$2200 per day; \$220 per hour
- Senior Counsel: \$3000 per day; \$300 per hour.

All fees are exclusive of GST.

### FMC

In 2017/18 we finally returned to a full staffing complement at the FMC after a number of staff departures in the preceding year. The work practices of the FMC were also successfully altered to more regular, ordinary business hours arrangements, which enabled a staffing restructure and the ability to offer some permanent part time roles rather than being reliant on a purely casual pool of staff.

We have found it difficult to recruit and retain mortuary technicians: there are few ACT residents with experience in this work, and many persons trialled in the role found themselves unable to continue long term due to an inability to develop the necessary skills, or because of the confronting nature of this work. I have directed that in the medium term work be undertaken to create a wider pool of appropriately trained staff within the ACT to ensure business continuity, but also to provide an ability to scale up the work of the FMC in the event of a multi-casualty disaster.

The FMC continued to be an important component of the training offered to medical and forensic students, consular staff, police recruits and members, and defence force personnel in 2016/17. The facility remained an identified ACT disaster response venue.

FMC staff are supportive of religious and cultural rituals conducted by families of the deceased prior to release of the body of the deceased and engage with local religious and cultural leaders to facilitate these rituals and ensure religious requirements are adhered to to the extent operationally possible.

Ongoing priorities for the FMC in the forthcoming year include:

- Formalising a system of health-based mentoring and professional supervision for technical staff via interstate counterparts
- A review of FMC Standard Operating Procedures (SOPs) and policy documents, particularly with an eye to the National Code of Ethical Autopsy Practice and Guidelines of the National Pathology Accreditation Advisory Council (NPAAC) to and benchmarking those against best practice in other jurisdictions
- A triage process for cases at the post mortem examination admission stage, to assist in coronial decision making

The FMC continued to offer reception and examination facilities to the NSW Coroner's Court on a fee-for-service basis for deaths occurring in neighbouring parts of NSW. Although there was some initial uncertainty in July 2017 as to whether this work would remain with the ACT, by December 2018 then NSW State Coroner Barnes committed to continuing this arrangement. This was important as to some extent the FMC relies on the NSW work to obtain efficiencies of scale and to maintain the caseload at a sufficient level to warrant the engagement of a full time equivalent pathologist.

#### Pathologist Services

Professor Johan Duflou and Associate Professor Sanjiv Jain continued to undertake coronial autopsies on a privately contracted basis throughout 2017/18. Specialist services in paediatric cases and locum support were provided by independent pathologists from other jurisdictions. We continue to be grateful in that regard for the assistance provided by QFS, VIFM and FASS. I wish also to record the appreciation of the Coroners of the Court for Professor Duflou and Associate Professor Jain's support of the coronial system in this Territory.

As noted earlier in my report, and although not occurring in this financial year, in July 2018 the ACT Government approved funding to recruit and appoint an ongoing resident forensic pathologist for the ACT. Work is presently underway to recruit and fill the position, as well as create an appropriate professional development and oversight framework. I thank the Attorney-General and others within Government for seeing the necessity of this role and providing funding.

#### Coroners Investigators



Section 59 of the *Coroners Act 1997* provides that a Coroner may appoint any person to assist the Coroner in the investigation of any matter relating to an inquest or inquiry. Section 63 provides that Coroners may request the assistance of police in conducting an investigation. The common law also recognises that Coroners may call on police assistance.

In the ACT, investigations are conducted generally by members of the ACT Policing arm of the Australian Federal Police, including specialist areas if required. There is some blurring of the boundaries with the criminal investigation function which can be problematic, although thankfully more commonly in theory than in practice. The AFP provides an excellent service to the jurisdiction.

The AFP also provides a dedicated unit – the ACT Coronial Liaison Unit – whose members who are the first point of contact in relation to possible reportable deaths, provide initial reports of deaths to the Coroner and subsequently perform coordination, liaison and investigative tasks as required. Members of that Unit perform a useful task in filtering out reports of deaths which do not fall within the Court's jurisdiction, which is highly efficient and obviates the need for additional work at the Court or by the Coroner.

I wish to specially acknowledge the work of Sergeant Rachel Hutka who until July 2018 had provided 4.5 years of excellent service to the coronial jurisdiction.

Primary investigatory responsibility for coronial fires not involving the death of a person falls to the ACT Emergency Services Agency through either ACT Fire and Rescue or ACT Rural Fire Service. These organisations also provide an invaluable service to the Coroner's Court. Worksafe ACT has also readily supported the coronial investigative function in relevant matters.

## **ENGAGEMENT AND EDUCATION**

### **Support Services in the Community**

All Coroners are acutely aware that grieving families can find the coronial process difficult. Relationships Australia Canberra Region continued to be funded in 2017/18 by ACT Health to operate the ACT Coronial Counselling Service to provide intensive therapeutic counselling, psycho-education and referral services to ACT residents who are affected by a traumatic death and are impacted by the coronial process. Clients may receive ongoing counselling services at no cost during the coronial process and for up to three months after the coronial process has been concluded. There is regular engagement between the Service, Court and Police to ensure that persons in need of help and support are directed to the Service, and Counsellors also regularly act as advocates and provide support to family members in dealings with the Court. The feedback to the Court about the Service and individual counsellors is uniformly positive and I thank ACT Health and Relationships Australia for their support to the jurisdiction.

### **Direct Engagement**

During the 2016/17 year, the Court and its staff engaged widely with groups and individuals whose interests intersect with the jurisdiction, including Suicide Prevention Australia, the Department of Foreign Affairs and Trade, the AFP's Disaster Victim Identification Commander and the ACT Domestic and Family Violence Coordinator General.

Coroners and staff of the Court also attended the Asia Pacific Coroners Conference in Adelaide, South Australia.

The Court also hosted a number of internship placements for university students to both obtain exposure to professional legal practice and to gain a greater understanding of the work of Courts and the Coroner's Court specifically. Due to the success of these ad hoc placements – generally arranged via direct request from interested students – the Court will be looking to formally partner with ANU to offer formal placements over the summer period 2018/19. If this trial is successful, consideration will be given to expanding the time periods of placements and also the feeder universities.

## **ENVIRONMENT CHANGES**

### **Amendments to Coroners Act 1997**

The following amendments were made to the *Coroners Act 1997* in the 2017/18 year:

- The *Justice and Community Safety Legislation Amendment Act 2017 (No 3)*, which came into effect on 16 November 2017, and made amendments to:
  - remove the unintended exclusion from reportability of deaths that occur in any of the circumstances prescribed by regulation, such as after an intravenous or intramuscular injection, artificial ventilation, resuscitation, or catheter or cannula insertion, by deleting the note at section 13(1)(c); and
  - remove the mandatory hearing requirement in section 34A for deaths which occur while under or as a result of anaesthetic (such deaths remaining reportable to the Coroner);
- The *Courts and Other Justice Legislation Amendment Act 2018*), which came into effect on 26 April 2018, and made amendments as follows:
  - The prohibition on Deputy Coroners signing release certificates (s 15(4)) was repealed;
  - Section 28, which required Coroners to have regard to cultural and spiritual concerns, was repealed and delinked from the post mortem examination process and now applies generally in relation to inquests [as a reframed s 17A];
  - A new form of examination process – ancillary examinations, intended to be those things of less invasiveness than autopsy – was inserted into the Act [new s 19A, 19C];
  - Directions to obtain medical records were delinked from the post mortem examination process, and can now be sought to decide whether to have an autopsy (to obviate the need for short service subpoenas); also a direction can now be made for any (all) medical records, not just the records of last admission [new s 19B];
  - The “assistance at PMs” authorisation in section 33 was delinked from the order for an examination and the language reframed to open the scope for standing directions for assistance; also the doctor conducting a post-mortem examination may also authorise assistants to help him or her [new s 33];
  - The provisions in relation to CISOs were corrected so that “other persons” can now use CISOs powers, not just Police [ss 68C-H etc.]; and
  - Other contingent amendments.

### Previous Amendments

The following amendments were made to the *Coroners Act 1997* in the 2016/17 year:

- The *Justice and Community Safety Legislation Amendment Act 2017*, which came into effect on 2 March 2017, and made amendments to section 57 in relation to reports made under that section to the Attorney-General and responsible Ministers.

### Forecast

The two key challenges facing the Court in the forthcoming year are continuing to manage (and hopefully decrease) the file backlog of historic matters, as well as prepare for the Asia Pacific Coroners Society Conference in November 2018, which the ACT will be hosting. The honour of hosting the conference rotates around the membership countries and Australian states and territories in parallel with the rotating Chair of the State and Chief Coroners Council, and I have assumed the role of Chair of that body for the 2018 year. The Conference is the primary annual event of the Asia Pacific Coroners Society, established in 1991 to promote the advancement, best practice and education of coronial law and practice.

There are also a number of matters listed or to be listed for hearing in 2018/19, or likely to be concluded in this period. It will be a challenge for the Courts to ensure that such matters continue to progress without undue disruption to routine, non-complex matters.

## **MANDATORY REPORTING**

Subsection 102(2) requires certain particulars to be reported in my report.

### **Paragraph 102(2)(a) matters – reports into ‘deaths in custody’**

For the purposes of the *Coroners Act 1997*, ‘deaths in custody’ are those deaths of persons that occur in certain specified circumstances listed in section 3C. Under paragraph 34A(2)(a), a Coroner must not dispense with a hearing into a death of a person if the Coroner has reasonable grounds for believing that the person died in custody. Accordingly, a hearing is held for all deaths in custody.

In the 2017/18 year, there was one inquest into a death in custody finalised by a Coroner: Steven Freeman (CD 125 of 2016). Summaries of this case, and the findings made, can be found later in the Report in the selected case notes section.

[I note that reports made to the Attorney-General under section 57, and section 76 responses to findings about the quality of treatment, care or supervision in deaths in custody, are reported separately below.]

### **Paragraph 102(2)(b) matters – decisions not to conduct a hearing**

Section 34 of the *Coroners Act 1997* authorises Coroners to conduct hearings for inquests or inquiries. Section 34A goes on to prescribe the circumstances in which a hearing must be held, or may not be held. When a Coroner decides not to conduct a hearing into a death, subsection 34A(3) requires the Coroner must give the Chief Coroner, and the family concerned, written notice of the decision and grounds for the decision. A family may apply in writing under section 64 to the Chief Coroner for reconsideration for a decision not to hold a hearing, and may ultimately apply under section 90 to the Supreme Court for an order directing a hearing be held.

In the 2017/18 year, there were 292 notices given by Coroners under subsection 34A(3), in respect of 292 deaths. (There were no inquiries into fires or disasters finalised in the 2017/18 year.) These cases have not routinely been reported on an individual basis in previous reports and will not be individually reported on in this report. There were no applications made to the Chief Coroner under section 64 in respect of matters finalised in this year.

A section 90 application to the Supreme Court was made on 20 September 2016 in respect of the inquest into the death of Corinna Medway (CD 127 of 2011). That matter – *Foote v Coroner's Court of the ACT* – remains outstanding at the present time.

### **Paragraph 102(2)(c) matters – reports to Attorney-General**

In making findings in relation to an inquest or inquiry, a Coroner must, among other things, state whether a matter of public safety is found to arise in connection with the inquest or inquiry, and if so, must comment on the matter: section 52(4)(a) of the *Coroners Act 1997*. Additionally, for deaths in custody, a Coroner must record findings about the quality of care,

treatment and supervision of the deceased that, in the opinion of the Coroner, contributed to the cause of death: section 74.

Section 57 permits a Coroner to make a report to the Attorney-General on an inquest or inquiry (and requires the making of a report in relation to an inquiry into a disaster). Where reports are made, subsection 57(3) requires the Coroner to set out any findings in relation to serious risks to public safety that were revealed in the inquest or inquiry, and permits the making of recommendations about matters of public safety that, in the Coroner's opinion, improve public safety. Subsections 57(5) and (6) require the Attorney-General to present these reports, and any response made on behalf of the Government, to the Legislative Assembly.

A Coroner may also decide to make a report to the Attorney-General without invoking section 57 and the process of tabling in the Legislative Assembly. This might occur, for example, when the key issues under consideration in an inquest involve parties other than the ACT Government, and/or any recommendations made are not capable of implementation by the ACT Government, but a Coroner nevertheless decides it is appropriate that the matter be brought to the attention of the Attorney-General. Such matters are not required to be reported under paragraph 102(2)(c), but due to the general public interest usually inherent in such matters, in most such cases a summary will be included as a case note in the Annual Report.

In the 2017/18 year, there were no reports made specifically invoking subsection 57(3) to the Attorney-General. The Government decided of its own accord to formally respond in the Legislative Assembly to the Coroner Cook's report in the Steven Freeman matter (CD 125 of 2016) and this occurred on 23 August 2018.

Two subsection 57(3) reports were presented to the Legislative Assembly in the 2017/18 year relating to coronial reports made in the previous year. The subsection 57(3) report in relation to the death of River Parry (CD 189 of 2015) was tabled in the Legislative Assembly on 3 August 2017, and the report in relation to the death of Paul Fennessy (CD 11 of 2010) was tabled on 17 August 2017.

#### Paragraph 102(2)(d) matters – agency responses to 'deaths in custody'

Under section 74 of the *Coroners Act 1997*, Coroners are expressly required to record findings about the quality of care, treatment and supervision of the deceased that, in the opinion of the Coroner, contributed to the cause of death for all deaths in custody. Copies of those findings are required to be distributed to specified people and agencies: see section 75. Custodial agencies are required to formally respond to those findings within three months of receipt of the findings and to provide copies of that response to the responsible Minister and the Coroner: see section 76.

For the one inquest into a death in custody finalised by a Coroner in the 2017/18 year, the Steven Freeman matter (CD 125 of 2016), Coroner Cook considered a number of the aspects of Mr Freeman's treatment but ultimately found that the treatment given to Mr Freeman

did not affect the quality of care, treatment and supervision of him to the extent that it could be said to have contributed to his cause of death. The ACT Corrective Services response to Coroner Cook's findings was tabled in the Legislative Assembly on 23 August 2018.

### SELECTED CASE NOTES

The following cases are reported as either cases about which a mandatory report is required, where public hearings were held, or as cases of public interest or regard.

The name of a deceased person is included in the case note where a hearing has been held in which the name of the person has been made public, or where other action is taken which results in the publication of the deceased's name (such as presentation of coronial reports to the Legislative Assembly or publication of reasons on website). In other cases, or where the deceased person is of indigenous origin and their name has not been publicised, the name of the deceased person is withheld.

Full copies of coronial findings and recommendations are available by searching for cases via <http://courts.act.gov.au/magistrates/judgment> .

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Court Reference: CD 71/15  
Age: 35 years  
Gender: Female  
Date of Death: 6/4/2015  
Place of Death: Garran, ACT  
Coroner: R.M. Cook  
Date of Findings: 10/7/2017

I find that:

1. That Angela Carina Mills died on 6 April 2015 at The Canberra Hospital, 1 Dann Close, Garran, in the Australian Capital Territory;
2. That the manner and cause of Carina's death is unascertained; and
3. That, pursuant to s 52(4)(a)(i) of the *Coroners Act 1997*, no matter of public safety is found to arise in connection with this inquest.

...

14. Notwithstanding that I have found no matter of public safety arises in relation to Carina's death, the *Coroners Act 1997* clearly contemplates that I can make recommendations in relation to the prevention of deaths, the administration of justice and the need for a matter to be investigated or reviewed by another entity. Coroners also have a well-recognised power at common law to make recommendations in the public interest. Accordingly, the recommendations I make in this inquest are as follows:

- a. The Canberra Hospital's maternity service should have a system for hourly rounds and wellbeing checks of postnatal patients. This could be achieved through the Maternity Care and Accountability Plan, which is presently under trial.
- b. The Canberra Hospital's policy in relation to handling death scenes for deaths reportable to the Coroner be revised to indicate that deceased persons and death scenes should not be cleaned or altered in any way until after police or the Coroner have been contacted for advice and where appropriate permission.



- c. Dr Sansum recommended that the Therapeutic Goods Administration be advised of Carina's death and the administration of thrombolysis agents during her attempted resuscitation. If The Canberra Hospital has not already made this report, I recommend that this be done.

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Court Reference: CD 44/17  
Age: 22 years  
Gender: Male  
Date of Death: 20/2/2017  
Place of Death: Hawker, ACT  
Coroner: K.M. Fryar  
Date of Findings: 1/9/2017  
Reported as: [2017] ACTCD 5

1. Tatu Wilhelm Michael Parzefall died on 20 February 2017 at Springvale Drive, Hawker, in the Australian Capital Territory;
  2. The manner and cause of death of Mr Parzefall are sufficiently disclosed and a hearing is unnecessary;
  3. The manner and cause of Mr Parzefall's death are multiple injuries due to a motor vehicle accident; and
  4. Pursuant to s 52(4)(a)(i) of the *Coroners Act 1997*, no matter of public safety is found to arise in connection with this inquest.
- ...
23. Notwithstanding that I have found no matter of public safety arises in relation to Tatu's death, the *Coroners Act 1997* (ACT) clearly contemplates that I can make recommendations in relation to the prevention of deaths, the administration of justice and the need for a matter to be investigated or reviewed by another entity. Coroners also have a well-recognised power at common law to make recommendations in the public interest. Accordingly, I make the following recommendations on that basis.
  24. I recommend that:
    - a. The ACT Government should review its adoption of the national LAMS scheme and reconsider its lack of adoption of the engine capacity limit for such motorcycles which applies in every other Australian jurisdiction.
    - b. Access Canberra (who I believe to be the responsible area within government) should review the 'List of approved motorcycles' it has promulgated to provide better guidance to learner and provisional riders of the status of the law in this area, and if it cares to, provide suggestions as to the appropriate type or classification of motorcycles it recommends for inexperienced riders.

*Due to an administrative oversight, these findings were not forwarded to Government until 22 August 2018.*

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Court Reference: CD 5/13

Age: 47 years  
Gender: Female  
Date of Death: 9/5/2013  
Place of Death: Banks, ACT  
Coroner: L.A. Walker  
Date of Findings: 11/9/2017  
Reported as: [2017] ACTCD 3

35. In accordance with section 52(1) of the Coroners Act I make the following findings: Lesley Maree Smith (DOB: 21 December 1965) died on 9 May 2013 at XXXXXXX, Banks in the Australian Capital Territory. The cause of Ms Smith's death was Sudden Unexpected Death in Alcohol Misuse.
36. I am required by section 52(4) to expressly consider and state in my findings whether a matter of public safety is found to arise in connection with the inquest. I accept the submission of Counsel Assisting that while certain of Dr Helmy's practices would be of concern were he still practicing, there is no current matter of public safety requiring attention. I also make no adverse comment in relation to Dr Helmy.
37. I make the following recommendation: the Royal Australian College of General Practitioners may wish to consider reviewing the guidance material and education it provides to its members in relation to the treatment of drug and alcohol addicted patients in the community, and specifically in relation to:
- a. current practices and guidelines for treating; and
  - b. baseline blood testing for patients who are about to commence treatment for drug and alcohol misuse.
- I direct that a copy of these findings be conveyed to the RACGP.
38. I direct that a copy of my findings in this matter, the transcript of the hearing and all exhibits be provided to the Australian Health Practitioners Regulatory Agency for their consideration as to further action in relation to Dr Helmy was appropriate.

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Court Reference: CD 174/17  
Age: 24 years  
Gender: Male  
Date of Death: 1/8/2017  
Place of Death: Campbell, ACT  
Coroner: B.C. Boss  
Date of Findings: 7/12/2017  
Reported as: [2017] ACTCD 4

1. Jacob James Kelly died on 1 August 2017 at Fairbairn Avenue, Campbell, in the Australian Capital Territory;
2. The manner and cause of death of Mr Kelly are sufficiently disclosed and a hearing is unnecessary;

3. The manner and cause of Mr Kelly's death are multiple injuries due to a motor vehicle collision with a retaining wall, and I find that Mr Kelly's death was due to suicide; and
4. Pursuant to s 52(4)(a)(i) of the Coroners Act 1997, a matter of public safety is found to arise in connection with this inquest.
- ...
12. From the facts I conclude that the physical design of the intersection of Mount Ainslie Drive and Fairbairn Avenue constitutes a matter of public safety. There is a significant risk to persons who would wish to engage in acts of self-harm at the location. Additionally, there is a risk to innocent bystanders and other road users who might be travelling on Fairbairn Avenue at the time when a driver with suicidal intent may be travelling down Mount Ainslie Drive and through the intersection at speed. Without some mitigation measure, I consider it would only be a matter of time before multiple injuries or death will be occasioned to innocent road users if this apparent trend in self-harming behaviour is facilitated by the physical design.
- ...
15. I therefore formally make the following recommendation:
  - (a) The ACT Government should implement a permanent road infrastructure measure at the intersection of Mount Ainslie Drive and Fairbairn Avenue, Campbell, which is designed to reduce the risk of harm to road users who might wish to engage in acts of self-harm at that location, as well as other road users who might be adversely affected by such acts.

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Court Reference:	CD 186/17
Age:	37 years
Gender:	Male
Date of Death:	16/8/2017
Place of Death:	Ainslie, ACT
Coroner:	R.M. Cook
Date of Findings:	22/12/2017
Reported as:	[2018] ACTCD 1

1. Andrew Nolan Christie died on 16 August 2017 at the Tall Trees Motel, 21 Stephen Street, Ainslie, in the Australian Capital Territory;
2. The manner and cause of death of Mr Christie are sufficiently disclosed and a hearing is unnecessary;
3. The manner and cause of Mr Christie's death is asphyxia due to oxygen deprivation secondary to inhalation of helium, and I find that Mr Christie's death was due to suicide; and
4. Pursuant to s 52(4)(a)(i) of the *Coroners Act 1997*, a matter of public safety is found to arise in connection with this inquest.
- ...
6. The apparent easy access to helium gas has been examined by Victorian Coroner Audrey Jamieson in a series of coronial cases including the deaths of Miki Yamamoto (finding delivered 22 February 2016), Olga Jucan (unpublished finding dated 28 November 2016), and Lauren Pilkington (finding delivered 19 April 2017).

In the latter case, Coroner Jamieson made a recommendation to the Australian Competition and Consumer Commission (ACCC) to consider working to restrict the ease of access to helium gas by members of the Australian public. I understand consideration is ongoing as to whether helium gas should be included in the Poisons Standard, which controls the availability of poisonous substances.

7. I consider the ease of access to helium gas constitutes a matter of public safety. In the light of Coroner Jamieson's existing recommendation, I do not believe it is necessary to make a formal recommendation on this matter. However, I add my voice to that of Coroner Jamieson, and other Australian Coroners, about this concerning issue.
8. I will forward a copy of my findings and comments to Coroner Jamieson and the ACCC for their information. I would be grateful in due course for a written response from officers of the ACCC as to any measures they have undertaken to restrict the ease of access to helium gas by members of the Australian public.
- ...
13. I am satisfied Police acted appropriately in dealing with Andrew and his arrest for a family violence charge was appropriate. My sole concern is however the presumption that police must negative before granting bail to someone with Andrew's background and history.
14. I have no doubt that the intention of section 9F of the *Bail Act 1992* is to protect victims of family violence from possible revictimisation. And there is nothing inherently wrong or illegal with placing a higher onus to meet in respect of police bail for family violence cases. However, as it is presently reads – and how the Sergeant appears to have interpreted it in respect of Andrew – it operates as an effective presumption against bail. How might Police ever satisfy themselves that a person poses no danger whatsoever to the victim of a family violence offence? I am not sure it was the intention of the ACT Legislature that no family violence accused could ever be granted police bail. I note also that it appears that NSW has moved away from a presumption against police bail in family violence matters in its recent reforms to its Bail Act.
15. Accordingly, I make the following recommendation:
  - (d) The ACT Government should review, and if necessary amend, section 9F of the *Bail Act 1992* to ensure that it does not or can not operate as an irrebuttable presumption against police bail for family violence accused.

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Court Reference:	CD 107/13
Age:	68 years
Gender:	Male
Date of Death:	11/12/2012
Place of Death:	Ainslie, ACT
Coroner:	G.S. Theakston
Date of Findings:	30/1/2018
Reported as:	[2018] ACTCD 2

Annexure A - Findings and Recommendations

Findings	Paragraph
1: In March 2012, Mr Douglas was suffering from lung cancer.	69
2: The treatment for Mr Douglas' lung cancer was appropriate.	78
3: Following Mr Douglas' re-admission to The Canberra Hospital on 24 October 2012, Mr Douglas received systematic and vigorous treatment for a respiratory infection.	128
4: On 11 December 2012, Mr Douglas died at The Canberra Hospital.	129
5: Mr Douglas' death was directly caused by respiratory failure, with antecedent causes including: (a) chronic emphysematic lung disease; (b) inflammatory lung damage, including possibly from radiation therapy; and (c) acute respiratory infection of unknown type and origin.	130
6: On 3 April 2012, Assoc Prof Sanjiv Jain, when reporting on the core biopsy sample taken from Mr Douglas on 30 March 2012, incorrectly diagnosed the sample as malignant and as evidencing primary pulmonary adenocarcinoma. The sample involved features making diagnosis difficult.	139
7: Treating clinicians relied upon Assoc Prof Jain's diagnosis, as the diagnosis informed treating clinicians about what treatment would be appropriate. It also deterred clinicians from repeating the biopsy that may have in turn provided a reliable diagnosis.	140
8: In April 2012, ACT Pathology had in place a process of reviewing lung core biopsies. That process was linked to a weekly quality assurance meeting. However, due to the Easter long weekend the quality assurance meeting of 10 April 2012 did not take place and the core biopsy taken from Mr Douglas' lung on 30 March 2012 was not reviewed by a second pathologist.	147
9: In 2013, ACT Pathology established a quality assurance process, decoupled from any meeting, with a protocol clearly setting out how biopsies, including all lung core biopsies, would be reviewed by a second pathologist. That process includes quarterly audits to ensure compliance and adequately addresses the systemic failings associated with Mr Douglas' biopsy.	148
10: A number of clinicians erroneously assumed the Epidermal Growth Factor Receptor Mutation Analysis conducted by the Peter MacCallum Cancer Institute critically reassessed the original diagnosis of adenocarcinoma.	158
11: There were limited records available from the Lung Multidisciplinary Meeting of 16 April 2012.	162
12: Following Mr Douglas' death, The Canberra Hospital conducted an autopsy, limited to the lungs and chest wall, as consented to by Mr Douglas' wife, Mrs Kerry Douglas. The limited nature of that autopsy was appropriate given what was known at the time.	171
13: During the autopsy Dr Lavinia Hallam directed the assisting registrar, to take photographs of the body and a section sample from the chest wall. The photographs and section sample were not taken. Dr Hallam did not check whether the photographs and section sample were taken, and did not discover that they were not taken until after the completion of the autopsy.	192

Recommendations	Paragraph
1: The Canberra Hospital continue to periodically review its quality assurance processes for core biopsies, to ensure that such processes appropriately balance the need to minimise the risk of errors with the costs of associated control measures. Such processes should involve an element to check and ensure compliance.	149
2: The Peter MacCallum Cancer Institute consider reviewing the words used within its reports for the Epidermal Growth Factor Receptor Mutation Analysis to ensure that treating clinicians are disabused of any erroneous assumption that the test either reassesses the original diagnosis or positively identifies tumour cells.	159
3: The Canberra Hospital consider introducing a protocol that require appropriate records be made of Lung Multidisciplinary Meetings, and that such records be appropriately stored.	163

Court Reference: CD 250/16  
Age: 85 years  
Gender: Female  
Date of Death: 21/10/2016  
Place of Death: Ainslie, ACT  
Coroner: P.J. Morrison  
Date of Findings: 27/2/2018  
Reported as: [2018] ACTCD 3

1. Elfriede Adele Tremethick died on 21 October 2016 at Calvary Hospital, Mary Potter Circuit, Bruce, in the Australian Capital Territory;
2. The manner and cause of death of Ms Tremethick are sufficiently disclosed and a hearing is unnecessary;
3. The manner and cause of Ms Tremethick's death is acute exacerbation of congestive heart failure, following injuries suffered in a fall; and
4. Pursuant to s 52(4)(a)(i) of the *Coroners Act 1997*, no matter of public safety is found to arise in connection with this inquest.
- ...
7. While the aspects of suboptimal care identified by Professor Duflou and ACTAS are generally of concern, I accept the opinion of Professor Duflou that it is unlikely that these contributed to Ms Tremethick's death. In those circumstances, I make no comments adverse to ACTAS, or the paramedics who attended on Ms Tremethick on the day of her death.
8. I have considered whether the findings in relation to the treatment by ACTAS, and particularly the airway management matter, otherwise give rise to a matter of public safety.
9. ACTAS has advised me of the remedial action it had already undertaken in response to this case. Most directly, feedback was provided to the relevant staff members on

the issues of concern. Specific steps taken to address the system and process issues arising from this incident were as follows:

- a. Key topics arising from Ms Tremethick's death were covered during the Paramedic clinical in-service training program in 2017, including revision of cardiac arrest management, teamwork and communication processes when multiple officers are on scene, review of advanced airway management, and an advanced airway management simulation exercise.
  - b. ACTAS's policy around termination of resuscitation and management of deceased persons is being reviewed and is in the process of being updated. Relevant to Ms Tremethick's case, the policy will reinforce current practice as to the circumstances under which paramedics should cease resuscitation and that urgent transport to an Emergency Department is not warranted after a patient has died.
  - c. A systemic review of airway management practices is underway for consideration by the ACTAS Clinical Advisory Committee in March 2018. Relevant to Ms Tremethick's case, the draft document reiterates the importance of placing an advanced airway in patients in cardiac arrest.
10. ACTAS has acknowledged that it did not fully meet its usual standards in caring for Ms Tremethick and it deeply regretted any distress this has caused her family. ACTAS adopted a proactive approach in identifying issues and concerns and undertaking remedial action as a priority.
11. In light of the rectification actions already undertaken by ACTAS, I am not persuaded that the issues of concern found in this case either singularly or in combination amount to a matter of public safety within the meaning of that term in the *Coroners Act 1997*. I do however note that while on the facts of this case the decision not to intubate Ms Tremethick probably made no difference to her outcome, it is foreseeable that in other cases such a decision could directly affect the outcome for a patient.

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Court Reference:	CD 250/16
Age:	28 years
Gender:	Female
Date of Death:	28/2/2015
Place of Death:	Calwell, ACT
Coroner:	P.J. Morrison
Date of Findings:	28/2/2018
Reported as:	[2018] ACTCD 4

1. Tara Maree Costigan died on 28 February 2015 at Unit 38, 12 Duggan Street, Calwell, in the Australian Capital Territory;
2. The manner and cause of death of Ms Costigan are sufficiently disclosed and a hearing is unnecessary;

3. The manner and cause of Ms Costigan's death are incised wounds to the neck and chest which were intentionally inflicted upon her by Marcus Rappel, her ex-partner; and
  4. Pursuant to s 52(4)(a)(i) of the Coroners Act 1997, no matter of public safety is found to arise in connection with this inquest.
  - ...
  10. I have identified two areas where processes could be improved.
    - a. Ms Costigan was advised by Police to apply for a protection order in person at the ACT Magistrates Court. Since the introduction of the FVCU after Ms Costigan's death, the involvement of that unit would be triggered and Police would assist applicants to obtain orders. In addition, the FVCU would assist and support the applicant in various ways, including in considering an immediate family violence safety plan and risk assessment. As arrangements presently stand, the involvement of the FVCU is triggered only by a victim presenting to Police, and not when a victim makes a direct application to the Court for a protection order.
    - b. Service of a protection order on a respondent is recognised as a potential trigger for family violence, as it was in Ms Costigan's case. At present an applicant is not routinely informed of the fact of service and this information may be of assistance to other applicants in the future.
  11. I recommend a review of court and police processes and practices with a view to:
    - a. The possible involvement of FVCU in all family violence order applications, not only those brought by Police; and
    - b. Timely notification to affected persons when service of an order on a respondent has taken place.
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Court Reference: CD 250/16  
Age: 88 years  
Gender: Male  
Date of Death: 18/12/2016  
Place of Death: Calwell, ACT  
Coroner: P.J. Morrison  
Date of Findings: 28/2/2018  
Reported as: [2018] ACTCD 5

1. Edward Robert (Ted) Davis died on 18 December 2016 at BUPA Aged Care Facility, 43 Were Street, Calwell, in the Australian Capital Territory;
2. The manner and cause of death of Mr Davis are sufficiently disclosed and a hearing is unnecessary;
3. The cause of death was left frontal lobe haemorrhage due to a fall; and
4. Pursuant to s 52(4)(a)(i) of the *Coroners Act 1997*, a matter of public safety is found to arise in connection with this inquest.
- ...
11. In all the circumstances I conclude that BUPA Calwell's current practices in respect of the use of sling lifters give rise to a matter of public safety in respect of persons



constituting that section of the public who are residents of the facility. I recommend that BUPA Calwell review and revise their practices, any relevant policies, and staff training in respect of the positioning of sling lifters around patients prior to active deployment of the equipment. I direct that a copy of my findings in this matter be sent to BUPA Calwell.

12. I direct also that a copy of my findings be sent to the Australian Aged Care Quality Agency, which oversees aged care facilities across Australia, for their information and any action they consider appropriate in relation to these types of lifters.

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Court Reference:	CD 125/16
Age:	25 years
Gender:	Male
Date of Death:	27/8/2017
Place of Death:	Symonston, ACT
Coroner:	R.M. Cook
Date of Findings:	11/4/2018
Reported as:	[2018] ACTCD 7

**Mandatory hearing – death in custody**  
**Reported under 102(a), (d)**

I find that:

1. The deceased was Steven Claude Freeman, an Aboriginal Bundjalung man born 13 February 1991 and aged 25 years at the time of death.
2. Narelle King, a Bundjalung woman originally from Lismore, is his mother and his father was Steven James Freeman. Steven Freeman was the fifth child of six siblings and one of three boys.
3. Steven passed away in the early hours of the morning of 27 May 2017, while sleeping on his bed, inside cell 13 as a prisoner within the Alexander Maconochie Centre (AMC). The AMC is an ACT Government owned and operated correctional facility, located at Symonston, in the Australian Capital Territory.
4. Dr Graeme Thompson declared Steven Freeman deceased at 11:11 AM on 27 May 2016 and a formal certificate of life extinct was made by Dr Jane Van Diemen at 3:15 PM that day.
5. On my direction, pathologist, Professor Dr Johan Duflou conducted a post-mortem examination of Steven on 30 May 2016. The post-mortem report dated 2 July 2016 and the Professor's supplementary report of 9 August 2016 declared the cause of death to be Aspiration Pneumonia secondary to Methadone Toxicity.
6. Aspiration Pneumonia is an inflammation of the lungs and bronchial tubes which occurs after the inhalation of oral or gastric contents.
7. A person given Methadone who is opioid or Methadone naïve may experience an adverse reaction, in that Methadone may cause the consumer to experience respiratory depression, cough suppression and obtundation (less than full alertness).

8. It is these respiratory consequences following the consumption of Methadone that enable the movement of gastric contents up and into the oesophagus and then into that person's lungs.
9. Steven made an application to be placed on the ACT Health Methadone Maintenance Program (MMP) at the AMC on 5 April 2016.
10. Steven had opioid history while at the AMC, the extent of which is unknown but it appears to have been minor. The first recorded evidence of Steven having used an opioid substance occurred on 12 December 2015 when he was found to have Buprenorphine, an opioid, in his possession. Steven further tested positive to Buprenorphine following urinalysis of the sample taken on 12 December 2015.
11. Further, there is the AMC medical officer Dr Luke Streitberg's Patient Progress Note said to record Steven's representation to the Doctor that Steven was smoking heroin while he was at the AMC in the months prior to his medical assessment to enter the MMP; that Steven represented to the Doctor that Steven had used heroin two days prior to the assessment; Steven is further recorded as having conveyed to Dr Streitberg he was considering using heroin intravenously and further that he was incurring '*debt*' as a consequence.
12. There is also limited evidence of Steven having non authorised access to Methadone referred to as '*drinks*' provided by other detainees. A '*drink*' is the regurgitation of a prisoner's oral Methadone dose after it has been administered and supervised by the dispensing medical staff. It is regurgitated into a container by the detainee, where it is mixed with water or disguised with orange juice for re-consumption by another detainee.
13. Methadone received in this manner is diluted, although as to what extent is not known, as it will all largely depend on what is in the stomach of person giving up the '*drink*', on any particular day. Ordinarily, Methadone is not absorbed by the body until 20 minutes after it has been consumed.
14. While I acknowledge there is some history of opioid use I am satisfied Steven had an extremely low use of opioids. As I accept the findings set out in both the post-mortem report and the supplementary report provided by Prof Dr Duflou that Steven was likely to have been a low user of opioid substances even to the extent that he may have been opioid naive.
15. Based on the evidence from the pathologist, the toxicologist, Steven's personal history and other sources identified in my reasons, I am satisfied that Steven was also more likely than not to have been a low consumer of '*Spit Methadone*' at the time of entering the MMP given that it is diluted both being a product of regurgitation then being mixed subsequently with either water or orange juice.
16. Dr Streitberg, notwithstanding the absence of any independent evidence before the Doctor at the time of the consultation that Steven was opioid dependent, accepted Steven's representations that he was a heroin user while within the AMC, had previously been smoking heroin and was considering using it intravenously having last used two days before the assessment. In doing so it was recorded by the Doctor that Steven was incurring debt as result of Steven's heroin use.

19. While there is evidence of Steven taking a 'drink' and an instance of having used Buprenorphine in December 2015<sup>6</sup> while in custody. At the time of making his application to the AMC's Hume Health Centre to be placed onto the MMP, Steven had 15 days earlier received the results of a urinalysis which showed no presence of illicit substance in his system.
20. The Dr Luke Streitberg following his medically assessed Steven for placement onto the MMP at the Hume Health Centre. Following that assessment Steven was placed onto the MMP.
21. Methadone is a Schedule 8 Drug. Steven required a prescription to legally obtain it. Dr Luke Streitberg, the assessing Doctor at the Hume Health Centre, issued a prescription for Steven Freeman to receive 30mg of Biodone (Methadone) daily.
22. The first dose was given to Steven following the medical assessment at 10:40 AM on the morning of 25 May 2016. Notwithstanding there was no authorisation for the prescription from ACT Health until the next day. Although the relevant guideline allows for a first dose to occur without receipt of the authorisation. This may create an inconsistency in the Schedule 8 prescription and dispensing laws.
23. Steven received a second dose on the morning of 26 May 2016 at 8:50 AM. On that day the ACT Health provided its authorisation approving dosing for Steven of up to 120 mg of Methadone daily.
24. The amount of 30 mg of Methadone fell within the therapeutic, toxic and lethal range. Steven received no further prescribed methadone from the Hume Health Centre.
25. I am satisfied, pursuant to section 13 of the ACT *Coroners Act 1997* (the Act), that the circumstances of Steven's death constituted a death in custody. As a consequence, I am required by the operation of section 34A(2) to hold a hearing as part of the inquest into Steven's death.
26. I find that, pursuant to section 74 of the Act, the steps undertaken by the supervising medical officer Dr Luke Streitberg at the Hume Health Centre for the placement of Steven onto the MMP did not affect the quality of care, treatment and supervision of Steven Freeman to the extent that it could be said to have contributed to his cause of death.
27. I am satisfied that Dr Streitberg, notwithstanding the absence of any independent evidence at the time before the Doctor, other than the representations of Steven Freeman and the Doctors own observations, that Steven Freeman was experiencing opioid withdrawal. Dr Streitberg accepted Steven Freeman's representations that he in fact was a heroin user while within the AMC, had previously been smoking heroin and was considering using it intravenously having last used two days before the assessment. In doing it was recorded by the Doctor that Steven was incurring debt as result of Steven's representation as to heroin use. Further, Steven had been recorded by corrections officers on 12 December 2015 as having used the opioid Buprenorphine when he tested positive on urinalysis and he also had more of a substance concealed in a tobacco papers packet.

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<sup>6</sup> P537-8 Coronial Brief Volume 2 of 3 Exhibit 2

28. I am satisfied Dr Streitberg, explained the rights and responsibilities of Methadone use, and the risks associated with Methadone use. Steven's signature on the Rights and Responsibilities form acknowledges the same. Dr Streitberg having formed the belief that Steven Freeman was in mild withdrawal at the time of the assessment, authorised Steven's placement onto the MMP and subsequently prescribed the amount of 30 mg of Methadone daily.
29. The Patient Progress Note made by the Doctor revealed that Steven had never been on a Methadone maintenance program before. There was no indication that Steven Freeman had relayed to the Doctor that he had consumed '*Spit Methadone*' or any other opioid like Buprenorphine in the past.
30. Further, pursuant to section 74 of the Act, I find that the dispensing of Methadone in accordance with the prescription and policies in place at the time by Hume Health Centre Nurses on 25 and 26 May 2016, did not affect the quality of care, treatment and supervision of the deceased to the extent that it could be said to have contributed to the cause of death.
31. Further, pursuant to section 74 of the Act, I recognise deficiencies and inconsistencies within the MMP administrative frameworks applied by ACT Health focusing on the ACT's Standard Operating Procedures (SOPs), the National Guidelines and a range of supporting literature in determining placement on to a Methadone maintenance program and the appropriate commencement doses. I am however, unable to conclude in this particular circumstance those deficiencies and inconsistencies affected the quality of care, treatment and supervision of Steven Freeman to the extent that it could be said to have contributed to his cause of death.

### **Matters of Public Safety**

32. Methadone maintenance programs have their place both within the broader ACT community and the prison community, all being administered by ACT Health.
33. I provide recommendations for the Government's consideration following my findings that matters of public safety are identified as a result of Steven's placement on to ACT Health's MMP. Such considerations apply to the broader community as much as they do to the AMC detainee community given that ACT Health is responsible for both communities and the authorised dispensing of Methadone within the ACT.
34. These recommendations highlight potential inconsistencies or uncertainties across ACT Health's SOPs, the National Guidelines and matters raised in evidence during the course of the hearing.
35. In regard to the Territory's submissions and the evidence of Mr Bruno Aloisi and Registered Nurse Lutz at hearing, the ACT Government has sought to respond quickly to matters which were identified as the hearing unfolded. It has done this through other jurisdictional visits and at the consequence of other recommendations arising from the Government's self-initiated reviews prior to and following the commencement of this inquest such as the Moss Review and the Health Services Commissioner's Review.
36. It was not appropriate for me to have considered the content of those self-initiated reviews or their recommendations given they came into existence as a consequence of Steven Freeman's death and not prior to it.

37. It should be noted however the Government's position to date appears to have been responsive to the Freeman family's underlying concerns to avoid, so far as systemically and humanly possible, a similar based death in the future.
38. I hope the following recommendations provide Government with the opportunity to address specific issues identified in the course of the hearing. Although not directly contributing to the cause of death, they were identified as part of the examination of circumstances underlying the manner of Steven's death.

## **Recommendations**

### **A. Security and Wellbeing Checks**

As an observation, life within a custodial environment appears amongst other things, to be one of repetition, rules, anger, frustration, observation and structure affecting both detainee and corrective officers equally, albeit differently, as they go about their daily routines.

From a Correctional Officer's perspective, complacency through routine can be an adverse consequence of such an operating environment. The procedures in place for the daily muster or headcount requires a Correctional Officer to be fully satisfied as to detainee health and well-being.

This recommendation is not a criticism of Corrections Officers. It is aimed at the complacency derived potentially from inconsistent policies they are required to operate within.

The fact the AMC's own review found it acceptable that *'a foot movement from a detainee was a typical and acceptable response to the morning headcount as most detainees are in bed'*, should no longer be deemed to be satisfactory compliance for establishing a detainee's health and well-being.

The morning welfare check on Steven Freeman, while not probably affecting his the quality of his care, treatment or supervision so as to have contributed to the cause of death, did not meet the AMC's then existing procedures.

Further, there is an inconsistency through the internal management review conducted by the AMC at 3.3.3 on page 50 which says that checks do not require a detainee response.

This does not appear to be correct. The first headcount for morning muster as observed on the CCTV recording conducted on Steven Freeman cell on the morning of 27 May 2016 is inconsistent to the AMC's established procedures set out within the Corrections Management (AMC Muster and Headcount) Policy for an account of detainee location, health and well-being.

I acknowledge while not requiring a detainee to formally respond, the policy suggests something more is required to be done than the movement of a foot, given the requirement is that a *face to name positive identification is to be undertaken* as set out within the AMC policy.

Further, the entry into the cell at 10:02 AM by a Corrections Officer did not appear to meet the requirements of a security and well-being check.

My recommendation: The ACT Government should review the then existing practices and to remove inconsistencies in policies and procedures relied upon by correctional services officers so as to ensure prisoner safety and welfare checks through musters and headcounts which require eye contact and facial recognition to be complied with. The extent of compliance with those procedures, given their purpose is to ensure the safety and well-being of a detainee, should be evaluated and tested periodically to ensure they are effective and practical and minimise complacency through their routine application.

### ***B. Physical Education and Training***

In the course of the inquest there was anecdotal evidence that there was no effective physical education awareness or daily training offered to detainees other than what they might generate or engage in themselves.

That there is a third of AMC detainee population on the MMP is perhaps unsurprising and is perhaps reflective of the pervasive role drugs are playing within the ACT community.

The fact there is no structured compulsory physical education or training sessions run by ACT Health for detainees was nonetheless startling.

The fact that a prisoner could remain in bed or at least be in their cell from approximately 6:30 PM on the evening before through the morning headcount at 7:45 AM until 11 AM is concerning.

My recommendation: The ACT Government should consider the viability or effectiveness that a daily structured compulsory physical education and training session might have on a prisoner focusing on the prisoner's well-being and rehabilitation coupled with drug rehabilitation counselling. Any consideration of such a course would need, I acknowledge, to be factored into current alcohol and drug support programs within the AMC and the various sentencing periods for detainees.

### ***C. Access to Illicit Substances in Custody***

Dr Streitberg on 25 May 2016 makes an entry on ACT Health Progress Note that Steven Freeman reported ongoing heroin use for the '*last few months*' and also consumed two days prior to the assessment. This is a concern given Steven Freeman, for at least the '*last few months*', had been a detainee at the AMC. It is a further concern given there was no evidence confirming a prior history of opioid-based substance use by Steven Freeman, prior to being remanded in custody.

My recommendation: The ACT Government should ensure that minimising the infiltration of illicit substances into custodial facilities remains at the forefront of screening technology.

***D. Cross Agency Referral of Court Alcohol and Drug Assessment Reports***

Steven Freeman's multiple prior contacts with the criminal justice and corrections systems suggests that he was well known to ACT Corrective Services.

It would therefore be reasonable to assume that ACT Corrective Services and other government and non-government entities involved in the preparation of sentencing reports were likely to hold significant information about Steven and his personal circumstances and use of illicit substances.

I am unable to ascertain from the evidence presented to me that the sharing of such reports and documents with the Hume Health Centre occurred or was even available. The fact that they existed may have been helpful to the treating doctor at the time of Steven's MMP assessment.

From a privacy perspective personal information may be used or disclosed where that use or disclosure is necessary to lessen or prevent a serious threat to the life, health or safety of any individual as permitted by section 16A of the Commonwealth privacy legislation.

Section 12 of the *Human Rights Act 2004* (ACT) provides that people within the Territory have the right to not have their privacy, family, home, or correspondence interfered with arbitrarily or unlawfully.

However, these are not unfettered rights. These rights can be impinged upon in order to ensure that appropriate action is taken in order to lessen or prevent a serious threat to the life, health or safety of an individual.

Court Alcohol and Drug Assessment Service (CADAS) reports made on Steven Freeman outlined his representations as to his use of illicit substances. The content of that report referred to in my reasons was significantly different to that of the AMC Hume Health Centre induction record, which was also based on Steven Freeman's revelations during that induction.

Had Dr Streitberg had access to that CADAS information it may have assisted in his assessment of Steven Freeman given the inconsistencies in information and his experience concerning the truth of claims made by detainees seeking access to drugs within the correctional facilities.

Steven Freeman was subject to 2 urinalysis tests conducted whilst detained in the AMC: the first on 12 December 2015, which ultimately revealed Steven's use of Buprenorphine an opioid, and the second on 10 May 2016, which returned a negative result. The results of both tests, had they been made available to Dr Streitberg, may have affected his considerations in placing Steven on the MMP or the commencement level of Methadone.

My recommendation: ACT Health should consider obtaining either by consent from a prisoner or through reliance on legislation, a prisoner's medical records and all relevant reports from alcohol and drug perspective created prior to incarceration for incorporating

into a detainee electronic medical file for the purposes of an AMC induction or prior to any assessment for access to pharmacotherapy treatment.

Further, for detainees who are placed onto pharmacotherapy programs, such as the MMP, that in the interest of the health and safety of the detainee and his or her well-being, information of this type should be shared with ACT Corrective Services conducting prisoner headcounts and musters for the very purpose of determining a detainee's location, safety and well-being.

Equally, any independent urinalysis results undertaken by ACTCS should be placed on the detainee's medical record to enable medical staff to have a complete picture of the detainee's use of illicit substances compared to those substances, if any, prescribed through the Hume Medical Centre.

#### ***E. Amendments to the ACT Standard Operating Procedures***

The relevant policies and procedures provide that the maximum dose for Methadone was 120 mg with the minimum dose being 2.5 mg. However, the dot point following immediately in the SOP, provides that doses of less than 25 mg will only be prescribed as part of a planned reduction schedule for a maximum of two weeks.

This suggests, if it is correct, that ACT Health adopt a practice that the minimum dose of Methadone would be at least 25 mg. The prescriptive nature of the commencement dose of 25 mg has the potential to remove individualised treatment options and to direct medical staff including those making prescriptions to a '*one fits all*' approach in the setting of the commencement of Methadone level.

My recommendation: The ACT SOP's should be reviewed and the focus should be on prescribing individualised treatment setting out the parameters for commencement doses of Methadone for instance be anywhere from 5 to 20 mg with the ability to increase daily on medical review only.

#### ***F. Detainee self-prescribing each Sunday increased doses of Methadone***

The current practice of allowing a detainee to increase each Sunday by up to 5 or 10 mg their existing Methadone dose without medical review is a safety concern.

My recommendation: The SOP should be reviewed to ensure that those who have only recently commenced on the Methadone program not be allowed to self-prescribe increases for a set period of time to ensure they are in a physiological sense, capable of accommodating the increased amount of Methadone. Further and in the alternative, the ACT Government should consider whether not it is even appropriate to allow such increases to occur for a Schedule 8 drug.

#### ***G. Clarifying inconsistencies between ACT SOPs and Guidelines and the National Guidelines***



A number of documents were tendered in evidence before the court they included the National Guidelines for Medication-assisted Treatment of Opioid Dependence (April 2014), Justice Health Services Standard Operating Procedures for the Management of adult patients receiving Opioid Replacement Treatment at the AMC and the ACT Health, ACT Opioid Maintenance Treatment Guidelines (ACTOMTG). In my reasons I set out a number of provisions which highlighted a number of inconsistencies between those relevant documents.

The detail for instance of the National Guidelines provide a clear approach to induction and immediate follow-up services for a person being commenced on methadone. The use of the terms Guidelines and Standard Operating Procedures can have an effect on the person subject to them in that SOP's set a defined course to follow were as guidelines only offer guidance.

The National Guidelines offer a very detailed approach to the assessment, induction and immediate medical services to be provided to a person commencing on methadone. The National Guidelines appear comprehensive, informative and easy to follow. Albeit recognising the discretion in commencing levels of methadone. They provide relevant forms and checklists.

While I acknowledge the work of Justice Health Services, as put into evidence through RN Lutz, in making amendments to relevant guidelines to rectify the deficiency as to the 2 to 3 hour medical follow-up after first dosing of methadone and other significant changes the review should not stop there.

My Recommendation: ACT Justice Health Services to consider whether or not adopting the National Guidelines to replace the ACTOMTG and incorporating random urinalysis or blood tests where there is no objective medical history of opioid dependence prior to placement on to the MMP.

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Court Reference:	CD 38/14
Age:	71 years
Gender:	Male
Date of Death:	16/2/2014
Place of Death:	Garran, ACT
Coroner:	P.J. Morrison
Date of Findings:	26/4/2018
Reported as:	[2018] ACTCD 8

1. John Bell died on 16 February 2014 at The Canberra Hospital, 1 Dann Close, Garran, in the Australian Capital Territory;
2. The manner and cause of death of Mr Bell are sufficiently disclosed and a hearing is unnecessary;
3. The manner and cause of Mr Bell's death was cardiac arrest, due to hyperkalemia due to acute on chronic renal failure, with a recent laparotomy for ileostomy reversal being a significant condition that contributed to death; and

4. Pursuant to s 52(4)(a)(i) of the *Coroners Act 1997*, no matter of public safety is found to arise in connection with this inquest.

...

7. While the aspects of suboptimal care identified by Dr Phoon and ACT Health are generally of concern, I accept the opinion of Dr Phoon that while these may have influenced Mr Bell's clinical course, the evidence does not rise to a level whereby these matters are directly contributory to Mr Bell's death. In those circumstances, I make no comments adverse to TCH, or the medical practitioners who treated Mr Bell, in the sense of any contribution to Mr Bell's death.
8. Were it not for the remedial actions of TCH and the ACT Health Directorate, I would have found a matter of public safety arose in connection with Mr Bell's death. Against the background of the response from the acting Director-General I conclude that no matter of public safety presently exists. On that basis there is no need to make a recommendation on this matter.

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Court Reference: CD 38/14  
Age: 71 years  
Gender: Male  
Date of Death: 16/2/2014  
Place of Death: Calwell, ACT  
Coroner: L.E. Campbell  
Date of Findings: 4/5/2018  
Reported as: [2018] ACTCD 9

1. Tahadesse Kahsai died sometime on or after 30 December 2015 and before 2 January 2016 in bushland bordered by Ginninderra Drive, Agar Street and Masterman Street, in Bruce in the Australian Capital Territory;
2. The manner and cause of Mr Kahsai's death is as a result of exposure and dehydration, preceded by alcohol withdrawal and a long history of chronic alcoholism, although a specific medical cause of death has not been established; and
3. Pursuant to the requirements of s 52(4)(a)(i) of the *Coroners Act 1997* I state that two matters of public safety arise in connection with this inquest.

...

**First matter of public safety: failures in the notification process**

38. As Senior Constable Callaghan identified in his brief the evidence supports (and I make) the following findings:
- a. Preliminary information about Mr Kahsai's disappearance, initially reported by the hospital to police via a phone call was not recorded on the police database awaiting dispatch. This resulted in there being no initial police record of the incident being kept and created a situation of individual memory reliance instead of the priority-based accountable computer aided dispatch system.

- b. Police waited for the Missing Patient Report form to be received before they took any action. This resulted in police inactivity in the hours after Mr Kahsai left the hospital.
  - c. An error was made by Nurse Liu entering an incorrect police email address when sending the Missing Patient Report to the police. The hospital believed that police were investigating Mr Kahsai's disappearance however as the police had not received the report they were not.
  - d. Different police received the Missing Patient Report a day later. They interpreted the delay between Mr Kahsai's leaving the hospital and the report being received as indicating a lack of urgency. The dispatch priority was changed to less urgent. This resulted in a police patrol being dispatched non-urgently. The responding patrol acknowledged the job but continued to conduct enquiries in relation to a previous disturbance. Thirty seven minutes after being dispatched the patrol conducted their first enquiry at Mr Kahsai's residence rather than at the hospital. The assumption was drawn that Mr Kahsai would have returned home by then.
39. It is clear that fault in this regard lies with the processes of both the hospital and the AFP. However as I have already indicated I make no adverse comment or finding against any individual.
40. As will be discussed later, both the hospital and the AFP have recognised their shortcomings in policy and procedures and moved quickly to rectify them.

## **Second matter of public safety: police handling of the missing person investigation**

### *Appropriateness of police risk assessment*

41. In late 2015 Constable Salleo and acting Sergeant Hoyer were inexperienced in conducting their respective roles in a missing person investigation. Mr Kahsai's case was their first as case officer and team leader respectively. While it was certainly open to them to have sought advice from other colleagues, it is clear that they relied heavily on the AFP National Guideline on Missing Persons to direct them in the investigations they should take and the timeframes which applied in respect of certain actions which were to be undertaken. Constable Salleo agreed that aspects of the National Guideline were confusing and acting Sergeant Hoyer acknowledged that he could have, and in hindsight should have, sought advice from more experienced colleagues.
42. Senior Constable Callaghan has suggested, and I agree, that the current risk assessment process which is required as part of the completion of the AFP Missing Person Report is inadequate. In Mr Kahsai's case the assessment process resulted in a critical decision, namely the determination of whether an incident was a 'high risk' matter, resting in the discretion of a 'Team Leader'. In this case that officer was an inexperienced acting Sergeant not a more experienced officer or an on-call Search and Rescue specialist.

43. The AFP have acknowledged the inadequacy of the process outlined by the National Guideline then in operation, including the process of risk assessment, and have moved quickly to rectify these shortcomings.

*Handover of investigation and case officer protocols*

44. The circumstances in this case appear to have been that Constable Salleo as case officer did not hand over the case on 31 December 2015 to another colleague as he understood then acting Sergeant Hoyer was continuing to work on the case the following day. Similarly acting Sergeant Hoyer did not hand over the job to the next Sergeant on duty because there were no further avenues of enquires available that night and because he was planning to attend Mr Kahsai's address the following day.
45. It was open to Constable Salleo to have relied upon guidance from his team leader in relation to handovers and conduct of the investigation, notwithstanding the comparative lack of experience of then acting Sergeant Hoyer. However, the outcome of his not handing over the job was that the investigation 'floated'. Only Constable Salleo actively worked on the case, and then only on the few days in January 2016 when he was actually at work.
46. Again the AFP have acknowledged the inadequacy of the process outlined by the National Guideline then in operation, including the impact of response taskings and shift allocations (including rostered days off) on case officers, and have moved quickly to rectify these shortcomings.

**Recommendations**

47. Senior Constable Callaghan proposed a number of recommendations for my consideration. During the course of the hearing it became clear that many of those suggestions have in fact already been taken up and were either already implemented or were under active consideration by the AFP and the hospital.
48. This reflects the quality and appropriateness of Senior Constable Callaghan's recommendations and the seriousness with which both the AFP and the hospital have taken them. I am greatly reassured by the approach taken by both the hospital and the police in responding to the recommendations.
49. Coroners are not experts in the administration of organisations such as hospitals or police forces so it is incumbent on me not to make recommendations that may be impracticable or inappropriate to implement. In all the circumstances I consider the only recommendations I need make about positive changes to processes and procedures are that:

I recommend the AFP and Calvary Public Hospital continue the reviews that are already ongoing with regard to the circumstances of Mr Kahsai's death having particular regard to the evidence in this matter and Senior Constable Callaghan's recommendations. I also recommend both agencies consider the recommendations contained in paragraph 14 of the immediate family's

statement and submissions to the coroner to see if any of those recommendations might further inform future institutional changes.

50. One matter which arose tangentially was that Mr Kahsai's treating practitioners did not appear to have a good working knowledge of the applicable mental health provisions and possible powers of emergency apprehension. I accept the submissions of Counsel for the Territory that this may not indicate a general deficit. However I consider it appropriate that I recommend that the director general of ACT Health, as the person with ultimate responsibility for mental health legislation, undertake an information campaign directed at persons in the health system who are likely to be asked to consider the possibility of emergency apprehension. This is to ensure that they are fully informed of the availability of powers under mental health legislation.

#### Comment

51. A recurring theme from the evidence of the witnesses was that there was an absence of good quality notes made contemporaneously by employees of both the police and the hospital in relation to various events or conversations. Detailed notes are so useful in corroborating an individual's memory of what actually occurred. Memory after all is notoriously unreliable especially when it is called upon so many years after an event. I am acutely conscious of the limitations of note keeping in emergency and clinical situations but I make a general comment by way of a reminder to all of the importance of good record keeping.

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Court Reference:	CD 312/13
Age:	57 years
Gender:	Female
Date of Death:	18/12/2013
Place of Death:	Turner, ACT
Coroner:	M.A. Hunter
Date of Findings:	25/6/2018
Reported as:	[2018] ACTCD 10

1. I, Coroner Margaret Hunter, find that Suellen Davis born 20 February 1956, died at 3/52 Ormond Street, Turner at 15:56 hours on 18 December 2013.
  2. I further find that the cause of her death was positional asphyxia caused by the combined effect of the consumption of several opiate containing medications, including Oxycodone, Fentanyl, Doxylamine, Promethazine and possibly Promethazine and Pregabalin which led to sedation, respiratory depression and positional asphyxia.
- ...
49. I am satisfied that the effect of consuming the over the counter medications of Dolased and Promethazine found on toxicology together with her regular opiate medications caused Ms Davis to experience a significant sedative effect. That effect would have been increased if she was also taking Pregabalin (Lyrica).

50. I am also satisfied that the significant sedative effect of those medications would likely cause Ms Davis to be unable to extricate herself from the position in which she was found.
51. I am also satisfied that she was becoming more sedated than usual in the weeks prior to her death and that she was more difficult to rouse than before.
52. I am satisfied that the position which she was found in was capable of occluding or partially occluding her airway in a setting where she would have experienced respiratory depression as a result of the sedative effect of the multiple medications found on toxicology.
53. I am satisfied that the substantial amount of fluid (blood) found upon attempted intubation, seen by ambulance officer Kelly supports a finding of asphyxia.
54. I am satisfied there is no other cause of Ms Davis's death found.
55. I have considered the evidence and conclusions I have drawn from that evidence in a setting of considering the 2 articles referred to above.
56. Those findings together with the position Ms Davis's body was found in lead me to the inexorable conclusion that she died from positional (sometimes known as postural asphyxia).
57. On the evidence before me I am satisfied Ms Davis's cause of death is positional asphyxia due to the sedative effect her prescription medications and over the counter medications had upon her. I make the formal findings announced at the start of my reasons.

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Court Reference:	CD 200/14
Age:	65 years
Gender:	Female
Date of Death:	10/9/2014
Place of Death:	Griffith, ACT
Coroner:	B.C. Boss
Date of Findings:	28/6/2018
Reported as:	[2018] ACTCD 11

1. Constance Carolle Harrison died on 10 September 2014 at the intersection of Canberra Avenue and Manuka Circle, Griffith, in the Australian Capital Territory;
2. The manner and cause of death of Ms Harrison are sufficiently disclosed and a hearing is unnecessary;
3. The manner and cause of Ms Harrison's death is severe crush injury of chest due to involvement in a motor vehicle accident; and

4. Pursuant to s 52(4)(a)(i) of the Coroners Act 1997, a matter of public safety is found to arise in connection with this inquest.
- ...
6. It became apparent during the course of the investigation that Ms Harrison was lawfully crossing Canberra Avenue at a marked pedestrian crossing in accordance with the lights ie. the "green man", but that the pedestrian light turned green at the same time as the ordinary traffic signal. I consider that this simultaneous signalling constitutes a matter of public safety insofar as turning vehicles are permitted to cross pedestrian crossings at exactly the same time pedestrians are told they can cross the road.
7. Ms Harrison's family made the suggestion, supported by the Police Crash Investigation Team, that the traffic signals at the intersection in question be modified to allow pedestrians to walk unimpeded for several seconds prior to any other traffic receiving green signals and entering across that intersection. The suggestion was informed by advice that NSW Roads and Maritime Services had adjusted approximately 5000 sets of signals across the Sydney CBD to achieve this outcome as a result of a similar fatality involving a pedestrian.
8. RoadsACT voluntarily agreed to modify the signals programming at the intersection of Canberra Avenue and Manuka Circle accordingly, and this was completed on 5 November 2015. Specifically, the new programming of the lights allows for four seconds between the commencement of the "walk" signal for pedestrians to cross the eastbound carriageway of Canberra Avenue on the eastern side of the intersection, and the start of the green signal for southbound traffic on Manuka Circle. I am grateful to RoadsACT for their responsiveness in this regard.
9. I then caused enquiries to be made with RoadsACT as to whether similar programming modifications should be rolled out to all appropriate intersections in the ACT. The advice received back was that many ACT intersections already provide protection for pedestrian crossings by way of red arrow protection, last start green lights or intersection geometry (which was described as including left turn slip lanes where turning drivers do not conflict with crossing pedestrians). However, there remained a number of intersections which either provided no protection for pedestrian crossings, or only some of the pedestrian crossings were protected. While many of these intersections could be modified in terms of their programming to provide some protection to pedestrians, some complex intersections could not be reprogrammed due to specific phasing arrangements and pedestrian protection would need to be provided in another way. RoadsACT indicated that it was developing a policy in relation to dealing with conflicts at traffic signals between turning traffic and vulnerable road users such as pedestrians or cyclists which emphasised the need to individually assess the intersection to determine what protection measures might be appropriate.
10. It is my personal observation that in the period since Ms Harrison's death, many more ACT intersections have now been modified to allow a period of time between the pedestrian walk signal and the allied green road traffic light so that pedestrians get a "head start" on the crossing and are therefore more visible to turning traffic.

While nothing will bring Ms Harrison back nor diminish the grief of her family and friends, these changes may be seen as something positive to have resulted from her death. In these circumstances I consider no further recommendation by me is necessary.

11. Ms Harrison's family also raised in their submissions to me concerns in relation to the standards required for a licence to drive a bus in the ACT, and suggested an effective reverse onus of proof upon drivers who have been involved in an incident resulting in the death of a person to prove that they remain suitable to hold a heavy vehicle license. With respect, the fact that Ms Harrison was unfortunately killed in a road traffic accident does not in and of itself call into question general ACT licencing standards. I am also advised that public vehicle licence holders are already required to provide an annual medical report to remain licenced in the ACT. Accordingly, I do not find this issue amounts to a matter of public safety, and I make no recommendation in relation to this issue. I do however note the family's concerns in my reasons in case this is a matter the ACT Government may care to voluntarily advance.

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Court Reference:	CD 136/14
Age:	52 years
Gender:	Male
Date of Death:	26/6/2014
Place of Death:	Garran, ACT
Coroner:	B.C. Boss
Date of Findings:	28/6/2018
Reported as:	[2018] ACTCD 12

1. Joseph Yatras died on 26 June 2014 at The Canberra Hospital, 1 Dann Close, Garran, in the Australian Capital Territory;
  2. The manner and cause of death of Mr Yatras are sufficiently disclosed and a hearing is unnecessary;
  3. The manner and cause of Mr Yatras's death is left chest cavity and abdominal cavity haemorrhage due to multiple rib fractures and splenic injury due to involvement in a motor vehicle accident, with cirrhosis of the liver with portal hypertension being a significant condition which contributed to his death but was not related to the direct cause of death; and
  4. Pursuant to s 52(4)(a)(i) of the Coroners Act 1997, a matter of public safety is not found to arise in connection with this inquest.
- ...
9. The pathologist who conducted the post mortem examination of Mr Yatras noted in respect of the injuries which caused Mr Yatras' death:

I note that the injuries had been diagnosed clinically, but a decision was made to treat these injuries conservatively (ie. without surgical intervention). The extent and severity of bleeding appears to have been underestimated in this patient, to the extent that death appears to have been unexpected. I



therefore recommend that review of the clinical management and autopsy findings by a qualified expert in the treatment of such patients be considered.

10. Initially I requested whether a physician from TCH would be available to conduct such a review. I did so because I am generally aware that hospitals conduct internal reviews of all adverse incidents such as deaths, and it seemed efficient that the two reviews be conducted concurrently. I was first told that TCH would consider my request, but ultimately some months later I was told that TCH would not conduct a review of Mr Yatras's treatment on my behalf.
11. I then caused the post mortem report relating to Mr Yatras to be forwarded to TCH and requested they comment on this issue. I received no response from TCH.
12. I then issued a subpoena to the TCH Clinical Review Committee (CRC) requesting a copy of its report of the internal review it had conducted into the treatment of Mr Yatras and the circumstances of his death. I note that I did so based on advice the Court received from TCH about the way in which this document could be accessed. I then received back a letter from the ACT Government Solicitor acting for the Territory (and therefore TCH) which included the following:

The Clinical Review Committee is an approved quality assurance committee established under the Health Act 1993 (the Act). Section 43 of the Act states that a quality assurance committee may give protected information to the Coroner's Court if the committee is satisfied that giving the information would be likely to facilitate the improvement of health services provided in the ACT.

The Clinical Review Committee Executive (the Committee) met to consider your request, noting that the report into the death of Mr Yatras contains protected information. The Committee formed the view that the release of the full report would be unlikely to facilitate the improvement of health services in the ACT, however, have agreed to release the suggestions for improvement arising from the review. ...

13. The suggestions for improvement were as follows:
  1. A process be developed and implemented to facilitate communication between treating consultants and consultation radiologists when a diagnosis is unclear.
  2. Consideration be given to the installation of the PACS system for on-call review at home by consultation radiologists.
14. I infer therefore that the TCH review identified an issue in relation to diagnosis of the extent of Mr Yatras's bleeding. In my view, which is fortified by the suggestions for improvement set out above, this constitutes a matter of public safety.
15. I did however still wish to gain insight as to what had or had not been considered by the review, so I caused a letter to be sent to TCH requesting the Clinical Governance

Executive Report, which my staff had been informed might be a “non-privileged version” or version for publication (indeed, possibly the version published internally to all TCH staff) of the CRC Report. I was informed by letter again that this report too fell to be considered under section 43 of the *Health Act 1993* and again the Committee formed the view that the release of the full report would be unlikely to facilitate the improvement of health services in the ACT.

16. The matter has been on foot for a considerable period of time and Mr Yatras's family are entitled to closure and findings. In respect of the matter of public safety I have found to arise, I will refer the circumstances of Mr Yatras's death to the Australian Health Practitioners Regulatory Agency for their investigation from a disciplinary perspective. I will also make a referral to the ACT Health Services Commissioner in relation to the process and systems issues identified by the TCH CRC, and to ascertain whether the suggestions for improvement have been implemented by this time.
  17. I wish to express my considerable concern with the course of action taken by TCH and specifically the CRC in this case. I accept the rationale behind protection of information given to Quality Assurance Committees such as the CRC – that confidentiality and qualified protection from liability will ensure practitioners are forthcoming and fulsome, and that this drives better health protection outcomes – and indeed the law recognises similar principles for example in relation to taxation information. However, I consider this principle needs to be qualified in circumstances where the CRC and the Coroner have a unity of purpose, which is to identify potential issues of public safety and take steps / make recommendations to mitigate against repeated incidents that could be preventable. I note also that any information released by the CRC under section 43 would still remain sensitive and subject to the protections afforded by the *Health Act 1993* whilst in the possession of the Coroner, and could not be admitted in evidence before a Court in any case (see section 47). For the CRC to take the view that release of information about the death of a patient that the Coroner is also investigating would not “facilitate the protection of health services in the ACT” is disappointing. If the CRC takes the view that section 43 acts as a barrier to information release to the Coroner's Court then I strongly suggest that it be reformed. I formally note that I have been frustrated in the conduct of my investigation by the conduct identified above. There may be an issue of public safety but the decision made to withhold information from me means that I cannot make any determination on that question.
  18. I recommend that the ACT Government amend section 43 of the *Health Act 1993* to avoid a repetition of this conduct.
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