ACT CORONERS COURT

ANNUAL REPORT 2016/17

[Coroners Act, section 102]

The ACT Forensic Medicine Centre, Phillip

Issued at the direction of
Chief Coroner Lorraine Walker

December 2017

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TABLE OF CONTENTS

Coroners Act 1997 (excerpt)

s 102 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

In my report last year I noted that 2014 legislative changes had caused a short term decrease in referrals but thereafter the number of referrals appeared to have plateaued. The number of referrals received last year is an increase on last year: see Table 1.

Table 1: Cases Lodged					
Type	**2016/17**	2015/16	2014/15	2013/14	2012/13
Deaths	**299**	291	290	295	324
Fires	**0**	1	683	846	1014
Disasters	**0**	0	0	0	0
Total Cases	***299***	*292*	*973*	*1141*	*1338*

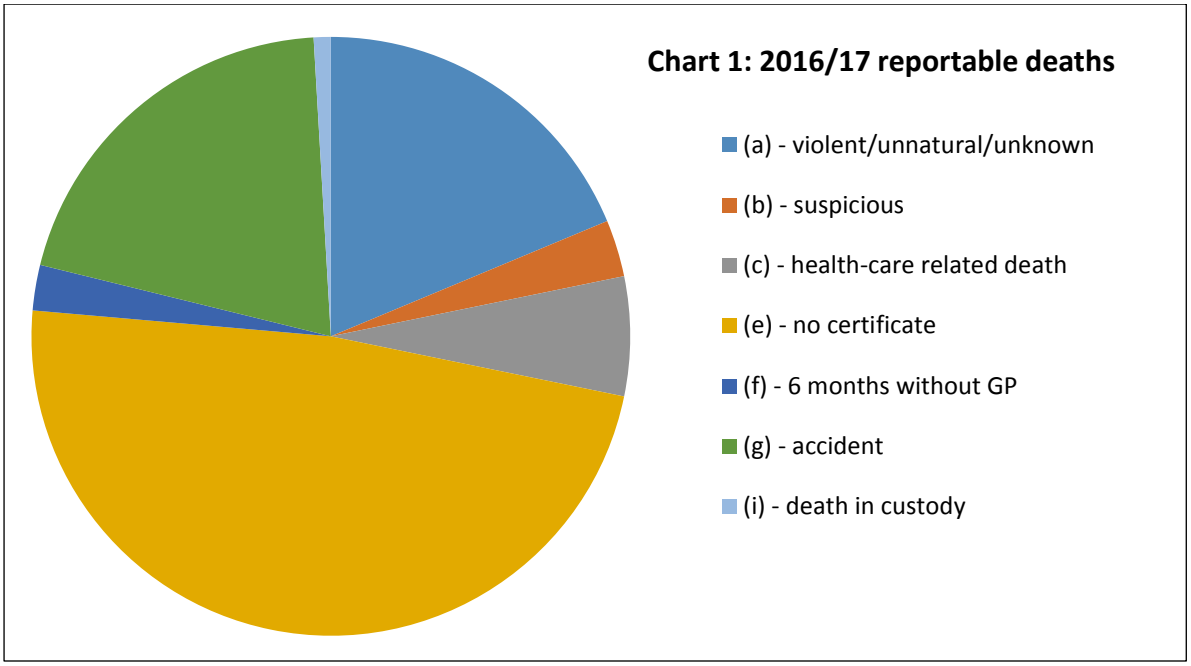
I received one notification of a fire in the reporting period for which I am actively considering whether to commence an inquiry.

Type of Referral

For the first 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.

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

These statistics need to be qualified somewhat however.



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. Thirdly, in retrospect it is likely that the "no certificate" numbers are artificially inflated by cases where a recent GP cannot be located, when more probably those should be categorised as "not having seen a GP in the last 6 months" – more care will be taken with collecting this statistic for 2017/18.

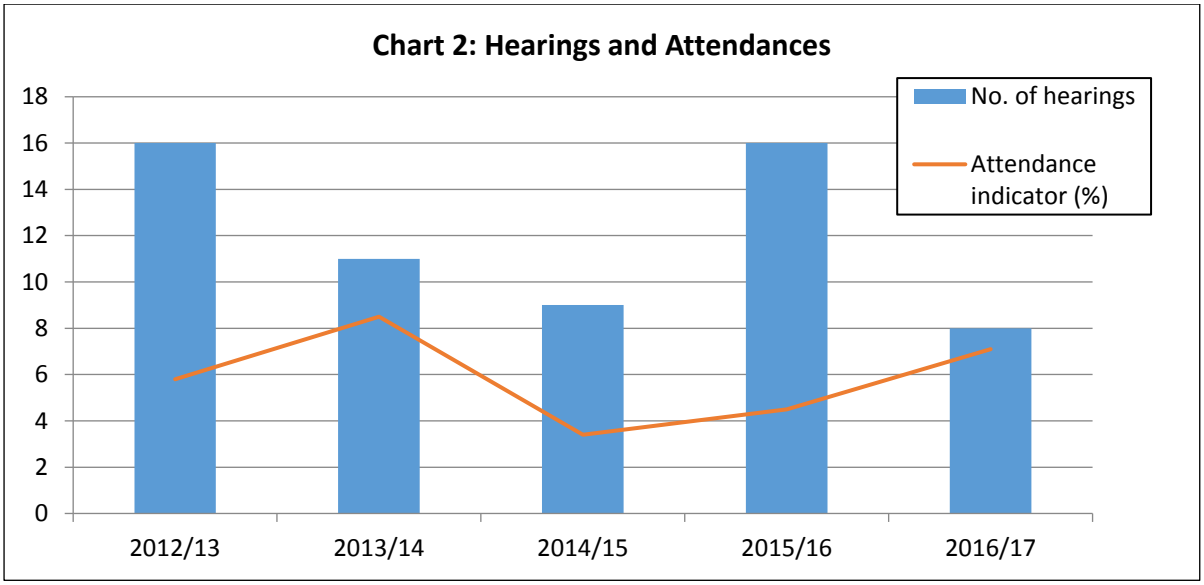
Hearings / Attendances

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

Table 3: Attendances

	2016/17	2015/16	2014/15	2013/14	2012/13
No. of hearings	**8**	16	9	11	16
No. of attendances	**57**	72	31	93	92
Attendance indicator (%)	**7.1**	4.5	3.4	8.5	5.8

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. Internal court records show that in the 2016/17 financial year, the Court sat for 28 days of hearing time across all Coroners.



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	**2016/17**	2015/16	2014/15	2013/14	2012/13
With a Hearing	***8***	*16*	*9*	*14*	*16*
Deaths	**8**	16	9	12	12
Fires	**0**	0	0	2	4
Disasters	**0**	0	0	0	0
By Chambers decision	***297***	*234*	*1007*	*1171*	*1375*
Deaths	**297**	234	305	317	376
Fires	**0**	0	702	854	999
Disasters	**0**	0	0	0	0
Total Cases	***305***	*250*	*1016*	*1185*	*1391*

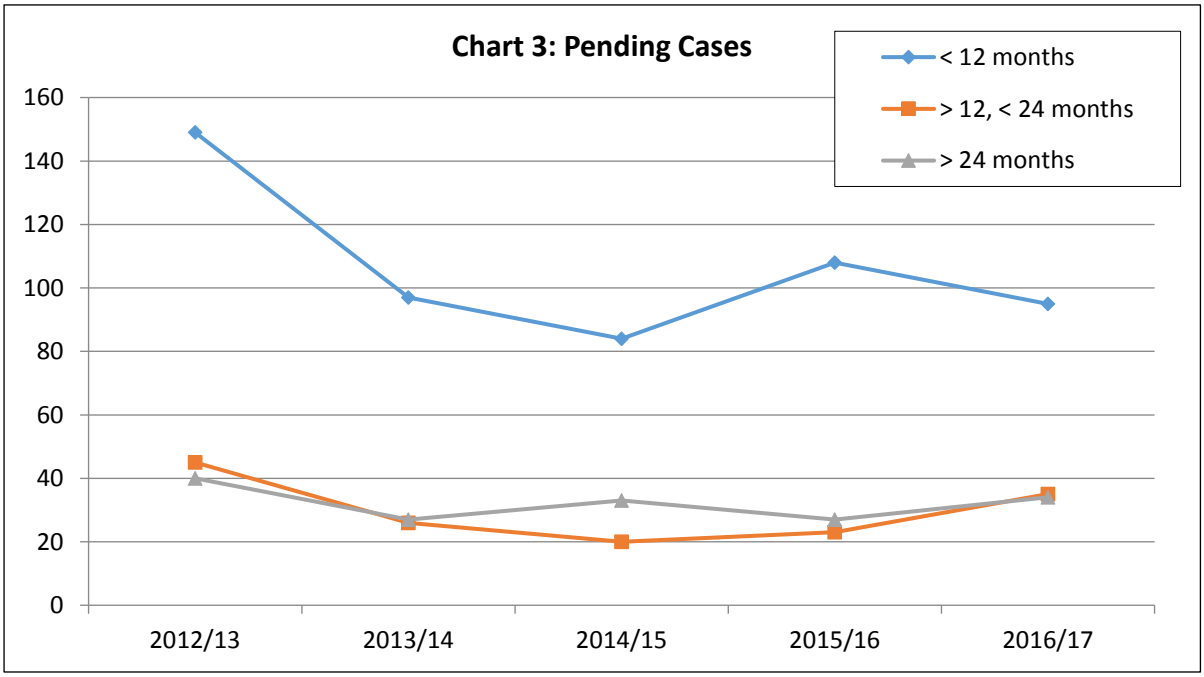
Matters resolved without hearing constitute 99% of all inquests into deaths finalised in the 2016/17 year. This year, 55 more matters were finalised than in the previous year. More matters were finalised than were lodged in the reporting period, with the Court achieving a clearance rate of 102% over 2016/17.

Timeliness / Backlog

While the overall number of cases pending at 30 June decreased from 2015/16 to 2016/17, the proportion of cases older than 12 months has increased year on year: see Table 5 and Chart 3.

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

Of the 305 cases finalised in 2016/17, as one might expect, most of these (281) were cases which were finalised in less than 12 months. However, significant progress continues in addressing the case backlog – 11 cases were finalised that were between 12 and 24 months old, and 13 were finalised which were older than 24 months old. Put another way: of all of the 234 cases that were pending at 30 June 2013, 34 of those cases remain pending at 30 June 2017, and 200 of those cases have been closed in the four years since.



For the first time an attempt has been made to quantify the number of cases where related criminal charges are on foot and either the inquest is formally statutory 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. At 30 June 2017, the number of cases that fell into that category was 13, or 7.7% of the total pending cases.

There has also been an increase in the time taken to finalisation indicator: see Table 6.

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

This statistic is comparatively recent and this data has only been collected for the last three financial years.

FMC STATISTICS

The total number of admissions[1] to the ACT Forensic Medicine Centre (FMC) in 2016/17 was 388 cases, made up of 350 ACT cases and 63 NSW cases, as well as one deceased person being held long term on a cost-recovery basis for the Queanbeyan Coroner. Medical certificates were ultimately issued in 32 ACT cases and nine NSW cases. Autopsies were conducted in 215 ACT cases and 37 NSW cases, with the remaining cases either being subject to an external examination or no examination where 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 5 days or less from admission to the facility. In 2016/17 the facility achieved a KPI of 57.7%. This is a significant reduction in last year's result of 93.6%. The reduction possibly reflects staffing issues at the FMC and the financial decision to conduct post mortems during normal business hours.

Length of Stay

The median period of stay at the FMC in 2015/16 for all cases was six days: see Table 7.

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

These numbers are 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. Additionally, we have become aware that it is the practice of some funeral directors to leave deceased persons at the FMC, notwithstanding the deceased has been cleared for release, where they see no need for the person to be taken to the funeral parlour expeditiously.

In the light of this information, and given staffing restrictions at the FMC discussed later in this report, in January 2017 the FMC changed its procedure in relation to release of deceased persons from an open release policy to three set "windows" when pickups of deceased persons were required to take place. (When there are compelling and exceptional circumstances in relation to a particular case, FMC staff exercise their discretion to permit a pick up to occur outside of these windows at an operationally convenient time.)

A small number of deceased persons were held for in excess of 30 days where identification or locating a next of kin was problematic. The FMC complies with its statutory obligations to

[1] 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.

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

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 slightly on last year: see Table 8 on following page.

Table 8: Post-Mortem Examinations[2]

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%)
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%)**

Further reduction in this rate will be depend on wider use of investigative tools pre-autopsy such as default rapid toxicology and CT scans in combination with a formal review and triage process.

Presently, a small fraction of cases are sent for CT scan, usually depending on case types, such as motor vehicle accidents. In contrast, best practice in autopsy service in Victoria and NSW is for all deceased persons to be CT scanned on admission to the coronial mortuary. Anecdotal evidence suggests that blanket CT scanning will pick up a number of cases where the CT scan will evidence cause of death – for example, ruptured aneurysms, strokes and internal ruptures of tissues – where otherwise an internal autopsy would be required. The

[2] 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.

ACT coronial jurisdiction has limited recourse to this option. Process enhancements such as pathologist-led medical reviews may also support further improvements. Professor Duflou who currently provides pathology services to the Coroner advises that with medical triage and CT scanning a further reduction of 25% in the number of invasive autopsies required is feasible.

Toxicology Services

Timeframes in relation to toxicology testing have been of concern to me for some time, and have been the subject of specific comment in my last two Annual Reports. Most ACT coronial cases will have toxicology testing undertaken, unless the manner and cause of death is evident from medical records or there is insufficient tissue or fluid available for testing, and most of the time this capability is sourced from the ACT Government Analytical Laboratory (ACTGAL). Routine toxicology testing undertaken by either ACTGAL or NSW FASS (Forensic and Analytical Science Service) ordinarily takes approximately 4-5 weeks, and is acceptable for most cases; that being said however, often toxicology results are the last piece of information the pathologist is waiting on to complete the autopsy report, and if this information was to be forthcoming more quickly, there is likely to be an improvement in the time taken to finalise routine cases.

Since 2013/14 ACTGAL has targeted a maximum 30 day turnaround time, and I am pleased to report ACTGAL continues to meet its target for turnaround times in this reporting period, albeit there appears no continued reduction: see Table 9.

Table 9: Toxicology Timeframes

Type	**2016/17**	2015/16	2014/15	2013/14
Average days	**26.9**	26.3	26.5	24.5

We will continue to monitor the sufficiency of this improved service and work with ACTGAL to drive further improvements.

For some case types, particularly suspected drug overdoses, if toxicology results can be obtained in a matter of days, this may obviate the need for an intrusive autopsy if the toxicology results evidence a cause of death. ACTGAL does not presently have a rapid toxicology service available in the ACT, and the limits of detection for some drugs are higher for ACTGAL than for other providers. In last year's report I noted that the limited pilot program whereby on request, certain drug classes could be priority tested by ACTGAL and results for that class returned within two days, if ACTGAL resourcing permitted, produced mixed results. ACTGAL can only target one drug class (so excluding all cases of potential multi-substance overdose) and cannot obtain fast results in relation to opioids (which are present in the majority of overdose deaths reported to the Coroner). I understand this position has not changed.

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 2016/17The appointment of the Registrar of the Coroners Court as a Deputy Coroner and delegating most of fire inquiry work to the Deputy Coroner continues 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.

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 billed back to the Commonwealth Government on a cost-recovery basis. In 2016/17 the ACT Coroner was notified of one death 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, continued in this year and will be the subject of a lengthy hearing to be held in the 2017/18 year.

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 originally sitting under the Magistrates Court Registry, but since November 2016 sitting under the Legal Team reporting directly to the Registrar.

The Coroners Section is headed by a Legal Manager (who also acts as Counsel Assisting in appropriate matters) 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, the mortuary manager and through them technical staff located at the FMC in Phillip. At my request, additional legal resources were made available to support Coroners in this financial year.

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 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 the occupant's capacity. I am pleased to report that Coroners appointed our in-house practitioner as Counsel Assisting in a number of inquests and our in-house practitioner appeared in five hearings and numerous interlocutory hearings) in the 2016/17 year.

The officers of the Director of Public Prosecutions have 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.

A number of cases were also briefed to the private bar in 2016/17 due to the complexity of the matter or the capacity of our in-house practitioner. In house practitioners instruct in such matters.

FMC

2016/17 saw significant staff turnover and vacancy at the FMC. Whilst placing pressure on court resources to supplement the area, this did provide an opportunity to review staffing arrangements. It has been difficult to recruit and retain mortuary technicians.

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.

The considerable saving on power consumption at the FMC due to the establishment of solar power as an energy source continues, with a cost saving in the order of 30% in this financial year.

Pathologist Services

From January 2017 the ACT has been fortunate to obtain the services of specialist forensic pathologist Professor Johan Duflou to regularly undertake coronial autopsies on a privately contracted basis. Professor Duflou is the former Clinical Director, NSW Department of Forensic Medicine at FASS, a role he held for 27 years, and is presently a Clinical Professor at Sydney Medical School at the University of Sydney. Associate Professor Sanjiv Jain also continued in 2016/17 to provide anatomical pathology services on a privately contracted basis in non-complex cases where no conflict of interest arose in relation to his usual employment by ACT Health. Specialist services in paediatric cases were provided by independent pathologists from other jurisdictions. We are grateful for the assistance provided by the Victorian Institute of Forensic Medicine (VIFM) and FASS.

The engagement of Professor Duflou was always only intended as an interim solution pending ongoing partnership with FASS. Professor Duflou indicated at the commencement of his engagement that he will withdraw his services to the ACT in December 2018.

Negotiations continued throughout 2016/17 with FASS about a partnership model for the long term provision of pathologist services to the FMC. However, on 3 July 2017 FASS unilaterally withdrew from negotiations and indicated that it was not now or would be any time soon in a position to progress a partnership with the ACT. The ACT will have no local coronial forensic pathology service from 1 January 2019 unless urgent action is taken to recruit a locally resident forensic pathologist. Alternatively, we will need to source a 'fly in, fly out' pathologist or transport of deceased persons interstate for autopsy.

Repeated budget bids to government at my direction in the past 18 months seeking a rebasing of funding to allow recruitment have not been accepted by government.

Coroner's 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.

Members of the ACT Coronial Liaison Unit provide initial reports of deaths to the Coroner and subsequently perform coordination, liaison and investigative tasks as required. Members of that Unit filter out reports of deaths which do not fall within the Court's jurisdiction. This is done efficiently and diverts unnecessary referrals. A recent review by the Coroners Sergeant of contacts with the Unit between July and December 2016 indicated that for this six month period, 131 matters were diverted out of the coronial jurisdiction by the issue of cause of death certificates by appropriate doctors. In the same period the Court accepted 153 coronial referrals. Clearly, this work greatly assists the Court.

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 2016/17 by ACT Health to operate the ACT Coronial Counselling Service to provide psycho-social support to eligible people for up to three months after the coronial process is concluded. Staff of the Service also provide support to family members in dealings with the Court. The feedback to the Court is uniformly positive and I thank ACT Health and Relationships Australia for their support to the jurisdiction.

Funding was formally ceased in July 2016 for the limited ACT Trauma Support Service provided by SupportLink Australia. While the decision was one for Government, I understand the decision to cease funding SupportLink was undertaken only after a thorough examination of existing support services available within the ACT community revealed the Trauma Support Service was largely duplicating existing services. Many services and networks already exist to assist persons affected by the impact of the sudden and unexpected death of a loved one, for example:

- the Standby Response Service, funded by the Commonwealth Government but in the ACT delivered by SupportLink, provides on-call 24/7 assistance to persons who have lost a loved one to suicide;
- the AFP contracts with SupportLink to provide referrals to community services for persons affected by crime or who otherwise come into contact with the AFP;
- family members of persons who die in ACT Hospitals receive pastoral care and assistance through the hospital system rather than the Trauma Support Service;
- the Community Services Directorate operates the ACT Human Services Gateway for members of the ACT community to access appropriate assistance and services; and
- the Coronial Counselling Service will also assist its clients to access support services in community where appropriate.

The Trauma Support Service received transitional funding through to the end of August 2016 to transition existing clients to other services. The Court records its appreciation for the work done by SupportLink over a number of years to support family members engaged in the coronial 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 Perth, Western Australia.

The FMC hosted a number of organisations to assist in their training requirements, including medical students from the Australian National University, forensic science students form the Canberra Institute of Technology and staff of the Australian Defence Force Investigative Service.

ENVIRONMENT CHANGES

Amendments to *Coroners Act 1997*

There were no amendments to the *Coroners Act 1997* made in the 2016/17 year. Some transitional provisions deriving from the *Courts Legislation Amendment Act 2015 (No 2)* in relation to then-current Special Magistrates retaining their status as Coroners expired on 10 December 2016. Two Special Magistrates were reappointed in May 2017 for a 12 month period, and were separately appointed as Coroners.

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 2016/17 year, there were two inquests into deaths in custody finalised by a Coroner:

Gwenda Membery (CD 27 of 2015)

ETL [an indigenous man whose name is not printed in this report] (CD 63 of 2015)

Summaries of these cases, 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, if refused, may apply under section 90 to the Supreme Court for an order directing a hearing be held.

In the 2016/17 year, there were 297 notices given by Coroners under subsection 34A(3), in respect of 297 deaths. (There were no inquires into fires or disasters finalised in the 2016/17 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). A decision in that matter remains outstanding. I noted in last year's report that a section 64 application had been made in 2014/15 in relation to the inquest into the death of Paul Fennessy (CD 11 of 2010). That matter was resolved by way of a hearing with findings and the findings and

recommendations made in this case can be found later in the Report in the selected case notes section.

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.

In the 2016/17 year, there were two reports made under subsection 57(3) to the Attorney-General, however neither was tabled in the Legislative Assembly within the reporting period. 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. Summaries of these cases, and the findings and recommendations made, can be found later in the report in the selected case notes section.

Two subsection 57(3) reports were presented to the Legislative Assembly in the 2016/17 year relating to coronial reports made in the previous year. The subsection 57(3) report in relation to the death of John Cardar Throckmorton (CD 215 of 2015) was tabled on 4 August 2016, and the report in relation to the death of Gail Maree Cleathero (CD 189 of 2015) was tabled in the Legislative Assembly on 9 August 2016.

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) however due to the public interest in such matters, these decisions are often published and some of them are included in the case notes in Annexure 1.

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.

Of the two inquests into deaths in custody finalised by a Coroner in the 2016/17 year, in neither were findings were made that the quality of care, treatment and supervision of the deceased contributed to the person's death. In the case of ETL (CD 63 of 2015), letters were received from the Attorney-General, the Minister for Health and the Director-General of the ACT Health Directorate noting the findings.

ANNEXURE 1 - 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, the name of the deceased person is withheld.

Full copies of coronial findings and recommendations are available for some cases via https://www.courts.act.gov.au/magistrates/courts/coroners_court/selected-findings .

Court Reference:	CD 63/15
Age:	24 years
Gender:	Male
Date of Death:	19/03/2015
Place of Death:	Yass, NSW
Coroner:	L.A. Walker
Date of Findings:	18/7/2016

Mandatory hearing – death in custody

Reported under 102(a), (d)

The death of ETL, an indigenous man, occurred in New South Wales. The deceased was an ACT resident and subject to an ACT Community Care Order at the time of his death, and is therefore considered a death in custody for the purposes of the ACT *Coroners Act 1997*. An Inquest was dispensed with by Magistrate Huntsman, Coroner at Goulburn, and the records then were referred to the ACT Chief Coroner. A hearing was conducted where Chief Coroner Walker found that the manner and cause of ETL's death was suicide, which occurred on 19 March 2015 at an address in Yass, New South Wales, in the form of hanging by the neck on a background of clinical depression and excessive alcohol consumption. The Chief Coroner also found that a matter of public safety was not found to arise in connection with the inquest, and there were no issues relating to the quality of care, treatment and supervision of the deceased that in Her Honour's opinion contributed to the cause of death.

Court Reference:	CD 20/12
Age:	94 years
Gender:	Male
Date of Death:	21/01/2012
Place of Death:	Narrabundah, ACT
Coroner:	P.G. Dingwall

Date of Findings: 10/08/2016

Coroner's Findings:

[72] As required by s 52 of the Act, I make the following findings –

- the deceased was Charles Rowan McCulloch, ...;
- he died in Room 43, Casuarina Ward, Jindalee Aged Care Residence, Goyder Street, Narrabundah in the Australian Capital Territory at some time between 7.05am and 7.35am on 21 January 2012; and
- he died as a result of blunt head and neck trauma inflicted upon him by another resident of Jindalee Aged Care Residence.

I found no matter of public safety arising in connection with the inquest into Mr McCulloch's death.

Recommendations

[73] I propose to make a number of recommendations. In making them, it is not to be implied that I have found general, or any specific fault, with the running and management of Jindalee beyond the matters on which I have commented. Many inquests result in matters surrounding the death being investigated and issues identified which, although they did not play a part in causing, or hastening, the death, appear as matters which might prevent similar deaths in the future, matters which will improve coronial investigations into such matters in the future or benefit the system of justice generally.

[74] I make the following recommendations –

(a) The policy recommended by Constable Tristan Thexton in relation to suspicious deaths and matters to be referred to the Coroner, which is Annexure C to these reasons, be adopted and implemented by Jindalee and all other aged care facilities in the Australian Capital Territory;

(b) Staffing requirements of aged care facilities be reviewed and a minimum staffing requirement be set for dementia specific units of aged care facilities such as C Wing at Jindalee. I note that a T – BASIS unit has a maximum of 16 residents at any one time, each housed in individual rooms. There is a registered nurse on duty at all times, with an additional three staff until 9 pm, and then an additional staff member until the commencement of day shift. In addition, a nurse manager is rostered on during the day. This should be the minimum staffing requirement for residents who suffer from dementia.

(c) Compulsory mandatory minimum training be implemented for staff employed in aged care facilities who are required to care for and deal with residents who have been diagnosed with dementia;

(d) To ensure the safety of both residents and staff of Jindalee, and all other aged care facilities with dementia specific units, with the assistance of an eternal provider with expertise in aged care, undertake a review and/or implementation of policies and procedures including but not limited to:

- behavioural management strategies for staff for the management of residents with dementia and specifically with those who have a tendency to be aggressive;
- mandatory reporting, and recording, of all incidents of violence of any level between residents , between a resident and a staff member or between staff members;
- procedures for dealing with deceased residents; and
- development and implementation of an efficient record keeping system, preferably electronic;

(e) To ensure the safety of both residents and staff, Jindalee and all other aged care facilities undertake, with the assistance of an eternal expert provider in aged care, training or updating in Compliance with Elder Abuse reporting and maintenance of a register in accordance with the requirements of the *Aged Care Act 1997* (Cth.).

(f) Jindalee undertake a review of the staff structure within the facility so as to ensure that management fulfil their requirement to supervise and monitor staff and ensure task compliance.

(g) That the discretion reposing in the management of aged care facilities to determine whether an assault is a "*reportable assault*" under the *Aged Care Act* 1997 (Cth.), where a resident has a cognitive impairment, be removed and that there be a requirement for mandatory reporting of all assaults in aged care facilities.

[75] Mr McCulloch's family has requested, through their Counsel, that I make a recommendation which, if adopted, will allow families who are considering placing their aged relative in an aged care facility to make an informed decision as to whether a placement poses an unacceptable risk to the safety of their relative, and whether the relative has capacity to cope in the environment of the facility.

[76] The feasibility of adopting the recommendation was not canvassed during the hearing. I have no basis for knowing whether or not it could be implemented. However, it seems to me that it may be capable of being implemented and, if necessary and appropriate, imposed. Accordingly, I make the following recommendation –

(h) that all aged care facilities with a dementia unit be required to disclose to families of prospective residents of the unit, prior to their admission, the following:
- the level of risk of violence for potential residents (taking into account their particular circumstances); and
- the established protocols for protecting residents from witnessing and/or experiencing regular violent events; and
- the protocol for advising relatives of violent incidents as they occur, such that the relatives are able to reassess circumstances from time to time.

[77] In making these recommendations, I share the view of Counsel Assisting that all aged care facilities have an obligation to ensure the safety of residents. All residents are entitled to be treated with dignity and respect, which no doubt they have earned as being past contributing members of a community, financially and practically and at one time loving and respectful parents, relatives and/or friends.

Court Reference: CD 220/12
Age: 2 months
Gender: Female
Date of Death: 21/01/2012
Place of Death: Narrabundah, ACT
Coroner: B.C. Boss
Date of Findings: 10/08/2016
Suppression order on name of deceased and siblings

Coroner's Findings:

1. The deceased was AMH ....

2. AMH died on 18 August 2012 at The Canberra Hospital, 1 Dann Close, Garran in the Australian Capital Territory. She was, at the time of her death, exactly 2 months old.

3. AMH died as a result of head and neck injuries, which I find were incurred as a result of a drop or fall or throw, likely to have been from the couch, and subsequent impact with the floor. I find that there may also have been a shaking component to the injuries AMH suffered. I find that these injuries did not occur as the result of an accident.

4. The evidence shows that the ACT Ambulance Service was called to [the] residence at approximately 5:09am to attend to AMH. When ambulance officers arrived, they found AMH was not breathing, and had no pulse. AMH was taken to hospital where despite the best efforts of doctors she could not be revived. On the evening in question, the only people in the residence with AMH were her parents, M and N, and their other daughter K.

5. I held a hearing for the purpose of this inquest on 3 and 4 February 2014. I heard oral evidence from a number of witnesses and experts, and received the brief of evidence prepared by Police into AMH's death. The expert evidence I received was to the following effect:

    a. Dr Sarah Parsons conducted a post mortem examination of AMH, and prepared a report and gave oral evidence before me. Dr Parsons concluded that AMH's cause of death was as a result of head and neck injuries. Dr Parsons was able to exclude that AMH's injuries were connected with a haematological or clotting disorder, and it was her opinion that there was no natural disease that may have caused or contributed to AMH's death. It was Dr Parsons' opinion that while some of AMH's injuries occured during resuscitation, the constellation of her injuries were due to inflicted trauma. Although the precise mechanism of injury could not be determined at autopsy, Dr Parsons noted that AMH's injuries were consistent with a drop and impact.

b. Dr Linda Iles conducted a post mortem examination of AMH's brain, and prepared a report and gave oral evidence before me. Dr Iles found evidence that AMH had suffered a significant blunt force injury causing a rapid accelaration and deceleration of her brain Dr Iles indicated that such injuries are said to be due to shaking but that there is controversy as to whether shaking alone cause the types of haemorrhages seen in AMH's brain. It was Dr Iles' opinion that the brain injuries suffered by AMH required forces in excess of normal handling of an infant, and were highly suggestive of traumatic injury.

6. At the conclusion of the hearing, as required by section 58 of the *Coroners Act 1997*¸ I suspended the inquest to notify the Director of Public Prosecutions of my belief that a person mentioned in the inquest had committed an indictable offence.

7. After the inquest hearing AMH's parents, N and M, were interviewed separately by Police in respect of an allegation that they were responsible for AMH's unlawful death. Each denied that they were responsible for the injuries which caused AMH's death.

8. On 27 May 2015, the DPP advised me that no indictment would be presented against any person for an indictable offence in relation to AMH's death.

9. The DPP's decision was based in part on a comprehensive expert opinion from Dr John Gall, to which I have had regard. Dr Gall confirmed the opinions of the other experts that AMH suffered a fatal non-accidental injury, that he said would have appeared to have occurred in the late evening or early morning immediately prior to her admission to hospital. Dr Gall's opinion was that the injuries were consistent with shaking AMH to generate some significant force within the head, and there may also have been direct trauma with some surface. Dr Gall stated that it was possible that AMH's injuries could have occurred while AMH was in the care of her mother, but that it was also possible they occurred while AMH was in the care of her father.

10. Despite the best investigative efforts of Police, there is insufficient evidence for me to be able to determine who inflicted the non-accidental injuries that AMH suffered and which ultimately resulted in her death. I consider that there is little likelihood that such evidence will become available to me in the near future. On that basis, noting that the DPP does not intend to lay charges in this matter, I will finalise this inquest.

11. No other issue of public safety arises in relation to this matter. I make no recommendations.

Court Reference: CD 168/16
Age: 47 years

Gender: Female
Date of Death: 6-8/7/2016
Place of Death: Belconnen
Coroner: P.J. Morrison
Date of Findings: 23/09/2016
No hearing held – hearing dispensed under s34A(1)

Coroner's Findings:

(1) The deceased died at ... Belconnen in the Australian Capital Territory between 6 July 2016 and 8 July 2016.

(2) The manner and cause of death was: Combined toxicity of ethyl alcohol, propranolol and citalopram, taken with the apparent intention to end her life.

(3) I find a matter of public safety arises in this case, in that an incorrect dosage of a medication was dispensed to Ms S by a pharmacist. Ms S was aware of the dispensing error.

(4) Comment on matter of public safety:

The circumstances of this case will be referred to the Australian Health Practitioners Regulation Agency for its review and any necessary action.

Note: AHPRA subsequently advised that the Pharmacy Board of Australia had considered the practice of the pharmacist in question and had decided that the pharmacist's conduct was unsatisfactory. The Board placed a number of conditions on the continuing practice of the pharmacist.

Court Reference: CD 25/15
Age: 49 years
Gender: Male
Date of Death: 31/01/2015
Place of Death: The Canberra Hospital, Garran
Coroner: L.E. Campbell
Date of Findings: 2/11/2016
No hearing held – hearing dispensed under s34A(1)

Coroner's Findings:

I find:

1 That Richard Roger John Stanton died on 31 January 2015 at The Canberra Hospital, 1 Dann Close, Garran, in the Australian Capital Territory;

2 That the cause of death was hypoxic-ischaemic encephalopathy due to or as a consequence of head, facial and neck injuries;

3 That the manner of death was as a direct consequence of Mr S falling from his bicycle when riding along Kent Street, Deakin, when the front Bontrager alloy steering tube carbon fork of Mr S's Trek 2000 racing bicycle unexpectedly and catastrophically failed;

4 That, 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.

Recommendations and Notes

12 The recommendations I make in this inquest are as follows:

(i) Although Trek's owner manuals already warn owners that bicycles are not indestructible and every part of a bicycle has a limited useful life, **I recommend** that Trek update its owner's manuals and consumer information to expand upon this warning and to note the risk of catastrophic failure without warning in some circumstances.

I note that Trek has already committed to amending its owner's manuals in this respect, and to notify consumers of this change by creating a temporary notice on its Australian website to direct Trek owners to the new version of the manuals. Trek will also communicate directly with the owners of Trek bicycles who have registered their purchase with Trek, to direct them to the website and new manual.

(ii) **I recommend** that Trek undertake public education activities within Australia, and particularly within the Australian Capital Territory, to bring the issue of bicycle component life to the attention of existing Trek bicycle owners, in addition to purchasers of new bicycles.

I note that Trek has committed to publish material on its Australian social media assets, including Facebook and Twitter, about the importance of rider safety and to encourage consumers to visit their local dealer if they own an older bicycle or a bicycle that has been involved in an accident. Trek will also include a reference and hyperlink to its Australian website, where consumers can access further information on rider safety and the updated owner's manual.

I also note that Trek intends to post a notification to its Australian dealers that will encourage them to educate consumers who pass through their shop about the issue of inspections, bicycle component life and, where appropriate, suggest replacing the component or the bicycle with a new model. Trek will also remind its dealers to inform existing owners about the updated owner's manual available on Trek's website.

I also note that Trek has indicated it is prepared to undertake outreach to bicycle advocacy groups to educate the cycling community on the issues of metal fatigue and bicycle component life. In particular, Trek will contact ACT Pedal Power, which is a local cycling advocacy group, and the Cycling Promotion Fund, which is a national advocacy group, to publicise these issues to cyclists throughout Australia.

(iii) **I recommend** that Standards Australia and other relevant international standards bodies investigate fixing an upper "safe life" limit (safe life) for the bicycle front steering fork, depending on the manufacturing process and material construction of the part, after which the owner is encouraged to replace the part irrespective of whether damage is visible.

I note that Trek's bicycles sold in Australia meet or exceed the Australian Standard (AS/NZS 1927:1998 – Pedal Bicycles – Safety Requirements), and also pass ISO 4210, an international standard that specifies the safety and performance requirements for the design, assembly and testing of bicycles and certain sub-assemblies. However, these standards do not address the issue of safe life, and the Australian Standard also has no reference to metal fatigue. Trek has advised me that previous attempts internationally to introduce this type of standardisation have failed due to industry views that individual bicycle usage is subject to such wide variability that assigning a safe life would not be meaningful or of assistance to a consumer. However, Mr Thompson's advice to me is that safe lifes are routinely fixed in respect of aerospace components. Given aerospace materials such as carbon fibre and aluminium alloys are now routinely used in high end racing bicycles such as Mr Stanton's bicycle, it seems to me that similar product safety considerations should apply.

Trek has undertaken to me that it will request international standardisation bodies to reconsider their prior rejections of safe life limits, and it will approach Standards Australia to reconsider the lack of reference in the Australian Standard to safe life or metal fatigue.

Court Reference:	CD 267/15
Age:	21 months
Gender:	Male
Date of Death:	30/12/2015
Place of Death:	Fisher, ACT
Coroner:	L.E. Campbell
Date of Findings:	4/11/2016

Reported under 102(c)

Coroner's Findings:

I find that River Arama Parry ... died at ... Fisher, in the Australian Capital Territory on 30 December 2015. The manner and cause of River's death was drowning after he entered an unfenced in-ground home swimming pool. I find a key factor in his death was a lack of supervision.

Matter of Public Safety

I found a matter of public safety arose in relation to River's death, in that the general legislative framework in the ACT for the fencing of home swimming pools (often referred to as backyard pools) is inadequate. The pool in which River drowned was unfenced and access to it was directly from the back door of the house. The door had no specific child locks or self-closing mechanisms to make access to the pool more difficult. And yet the pool was compliant with the applicable ACT pool fencing legislation. As it had been installed decades ago it was not required to comply with any changes and improvements in pool fencing and barrier standards which had subsequently been introduced. The ACT law does not require that historically and lawfully erected pools must be retrofitted with pool barriers or that pool barriers must be upgraded or enhanced as requirements for newly constructed pools are strengthened. ...

Recommendations

I make the following recommendations:

1. That the ACT Government develop and implement as a matter of some urgency, bearing in mind the advent of summer, a public awareness campaign with two key messages:
   - First, to remind the community of the importance of active and close adult supervision of small children in the vicinity of home swimming pools; and
   - Second, to raise awareness in the community of the efficacy of prompt resuscitation in reviving children who have falling into water, and to encourage adults involved in supervising children in water to obtain and maintain appropriate life saving skills.

2. That the ACT legislative framework applying to home swimming pools be amended to require that all existing home swimming pools, irrespective of when they were constructed or installed, be required to comply with the latest version of the *Building Code.* I note that it is a matter for Government as to what transitional periods or arrangements might be adopted, but the outcome of having all home pools protected by child-resistant safety barriers should be achieved as soon as possible.

3. That the ACT legislative framework applying to home swimming pools be amended to provide methods for ensuring all existing pools continue to comply with the latest standards as they change over time. It is not necessary for the purpose of this inquest to recommend a method, but I note that other jurisdictions have employed the following tools, often in combination, which are worthy of consideration:

- A register of all home swimming polls and a compliance certificate regime;
- A regime of periodic safety inspections;
- Sale or lease triggering a requirement to make the pool barrier compliant with the standard in force at the time.

4. That the ACT Government have regard to the findings and recommendations of Coroners in other States and Territories since March 2011, in so far as they are relevant, and to the material in evidence in this inquest, in taking the actions recommended by me.

Court Reference: CD 11/10
Age: 21 years
Gender: Male
Date of Death: 6/01/2010
Place of Death: Holder, ACT
Coroner: M.A. Hunter
Date of Findings: 23/12/2016
Reported under 102(b), (c)

Coroner's Findings:

I find that Paul Fennessy ... died outside and adjacent to the northern perimeter fence of xxxx Holder in the Australian Capital Territory at 23:15 hours on 6 January 2010.

I further find that the cause of his death was the combined effect of a cocktail of drugs taken by him, which caused central nervous system depression and respiratory depression leading to positional asphyxia.

I further find that a matter of public safety arises in relation to Mr Fennessy's death, as further detailed in my reasons.

Conclusion

[427] I find that it was not unreasonable, on the balance of probabilities, for medical staff to have discharged Mr Fennessy on 6 January 2010, given they believed they had no mechanism available to detain him.

[428] I further find that Mr Fennessy was given a double dose of Methadone on 6 January 2010 where he was only prescribed one dose.

[429] I further find Mr Fennessy was able to access prescriptions from multiple prescribers and have the prescriptions dispensed by multiple pharmacies. It was clearly evident that Mr Fennessy successfully doctor shopped his prescriptions enabling him to consume significantly more quantities of drugs than proposed by the treating medical practitioners, to the point he overdosed on numerous occasions.

[430] It appears that neither the doctors nor the pharmacists were aware of just how many prescriptions Mr Fennessy had available to him. If there had been a real time mechanism for detecting overprescription and overdispensing such as that described by Ms Hughes in her evidence (DAPIS and DORA) the pharmacists would have been able to detect the misuse of the prescriptions in real time thus avoiding over supply of prescription drugs. This would have prevented Mr Fennessy from having access to the multitude of drugs he did have access to, thus preventing him from overdosing at least on prescription drugs and at least in the ACT. It would have also shown just what drugs were being prescribed and which doctors were prescribing them.

[431] I note that the ACT has available a data base (DAPIS) which could if utilised in the Territory, be adapted to provide a real time monitoring system (DORA). I am also aware that Coroners across Australia have called for such a system to be available nationwide.

Recommendations:

1. That the ACT Government implement DAPIS and adapt the real time monitoring system know as DORA.
2. That all medical files, including mental health records, in relation to a patient being treated at a Canberra Public Hospital be made available to all clinical staff at the hospital when required.

Court Reference: CD 153/14
Age: 74
Gender: Female
Date of Death: 07/07/2014
Place of Death: Calvary Hospital, Bruce
Coroner: P.J. Morrison
Date of Findings: 15/03/2017

Mandatory hearing – death in custody

Reported under 102(a), (d)

Coroner's Findings:

Gwenda Margaret Membery died at Calvary Hospital, Mary Potter Circuit, Bruce, in the Australian Capital Territory on 7 July 2014. The manner and cause of Ms Membery's death was

1. DIRECT CAUSE
   (a) Acute bronchopneumonia
2. OTHER SIGNIFICANT CONDITIONS contributing to the death but not related to the disease or condition causing it
   (a) Chronic obstructive pulmonary disease
   (b) Dementia
   (c) Schizophrenia

(d) Type II diabetes mellitus
(e) Chronic renal disease

…

4. Some special provisions are made in the Act about "death(s) in custody". Under section 3C of the Act, the death of a person who is subject to an order under the *Mental Health (Treatment and Care) Act 1994* (as it then was) is taken to be such a death in custody. I am satisfied that Ms Membery was at the time of her death subject to a psychiatric treatment order under s 24 of that Act (Exhibit R), such that her death is a death in custody for the purposes of the Act.

…

53. Not all of the evidence of the observations made of Ms Membery's condition at the relevant times are supported by truly contemporaneous notes by the witnesses. There are however no material conflicts or inconsistencies in the evidence of RNs Lacsao and Delos Santos and nothing about their testimony leads me to question their reliability. I accept the testimony received from them at the hearing.

54. I make the following observations on the evidence of Dr Austen and RNs Lacsao and Delos Santos about what took place in the period leading up to Ms Membery's death:

a. There is no evidence to suggest that any diagnosis or treatment or lack thereof by Dr Austen in any way contributed to the death of Ms Membery.
b. I accept that a decision about whether and when hospitalisation for Ms Membery was necessary called for consideration of many factors including her body temperature, her level of apparent consciousness, her oxygen saturation levels, and any signs of distress or difficulty in breathing, as well as any changes in those things just mentioned and Ms Membery's apparent response to treatment by way of the administration of paracetamol, antibiotics and cooling baths.
c. I accept that consideration of a decision on hospitalisation required nursing staff to make a judgment about the significance of those factors in the context of Ms Membery's overall circumstances at the time. I accept that the decision was properly a decision to be made by nursing staff on duty at the time.
d. Ms Membery's ongoing high body temperature was a factor weighing in favour of a decision to call for her hospitalisation earlier, but, as against that she did not demonstrate any signs of distress or difficulty in breathing. I accept what I understand to be the professional opinion of Dr Austen that the latter (distress or difficulty in breathing) is a more reliable indicator of the need for hospital treatment than the former (ie. a high temperature per se).

55. I make a formal finding as to the cause of Ms Membery's death in accordance with the unchallenged expert opinion of Professor Lyons.

56. I find that the decision to hospitalise Ms Membery was made by RN Delos Santos at 6.30am on 6 July 2014. Having regard to the considerations just referred to, the evidence does not, in the circumstances, support a conclusion that the decision should properly have been made at any earlier point in time.

57. Accordingly I make no finding that the quality of care, treatment or supervision of Ms Membery contributed to the cause of her death. Additionally I find that no matter of public safety arises.

Court Reference:	CD 5/15
Age:	55 years
Gender:	Male
Date of Death:	28/12/2014-5/1/2015
Place of Death:	Florey, ACT
Coroner:	R.M. Cook
Date of Findings:	23/03/2017

Suppression order on name of deceased

Coroner's Findings:

I find that:

1. The deceased was PAP, ...

2. Mr P died between 28 December 2014 and 5 January 2015 at his home [in] Florey, in the ACT having been found by his former partner, and next of kin, GP on 5 January 2015.

3. Mr P was declared life extinct by Dr Thompson on 5 January 2015. Pathologist Dr Sanjiv Jain conducted the post-mortem examination of Mr P at my direction. Dr Jain formed an opinion that the cause of death was septicaemia due to hydronephrosis and infection.

4. A contributing cause in Mr P's death was his own behaviour in refusing to accept medical treatment and services which were offered to him in order to provide ongoing treatment following discharge from hospital on a number of occasions.

5. Mr P was a hoarder and lived in squalor. I am satisfied Mr P had an undiagnosed mental illness. That he did not actively engage with medical or mental health services, although had frequent admissions to hospital prior to and following a mitral valve replacement operation.

6. I am satisfied no matters of public safety arose in connection with this inquest. I make no adverse findings to the effect that the quality of care, treatment and supervision of the deceased contributed to Mr P's death.

7. However, I provide recommendations given the unique opportunity afforded through the inquest to consider specific issues concerning first: the understanding of privacy laws and their application by health care professionals

in decision making concerning referrals to other appropriate health care providers.

8. Second, establishing a mechanism by which health care providers could have access to a patient's health records across the health services entities within the ACT through the use of flags that identify areas of health care provided to the patient both historically and currently without necessarily disclosing the illness or treatment regimes.

9. This it is hoped would alert health care professionals that broader considerations of other medical issues may need to be considered for example: a coloured coded flag on a patient medical record might indicate that a patient may have or have been subjected a Psychiatric Treatment Order with a strong medication regime and as a consequence treating the current physical injury/illness with an additional medication regime would need to be taken into account.

10. Or where a person appears to have an underlying mental health condition on presentation to ER, a flag mechanism may provide medical professional a more complete picture of the patient.

11. These recommendations would hopefully, enable where possible, timely access by health care professionals to such information or at least be placed on notice about its existence to allow effective diagnoses, treatment and delivery of in hospital and post discharge care, having afforded relevant health care providers the opportunity to consider holistically a patient's various medical conditions.

Recommendations

1. ACT health care providers should be reminded through either ongoing professional development and/or training about the extent and application of privacy and particularly its relationship to the lessening or prevention of a serious threat to the life, health or safety of an individual within the ACT.

   Additionally, they should be reminded that they have the capacity to ensure referrals can be made to relevant agencies that might potentially provide support to a person within the Territory, recognising that it will always remain that person's right not to accept that support or to consent to any treatment - provided they are not incapacitated or incompetent to do so.

2. That ACT health services examine their capacity to cross reference relevant data management systems, in particular mental health and physical health service providers, to enable health service providers to interact with respective data management systems so as to provide timely access to relevant medical information for health care professionals to effectively diagnose, treat and deliver in hospital or post discharge care having been able to consider holistically a patient's various medical conditions.

ANNEXURE 2 - FIRST RETROSPECTIVE ON THE NAYLOR REPORT

On 26 July 2013 Dr Charles Naylor, Chief Pathologist, Forensic and Scientific Services Queensland, handed down his *Review of ACT Coronial and Post Mortem Process and Practice*. It seems appropriate now, four years later, to revisit each of the 33 recommendations made by Dr Naylor and report publicly against each as to the status of implementation. This exercise might usefully be repeated again in another four or so years and report against the recommendations that remain yet to be fully implemented.

Recommendation 7.1

That, unless serving a policy objective, the ACT coronial investigation and autopsy rate be reduced to around 10% of deaths, and resources redeployed, by a combination of revising the criteria for reportable deaths and strengthening the screening of deaths reported – HIGH priority.

Pathway to implementation

Dr Naylor conducted a survey of jurisdiction-registered deaths that are certified across Australia for each of the years 2006 to 2011 (Table 2, page 45 of his *Review*). He determined that the average rate in 2011 of deaths that are coroner-certified across Queensland, NSW, Victoria and Tasmania was 10.5%; and that the South Australian, Western Australian and Northern Territory rates were 16.3%, 14.9% and 28% respectively. He also noted a general downward trend in these rates over time.

Dr Naylor conducted a detailed examination (Table 1, page 43 of his *Review*) of ACT deaths and reportable deaths by registration and residence in the ACT containing for the years 2006 to 2011 inclusive – for ease of reference, that table and its footnotes have been duplicated on the following page as Table 10. He concluded that the 2011 ACT rate was 16.4% and that in the absence of unusual social factors applying only to the ACT, the rate was significantly higher than other eastern seaboard state. He expressly suggested that unless there was a deliberate policy decision to have such a high coronial investigation rate, it would be appropriate to reduce the rate to approximately 10% and there would be a consequential cost and resource saving.

Many of the other recommendations made by Dr Naylor in his *Review* were directed towards achieving this key objective.

I have seen nothing to suggest that such a high rate of coronial investigation is a deliberate decision of government. Accordingly I too consider that such a rate reduction would be appropriate and would ensure scarce resources are directed to cases of greatest concern. Given that some changes to practice, procedure and legislation have occurred since Dr Naylor's *Review*, it is appropriate to repeat Dr Naylor's exercise again with more recent data to investigate if the rate has decreased further since 2011: see Table 11 on page following.

Table 10: (Dr Naylor's Table 1) ACT deaths and reportable deaths by registration and residence in the jurisdiction

	1	2	3	4	5	6	7	8	9	10	11
Year	ACT population	Total deaths by usual residence in ACT	Deaths reported to Coroner [3]	Deaths accepted for invest-igation	Deaths undergoing coronial autopsy at FMC:			Coroner certified deaths in ACT:		Total deaths by registrat'n in ACT	% of ACT reg'd deaths undergoing coronial autopsy
					Total = ACT + NSW	From NSW[4]	From ACT[5]	By usual residence in ACT [6]	By death registrat'n in ACT		
	ABS (ACT Coroners Court)	ABS (ACT Coroners Court)	ACT Coroners Court	ACT Coroners Court	FMC & ACT Coroners Court	Data obtained from FMC	Data obtained from FMC	Direct from ABS	Direct from ABS	Direct from ABS	Column 9 as % of column 10
2006	334k	1,484	401	401	401	50	351 [7]	279	309	1,656	18.7%
2007	341k	1,597	392	392	392	61	331	n.a.	329	1,781	18.5%
2008	346k	1,697	405	405	405	67	338	n.a.	348	1,931	18.0%
2009	352k	1,648	427	427	427	87	340	n.a.	333	1,865	17.9%
2010	359k	1,679	385	385	385	51	334	282	331	1,889	17.5%
2011	366k	1,700 [8]	373	373	372	53	319	262	314	1,917	16.4%

[3] This data from the ACT Coroners Court was assumed to refer to ACT Coroners' cases. However, it apparently includes NSW reportable deaths undergoing autopsy at FMC.
[4] These are deaths that have occurred in NSW and are being investigated by a NSW Coroner. Referral to the FMC for coronial autopsy is solely due to geographic proximity.
[5] These are deaths that have occurred in the ACT and are undergoing investigation by an ACT Coroner.
[6] Lower figures for deaths by usual residence in ACT, compared with deaths by registration in ACT, is attributable to reportable deaths of persons residing outside ACT who happen to die in the ACT (e.g. at work, receiving health care). In 2010 and 2011, 15% of reportable deaths in the ACT involved people residing outside the ACT.
[7] This is the only annual total for ACT autopsies at FMC that differs substantially from coroner certified deaths by registration in the ACT (column 9). The reason is obscure.
[8] In recent years, about 89% of those dying in the ACT are resident in the Territory. This percentage represents column 2 expressed as a percentage of column 10.

Table 11: ACT deaths and reportable deaths by registration and residence in the jurisdiction (Dr Naylor's Table modified[9] and updated)

	1	2	3	4	5	6	7	9	10	11
Year	ACT population	Total deaths by usual residence in ACT	Deaths reported to Coroner	Deaths accepted for invest-igation [10]	Admissions to FMC: [11]			ACT Coroner certified deaths by death registrat'n in ACT	Total deaths by registrat'n in ACT	% of ACT reg'd deaths undergoing coronial autopsy
					Total = ACT + NSW	From NSW	From ACT			
	ABS (ACT Coroners Court)	ABS (ACT Coroners Court)	ACT Coroners Court	ACT Coroners Court	FMC	FMC	FMC	Direct from ABS	ABS (ACT Coroners Court)	Column 9 as % of column 10
2012	375k	1,649	335	335	394	59	335	321	1,937	16.6%
2013	381k	1,643	320	320	420	49	371	322	1,921	16.8%
2014	385k	1,762	295	295	337	44	293	294	2,015	14.6%
2015	391k	1,809	267	267	312	47	265	253	2,081	12.2%
2016	406k	1,839 [12]	314	314	426	76	350	278	2,084	13.3%

[9] The ABS did not supply data as to Coroner certified death in the ACT by usual residence in the ACT (column 8 of Dr Naylor's original table); however there is no reason to suspect that this proportion would be dramatically different from other years.

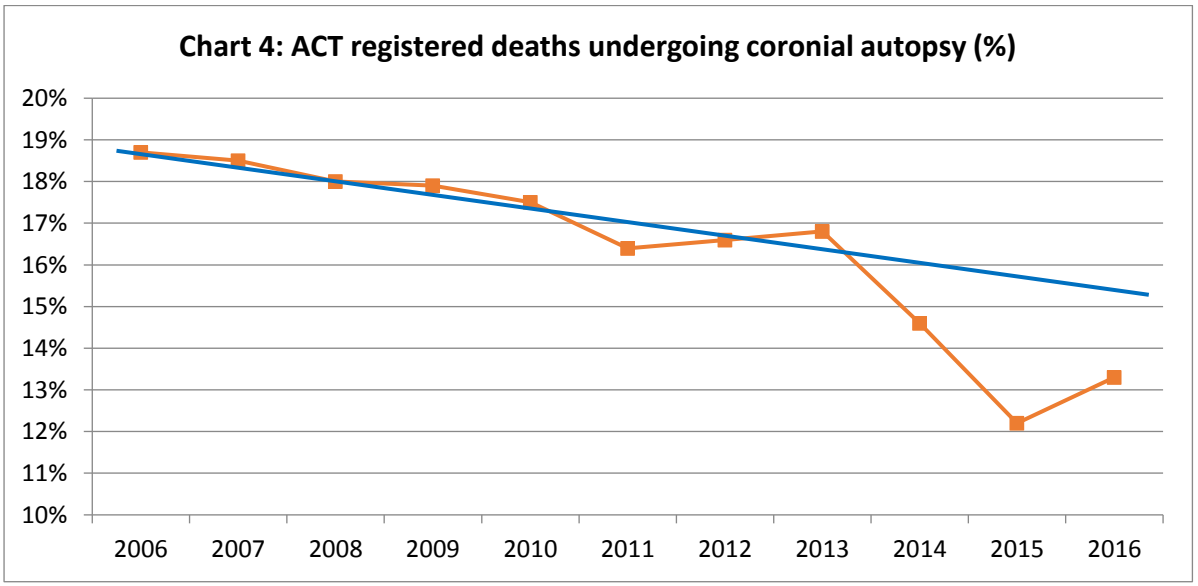
[10] Dr Naylor at page 9 of his *Review* said "[i]n reality, there should be significantly fewer deaths investigated than are reported, as the need to report may be at first unclear, or there may be a delay in the treating doctor issuing a death certificate", and referenced the fact that in April 2013, 27% of reported deaths in the Queensland system received a cause of death and exited the coronial system. As discussed earlier in this report, the practice that has developed over time in the ACT is that these cases are filtered out at the notification stage by the AFP Coronial Liaison Unit, and as such do not end up being reflected in court statistics.

[11] This group of columns in Dr Naylor's table was titled "deaths undergoing coronial autopsy at the FMC", presumably because at that time "figures for full and partial autopsy were not available": see page 9 of the Naylor Report. The group has been renamed "admissions to the FMC" to better reflect the fact that not all such cases will receive an autopsy. The proportion of cases which receive invasive autopsy can be seen in Table 8 earlier in this report.

[12] In 2016, about 86% of those dying in the ACT were resident in the Territory, according to ABS commentary for *ABS3302.0 – Deaths, Australia*, 2016, released 27/09/2017.

Population[13] and death[14] data was obtained from the Australian Bureau of Statistics (ABS) website; however data on the specific numbers of coroner-certified deaths was obtained directly from the ABS[15], and I am grateful to James Eynstone-Hinkins and Lauren Moran in the ABS Social and Demographic Statistics Team for their assistance in that regard.

It can now be seen that while the rate of 16.4% that Dr Naylor determined for 2011 remained fairly constant for the next two years, the rate has dropped considerably since about 3-4% and sits in 2016 (despite a small increase from last year) at 13.3%: see Chart 4.



This change appears to be attributable to the legislative changes to the scope of jurisdiction and reportability urged by Dr Naylor and subsequently implemented successively from 2014. In terms of how our rates of coronial investigation presently compare across Australia, I note the following commentary from the ABS in its Explanatory Notes to the *3303.0 - Causes of Death, Australia, 2016* data set:[16]

> **71** For deaths in the 2016 reference year, 12.1% were certified by a coroner. There are variations between jurisdictions in relation to the proportion of deaths certified by a coroner, ranging from 9.2% of deaths certified by a coroner and registered in New South Wales, to 23.6% of deaths certified by a coroner and registered in the Northern Territory. The proportion of deaths certified by a coroner in 2016 is comparable to previous years.

Consistent with Dr Naylor's recommendation, the ACT is now more closely approaching the Australian average.

[13] *ABS3101.0 – Australian Demographic Statistics*, December 2016, released 27/06/2017.
[14] *.ABS3302.0 – Deaths, Australia*, 2016, released 27/09/2017.
[15] *.ABS Causes of Death data: Customised report*, received 27/09/2017.
[16] *ABS3303.0 – Causes of Deaths, Australia*, 2016; explanatory notes accessed on 27 September 2017 at http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/3303.0Explanatory%20Notes12015?OpenDocument .

Recommendation 8.1

That section 13 (and Coroners Regulation 1994*) be reviewed in comparison to other Australian legislation, and amended to replace any redundant or ambiguous provisions (and possibly to include "deaths in care"), and to limit reportable deaths to those serving defined policy objectives and coronial investigations (e.g. death registration, prosecution of crime, and making beneficial recommendations) – HIGH priority.*

Partially implemented

No comprehensive review of section 13 has taken place from a policy perspective. There have been a series of ad hoc amendments to section 13 after the Naylor *Review*, as follows:

- The *Courts Legislation Amendment Act 2014*, which came into effect on 2 April 2014, and made amendments to:
    - paragraph (e), which required deaths occurring within 72 hours of a medical procedure, where the timeframe was changed to 24 hours; and
    - paragraph (g), which in effect required a deceased person to have been seen by a doctor within the three months preceding death, where the timeframe was changed to six months; and
- The *Courts Legislation Amendment Act 2015*, which came into effect on 21 April 2015, and made amendments to:
    - paragraph (a) , which formerly read "is killed", was amended to "dies violently, or unnaturally, in unknown circumstances";
    - paragraph (b), which formerly read "is found drowned", was omitted; and
    - paragraph (c), which formerly read "dies, or is suspected to have died, a sudden death the cause of which is unknown", was omitted; and
- The *Courts Legislation Amendment Act 2015 (No 2)*, which came into effect on 10 December 2015, changed the reportability basis for health care-related deaths from a time based criterion to a causation based criterion – see response to Recommendation 9.1.

I note that any expansions to jurisdiction on a policy basis would also need to be accompanied by sufficient resourcing to the Court.

Recommendation 8.2

That the Chief Coroner issue guidelines for best practice under section 7; or, if necessary, the Coroners Act 1997 *be amended to make this possible – HIGH priority.*

Pathway to implementation

From 1 February 2012, a new section 51 "Practice and procedure for inquests and inquiries" was inserted into the Act by the *Coroners Amendment Act 2011* and which permitted the

Chief Coroner to make Coronial Practice Directions. This section would have been operative at the time Dr Naylor was conducting his review but he makes no reference to it; indeed his discussion about the desirability of guidelines is quite scant and refers only to section 14 of the Queensland *Coroners Act 2003* which permits the making of both directions and guidelines.

The Legal Manager has developed a suite of Coronial Practice Directions for my consideration.

Recommendation 8.3

That reported deaths be screened and, if investigation is not warranted, the issue of cause of death certificates maximised, under the Chief Coroner's guidelines and coroners' oversight – HIGH priority.

Pathway to implementation

Previously, screening of all reported deaths was impossible in the absence of suitable resident medical staff. However, retention of Professor Duflou has permitted a number of pathologist-led medical reviews.

Should the Legislature determine to implement changes to the *Birth, Deaths and Marriages Registration Act 1997* urged on the ACT by Dr Naylor – see Recommendation 8.5 – this would allow for a forensic pathologist to issue death certificates in appropriates cases. This would barely increase the work of the pathologist but may produce a significant reduction in the Court's workload given that many cases rely almost exclusively on the findings of the pathologist.

Towards the end of 2016/17 the Coroner's Legal Manager commenced work on a project, in consultation with our consultant pathologists, on a possible model for a triage process for cases at the post mortem examination stage.

Recommendation 8.4

That, under the Chief Coroner's guidelines, coroners release the body under section 16 in deaths where investigation is not warranted and a cause of death certificate can be issued; or if this is not possible, the legislation be amended – HIGH priority.

Implemented currently

Increasingly Coroners are making orders under section 16 to release deceased persons without post mortem examination where the cause of death is evident or able to be ascertained by way of review of medical records. In such cases, rather than issue of a cause of death certificate, Coroners make formal findings under the Act but are doing so expeditiously.

Recommendation 8.5

That section 35 of the ACT Births Deaths and Marriage Registration Act 1997 *be amended to enable doctors to issue Cause of Death Certificates based on information about the deceased person and the death– HIGH priority.*

Implemented

The *Courts Legislation Amendment Act 2014*, which came into effect on 2 April 2014, added in to the section a new paragraph (c) as follows:

> (1) A doctor must give the registrar-general written notice of the death and cause of death of a person within 48 hours after the death if the doctor ... (c) has considered information about the deceased person's medical history and the circumstances of the deceased person's death and is able to form an opinion as to the probable cause of death.

The amendment also included examples for this paragraph to make it clear that this could include examining medical records or speaking to the deceased person's treating doctor, or the account of someone who was with the deceased person when the person died or who discovered the deceased person's body. It is possible that with a permanent forensic pathologist capability, this section could be utilised by that practitioner to divert natural cause cases out of the coronial system. I am not in a position to report as to whether this section is being utilised by the wider medical profession.

Recommendation 8.6

That ACT practices be modified so that Coroners make explicit orders about the extent of autopsy, the samples taken and the retention of large specimens under guidelines issued by the Chief Coroner – HIGH priority.

Partially implemented

A practice has developed over time that the standard order made for autopsy is for an examination "sufficient to determine the cause of death", which limits the possibility of unnecessary examination. Similar practices have been created over time whereby express coronial approval is required for the taking of samples prior to autopsy and for the retention of large samples after autopsy. However, it would be appropriate for these practices to be formalised by way of a Coronial Practice Direction.

Recommendation 8.7

That consideration be given to whether any clarifying amendments of the Transplantation and Anatomy Act 1978 *would be useful.*

Not yet implemented

The specific anomalies highlighted by Dr Naylor were: a risk that pathologists or coroners may not differentiate retention of tissue taken during a coronial autopsy for coronial versus

transplantation purposes, that the issue of taking of tissue for other non-coronial and non-scientific purposes is not addressed, and the drafting of section 35 is possibly in conflict with the coronial jurisdiction.

None of these issues appear to have been addressed. The *Transplantation and Anatomy Act 1978* is administered by the ACT Health Directorate and any changes are within that directorate's purview. It would be useful to have the *Transplantation and Anatomy Act 1978* deal with the issue of post mortem sperm collection also. This omission may have been intentional at the time the Act was drafted but probably warrants review now.

Recommendation 9.1

That section 13(1)(e) of the ACT Coroners Act 1997 *and the* Coroners Regulation 1994 *be reviewed and amended to better target healthcare deaths that warrant investigation – HIGH priority.*

Partially implemented

As an interim measure, the *Courts Legislation Amendment Act 2014*, which came into effect on 2 April 2014, amended paragraph (e), which required deaths occurring within 72 hours of a medical procedure, to change the timeframe was changed to 24 hours.

The *Courts Legislation Amendment Act 2015 (No 2)*, which came into effect on 10 December 2015, changed paragraph (e) from a time based criterion to a causation based criterion as follows:

From:	dies during or within 24 hours after, or as a result of— (i) an operation of a medical, surgical, dental or like nature; or (ii) an invasive medical or diagnostic procedure; other than an operation or procedure prescribed by regulation to be an operation or procedure to which this paragraph does not apply;
To:	dies and the death appears to be completely or partly attributable to an operation or procedure (other than an operation or procedure prescribed by regulation for this paragraph).

However, it became apparent that that the unintended effect of this amendment is to exclude from reportability deaths that occur in any of the circumstances prescribed by regulation, such as after an intravenous or intramuscular injection, artificial ventilation, resuscitation, catheter or cannula insertion. I consider that if death occurs due to any of these methods, a coronial investigation would be warranted, and I have asked for this to be corrected (and the Regulation repealed) as soon as practicable. That legislative change was effected with date of effect 16 November 2017 to delete the qualifying words in brackets from the section.

Recommendation 9.2

That, if necessary, the Act be amended to ensure coroners can authorise the issue of cause of death certificates in healthcare deaths that do not warrant investigation – HIGH priority.

Not implemented

The scheme of the Act, and that of the *Transplantation and Anatomy Act 1978*, is that doctors issue cause of death certificates rather than Coroners. I do not consider it appropriate for a Coroner to issue a cause of death certificate. However, increasingly ACT Coroners are exercising their discretion under section 16 to dispense with post mortem examinations and make formal findings under the Act expeditiously, which achieves a similar outcome.

Recommendation 9.3

That healthcare deaths undergo specialist screening, e.g. by forensic medical officers or pathologists.

Pathway to implementation

Given the small size of the ACT jurisdiction and the likelihood of conflict of interest issues arising, it is not possible to use ACT Forensic Medical Officers (who are employed by ACT Health) to screen health-care related deaths, the majority of which occur in an ACT Health setting.

A possible model for a triage prior to post mortem examination referred to above would address this issue.

Recommendation 10.1

That autopsy reports include adequate detail, as well as sufficient commentary to assist coroners, under the Chief Coroner's guidelines, or a Service Agreement, if necessary.

Implemented currently

Since the engagement of Professor Duflou in January 2017, the utility of autopsy reports prepared for ACT Coroners has improved without the need for Chief Coroners Guidelines or a Service Agreement. I consider that this is a matter best dealt with in quality standards requirements of the FMC rather than by way of coronial guideline.

Recommendation 10.2

That autopsy reports avoid opinions or interpretations which more properly lie within the coroner's domain.

Implemented currently

This is a matter of professional competence best addressed in FMC quality standards. However, reports which traverse the function of the Coroner are unlikely to be relied upon.

Recommendation 10.3

That opinions as to causes of death should be expressed in the standard international format in use in Australia.

Implemented currently

This is also a matter best addressed in FMC quality standards.

Recommendation 10.4

That about 5% of autopsy reports, focussing on more complex cases, should undergo peer review immediately prior to completion.

Partially implemented

The pathologists currently performing ACT coronial autopsies do not have a formal system of peer review. Certain autopsy reports are on request sent for peer review on an ad hoc basis. Further implementation of this recommendation will depend on the staffing model ultimately adopted in relation to forensic pathology services: see response to Recommendation 17.1.

Recommendation 11.1

That the objectives and measures required to ensure respect for the deceased and their families, and the corresponding recommendations, be adopted as a priority – HIGH priority.

Implemented

It is important to note that Dr Naylor did not identify specific instances where appropriate respect was not being paid to deceased persons and their families; his concerns appear to have been structural. Dr Naylor repeated the point that fundamentally, respecting family members and the dignity of deceased persons requires that the deaths investigated and the extent of autopsies should be limited to those examinations that are strictly necessary.

After receipt of the Naylor Review, a process review was undertaken by the then Mortuary Manager to integrate respect for the deceased and their families into all aspects of FMC business. Policy documents were prepared, and training specifically provided to staff on dealing with persons affected by grief and trauma. That training is regularly repeated and enhanced for staff working directly with deceased persons or with families of deceased persons.

I consider that all Coroners and staff working within the coronial jurisdiction, as well as the Police Coronial Liaison Unit, demonstrate a compassionate and respectful approach.

Recommendation 12.1

That awareness of codes of ethics relevant to respecting families and deceased should be promoted amongst staff.

Implemented but more can be done

Again, Dr Naylor did not identify specific instances where ethics were not being adhered to; his concerns appear to have been structural. He noted the existence of the National Code of Ethical Autopsy Practice and NPAAC Guidelines, and that these standards are used when a mortuary is assessed for National Association of Testing Authorities (NATA) accreditation: see also Recommendation 15.4 and the response also to that Recommendation.

The process review undertaken by the then Mortuary Manager after receipt of the Naylor Review also reviewed ethical considerations regarding respect for the deceased and families. As for the previous recommendation, policy documents were prepared, and training specifically provided to staff. Again, I hold no concerns that staff working within the coronial jurisdiction, or the Police Coronial Liaison Unit, are acting unethically. However, I believe that formal adoption of the National Code and NPAAC Guidelines was thought to have been contingent on moving towards NATA accreditation, which in the immediate aftermath of Dr Naylor's Review may have been thought to have been imminent, but is likely still to be some way off. I will ask the new Mortuary Manager to be recruited in 2017/18 to revisit this issue with a view to incorporating these standards into FMC processes.

Recommendation 12.2

That research proposals and practice issues should referred to an NHMRC-registered human ethics committee with substantial membership from outside the coronial system.

Not yet implemented

I am supportive of this recommendation in principle. Although I note that requests from researchers to access coronial data and information are generally referred to NCIS. Should that situation change in future, I would favour pursuing a 'coronial' or 'forensic' presence on an existing ethics committee within the ACT, such as the Health Ethics Committee.

Recommendation 13.1

That innovations such as introduction of a judicial registrar, coronial nurse and CT scans be implemented as comprehensively as possible within budgetary constraints – HIGH priority.

No longer necessary / Not yet implemented

The Courts Registrar has been appointed as a Deputy Coroner, addressing the first of these recommendations. In the appointment process for a new mortuary manager in the next financial year, consideration will be given to the broader functions that role may undertake.

I also note with approval the recent adoption of a "PM review" process in respect of recent cases whereby upon receipt of a post mortem examination report, legal staff conduct a review of the file, checking for outstanding materials and information, ensuring that the views of the family as to potential issues and concerns have been sought and bringing relevant matters to the attention of Coroners. This process has assisted in quicker throughput of routine cases and ensured that cases which require further investigation are promptly identified and that appropriate instructions for investigation given at an early stage.

Presently, a small fraction of FMC cases are sent for CT scans, which are conducted at The Canberra Hospital (TCH) on a fee-for-service basis. In 2015/16 CT scans were obtained in 32 cases, constituting 11% of the ACT cases handled in that year; and in 2016/17, CT scans were obtained in 10 cases, constituting 3% of the ACT cases in that year. The limitation on the expanded use of this tool is primarily financial, but TCH also prohibits use of its scanner for decomposed human remains. In contrast, best practice in autopsy service at VIFM and FASS is for all deceased persons to be CT scanned on admission to the coronial mortuary, and both of those agencies have a dedicated on-site CT capability for that purpose. The capital cost for a CT scanner for the FMC, and the significant unused capacity, mean that a dedicated machine located at the FMC is not feasible, however, ACT Health has indicated that it has excess capacity at its TCH facilities if the FMC can pay. A budget bid for increased funding in that regard for 2017/18 was unsuccessful, however ACT Health have indicated a preparedness to consider revision of their rates to allow more scans to be conducted within the existing budget envelope.

Recommendation 14.1

That a dedicated coronial counselling service (Option 1) be recognised as the ideal model, and a "coronial nurse-counsellor" (Option 2) as an alternative or adjunct, but strengthening the service to families by coroners' officers (Option 3) be implemented in the short term as achievable and cost effective.

Implemented

Since 2015, ACT Health has funded Relationships Australia Canberra and Region to provide the ACT Coronial Counselling Service. I have discussed the value of this Service earlier in my report.

Recommendation 14.2

That, whichever option(s) is/are chosen, bereaved families have timely access to appropriate information and support, fully integrated into the coronial system, and that their views are considered, especially objections to autopsy and the retention of large specimens.

Implemented but more can be done

After receipt of the Naylor Review, a process review was undertaken by the then Mortuary Manager to improve the procedures for objections to autopsy, observers at autopsy and the

retention of large specimens, including improving forms and process documents. The documents have also been subsequently reviewed more recently to ensure they continue to meet the needs of families and the jurisdiction. Families are routinely advised of the need to retain large specimens when the issue arises and their views always sought.

As required by the Act, Coroners are particularly attentive to the views of the family in making decisions as to whether an autopsy takes place and the extent of any autopsy. Police take a lead role in explaining the autopsy process to families, obtaining any objections and relaying that information to Coroners. A practice has developed over time that the standard order made for autopsy is for an examination "sufficient to determine the cause of death", which limits the possibility of unnecessary examination.

I would welcome an update and improvement to the court's website and hard copy information brochures. However, in the light of limited resourcing of the Court, I have instructed the Coroner's Legal Manager to focus on case management and resolution, with a particular view to reducing the file backlog and dealing with historic cases. Unfortunately, without additional resourcing, this project will be delayed.

Recommendation 15.1

That the FMC continue to be managed within the court system, but only if health-based mentoring and professional supervision of the manager is strengthened and formalised.

Not yet implemented

Implementation of this recommendation was stayed pending negotiations with NSW FASS about a possible partnership in relation to coronial pathology services and support for ACT technical staff. This recommendation will be actively revisited in 2017/18 at the time of recruitment of the new mortuary manager.

Recommendation 15.2

That, depending on annual autopsy workloads, one or two permanent full-time mortuary assistants be appointed, reporting to the FMC manager – HIGH priority.

Pathway to implementation

Implementation of this recommendation was stayed pending negotiations with FASS about a possible partnership in relation to coronial pathology services and the possible implications for staffing models. Given the continued uncertainty in relation to any partnership with FASS, this recruitment action cannot be stayed any longer and action will be taken to recruit two permanent part-time mortuary assistants in 2017/18.

Recommendation 15.3

That suitable ICT systems be accessible at FMC and all necessary sites – HIGH priority.

Not yet implemented

The Court has no dedicated coronial case management system. Even the pending ICMS system will not apply to coronial matters. Ultimately, I would like to see such a system developed into which all relevant data – court, FMC and police investigator data is entered. This is presently a pipe dream.

What has been achieved is access by FMC staff and pathologists to ACT Health systems for pathology and radiology to access results on coronial cases, which assist quicker turnaround for pathologist advice and reports to Coroners.

Recommendation 15.4

That NATA accreditation of the FMC be actively sought and, to this end, potential obstacles to achieving accreditation be addressed.

Not yet implemented

Implementation of this recommendation was stayed pending negotiations with FASS about a possible partnership in relation to coronial pathology services and possible adoption of NSW procedures and systems which have already received NATA accreditation. The lack of a fulltime resident forensic pathologist for the ACT is a significant obstacle to the FMC achieving NATA accreditation. However, Standard Operating Procedures have been developed and NATA accreditation remains a medium term goal for the court.

Recommendation 15.5

That preparation for NATA accreditation include SOPs to ensure respect for the deceased (e.g. covering deceased, good quality reconstruction).

Implemented

Comprehensive SOPs have been prepared and in operation for some time. It will be a priority task for the new mortuary manager to review these SOPs and to benchmark them against best practice in other jurisdictions.

Recommendation 16.1

That an interdisciplinary committee or working group chaired by the Chief Coroner be established to oversee, coordinate and improve practices of the different agencies – HIGH priority.

Pathway to implementation

The different agencies referred to by Dr Naylor here were coroners, coronial staff, police, pathologists, the mortuary manager, a coronial counsellor, and other stakeholders. I am supportive of this recommendation in principle. Implementation of this recommendation

was stayed pending negotiations with FASS about a possible partnership in relation to coronial pathology services. Pending establishment of this committee, I meet regularly meeting with the Coroner's Legal Manager, who regularly meets with all the above stakeholders. Given the lack of progress from FASS, it seems sensible to move further on implementation, however, the availability of a dedicated coroner would allow the recommendation to be implemented sooner.

Recommendation 16.2

That the ACT Coroners Court establish a "judicial registrar", and also consider establishing one or two coroners dedicated to coronial work – HIGH priority.

No longer necessary / Not yet implemented

As discussed above in the response to Recommendation 13.1, the need for a "judicial registrar" has been addressed by appointment of the Registrar as Deputy Coroner and appointment of the Legal Manager with authorisation to attend to some of the functions which might fall within the scope of work of a judicial registrar.

I continue to advocate for the appointment of a dedicated coroner. My oft-repeated opinion is that such an appointment would result in improved efficiency and timeliness, the development of expertise and improved coordination and oversight of the jurisdiction.

Recommendation 17.1

That Option 2 (two salaried pathologists) for the forensic pathology service be recognised as the ideal, but Option 4 (strengthened fee-for-service model) be adopted under a Service Agreement, if dictated by budgetary constraints.

Not yet implemented

Dr Naylor's Option 2 has always been my preferred option but to date the ACT has not been funded to recruit one full time salaried forensic pathologist, let alone two. For this reason, Option 4 has been primarily progressed, firstly with VIFM and then ultimately with FASS. However, as discussed earlier in my report, although negotiations with FASS about a partnership model have been ongoing for the last few years, FASS has now unilaterally withdrew from negotiations and indicated that it was not now or in the near future be in a position to progress a partnership with the ACT.

Funding is required to recruit a resident forensic pathologist. There is interest from the profession despite the shortage of such professionals. As of 1 January 2019, unless this or some other arrangement is arrived at, the ACT will have no coronial forensic autopsy capability.

Recommendation 17.2

That pathologists performing ACT coronial autopsies adopt peer review, credentialing and continuous professional development, in keeping with a Service Agreement.

Not yet implemented

The pathologists currently performing ACT coronial autopsies do not have a formal system of peer review, credentialing or continuous professional development. As independent contractors, the pathologists are expected to maintain appropriate qualifications and expertise. Certain autopsy reports are on request sent for peer review on an ad hoc basis. In the event that a permanent pathologist is recruited, this would be a requirement of the position.

Recommendation 18.1

That the resource imposts of performing NSW autopsies be carefully assessed to ensure full costs are being recovered; and that if true costs cannot be recovered, or if there are no benefits to FMC (e.g. economies of scale), the coronial autopsy service to NSW be discontinued.

Under consideration

At the time of Dr Naylor's Review, July 2013, the FMC was undertaking between 50-60 autopsies for NSW on a cost recovery basis at $1,939 per case (not including toxicology and pathology). Dr Naylor considered that these costs did not represent full cost recovery, noting that the equivalent costs in Queensland for an external examination or a full autopsy were $2,725 and $7,485 respectively. A review is planned for the 2017/8 year.

Recommendation 18.2

That mutually beneficial university collaborations be explored – ACT Law Courts would receive professional services, while academics gain access to coroners' cases for teaching or research – HIGH priority.

Partially implemented

I am supportive of this recommendation in principle. The FMC has long been engaged with the ANU Medical School and the University of Canberra's forensic science courses and provide teaching opportunities for students (with the express permission of the families of the deceased persons in question). However, to date these partnerships have largely been one way with little return to the coronial jurisdiction. Additionally, these relationships are largely informal and historic and could usefully be formalised and renewed.

In 2016/17 the Coroner's Legal Manager was involved on an ad hoc basis with providing legal internships to university law students who need experience in a legal practice to complete their qualifications, by way of applications made directly to the Court. This has been a mutually beneficial collaboration with benefits to both parties, as the students have been involved in assisting in case summaries and preparation that would otherwise need to

be completed by court legal staff. I would like to see this program formalised and expanded in future.

Recommendation 19.1

That reforms be adequately resourced but structured as cost effectively as possible.

Not yet implemented

The court continues to make budget bids on an as required basis. These have largely been unsuccessful. It would be helpful to have a budget rebasing for the Coroner's Court as part of a wider rebasing of the Magistrates Court budget, which in my view is long overdue.

<end of report>