CANBERRA

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Mr Simon Corbell MLA
Attorney-General
ACT Legislative Assembly
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Dear Attorney-General

Please find enclosed my report in accordance with section 102 of the *Coroners Act 1997*, relating to the activities of the ACT Coroner's Court for the financial year ending 30 June 2015.

Yours sincerely

Lorraine Walker
Chief Coroner

December 2015

TABLE OF CONTENTS

Coroners Act 1997 (excerpt)

s102 Annual report of court

(1) The Chief Coroner must give a report relating to the activities of the court during each financial year to the Attorney-General for presentation to the Legislative Assembly.

(2) The report must include particulars of—

(a) reports prepared by coroners into deaths in custody and findings contained in the reports; and

(b) notices given under section 34A(3) (Decision not to conduct hearing); and

(c) recommendations made under section 57(3) (Report after inquest or inquiry); and

(d) responses of agencies under section 76 (Response to reports) including correspondence about the responses.

(3) The Chief Coroner must give the report to the Attorney-General as soon as practicable after the end of the financial year and, in any event, within 6 months after the end of the financial year.

(4) If the Chief Coroner considers that it will not be reasonably practicable to comply with subsection (3), the Chief Coroner may within that period apply, in writing, to the Attorney-General for an extension of the period.

(5) The application must include a statement of reasons for the extension.

(6) The Attorney-General may give the extension (if any) the Attorney-General considers reasonable in the circumstances.

(7) If the Attorney-General gives an extension, the Attorney-General must present to the Legislative Assembly, within 3 sitting days after the day the extension is given—

(a) a copy of the application given to the Attorney-General under subsection (4); and

(b) a statement by the Attorney-General stating the extension given and the Attorney-General's reasons for giving the extension.

(8) The Attorney-General must present a copy of a report under this section to the Legislative Assembly within 6 sitting days after the day the Attorney-General receives the report.

(9) If the Chief Magistrate fails to give a report to the Attorney-General in accordance with this section, the Chief Magistrate 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.

STAFFING

Coroners

The Coroner's Court receives no allocated resourcing for the performance of judicial coronial functions. The arrangements of some long standing whereby every Magistrate retains an active coronial case load continued in 2014/15. In practice this means that duties as a Magistrate generally demand more immediate attention with the result that Coroner's work is exercised as a secondary priority as time permits. Although Magistrates are allocated chambers days to attend to out of court obligations, including attending to their coronial cases, in practice Magistrates are often engaged with finalising reserved criminal and civil decisions with little time remaining for coronial work. I have from time to time needed to list Special Magistrates to conduct hearings where I have been unable to appropriately allocate matters from within existing judicial resourcing.

The appointment of the Registrar as a Deputy Coroner last year allowed most of the fire inquiry work to be delegated from the Chief Coroner to the Deputy Coroner. This has proven efficient and beneficial, noting also the reduction in scope of the jurisdiction discussed later in my report.

During this year I made public comment to the effect that the ACT has, in my opinion, reached a point at which the community would benefit from the appointment of a dedicated Coroner, supplemented as required from the existing complement of Magistrates to provide out of hours duty cover, absences on leave and the like. This observation is not based purely on a workload assessment; the reality is that the workload would not necessarily keep a single person fully occupied. However, appointment of a dedicated Coroner would facilitate the earliest possible resolution of matters and allow appropriate and timely listing of hearings, without the delays in listing and fragmentation of hearings which is frequently necessary because of other court commitments. A dedicated Coroner would enable the development of expertise in coronial practice generally and areas of community concern, such as suicide and domestic violence. A dedicated Coroner would also lead improved coordination and oversight of the jurisdiction. Any additional capacity could readily be utilised as a supplement to other Magistrates Court work, under my direction. I recommend that serious consideration be given to establishing a dedicated Coroner appointment for the ACT.

Administrative Staff

The administrative needs of the ACT Coroner's Court are met from within the ACT Law Courts and Tribunal (LCT) Administration, a business unit of the Justice and Community Safety Directorate (JACS), by way of a dedicated support unit sitting under the Magistrates Court Registry. The Coroners Unit is headed by a Legal Manager and includes court support and forensic medicine staff.

As I noted in last year's report, the Legal Manager position is newly created, designed to facilitate early and close liaison with investigative and pathology support, allowing for timely legal "triage" to assist Coroners in early resolution of cases. The occupant of the role took up her position in May 2015, and accordingly while this report for 2014/15 is unable to evidence changes arising from the appointment, already it is apparent that significant benefits are flowing from the new arrangements, not least in case progression and timeliness. I will report more fully on these matters in next year's report.

The Legal Manager directly manages two administrative support staff co-located with the Magistrates Court Registry, and the mortuary manager located at the Forensic Medicine Centre (FMC) in Phillip. Five technical officers are also employed at the FMC for post-mortem purposes and operational support. All Coroners Unit staff have received trauma, grief and loss management training both to assist the public that they deal with and in relation to their own exposure. FMC staff have also received additional job-specific training, including dealing with dangerous goods and biological materials.

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).

For many years the Office of the ACT Director of Public Prosecutions assisted Coroners by providing lawyers to act as Counsel Assisting as requested. That support was gratefully received. The private bar has also been called on for more complex or specialised matters. In my report last year I foreshadowed that part of the rationale for appointing a Legal Manager to the Coroners Unit, however, 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. Coroners now have an additional resource to call upon when considering whether to appoint Counsel Assisting in new cases. Cases may still be briefed to the ACT DPP, or to the private bar, depending on the complexity of the matter or the capacity of our in-house practitioner, although I anticipate that such referrals will in future be exceptional.

As noted above, given the occupant assumed the role in May 2015, I am unable in this report to comment in detail about the impact of an in-house Counsel Assisting to the coronial jurisdiction. I note that notwithstanding her short time with the Court, our in-house Counsel Assisting was appointed and appeared in two hearings in the 2014/15 year.

FACILITIES AND SERVICES

FMC

In 2014/15 the Forensic Medicine Centre (FMC) continued to develop its Standard Operating Procedures for the Centre working towards obtaining quality accreditation. Underpinning this, an extensive quality assurance framework has been established at the FMC that draws on best practice principles in autopsy services and mortuary management and is consistent with industry standards. The facility remained an identified ACT disaster response venue.

The FMC continued to offer reception and examination facilities to the NSW Coroner's Court on a fee-for-service basis for deaths occurring in neighbouring parts of NSW. Additionally, the Australian Defence Force continued to utilise the facility for operational training for its service investigators, as did the Australian Federal Police for disaster victim identification training.

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. We are looking to engage further in 2015/16 with local religious, cultural and ethnic groups to better improve the services we provide to families and communities of the deceased in our care.

In last year's report I noted the establishment of solar power as an energy source at the FMC. Solar panels were installed in April and December 2014. Even with only half of the panels being available for six months, I am pleased to be able to report a 20% decrease in power consumption as between 2013/14 and 2014/15. We expect the saving on power consumption to be even greater in the next reporting period.

Pathologist Services

Dr Sanjiv Jain continued in 2014/15 to provide regular pathology services on a privately contracted basis. Coroners of the Court appreciate Dr Jain's longstanding and flexible support of the coronial system in this Territory. Specialist services in paediatric and complex cases, and leave coverage, were provided by locum pathologists and independent pathologists from other jurisdictions. We continue to be grateful for the assistance provided by the Victorian Institute of Forensic Medicine and the NSW Forensic and Analytical Science Service (FASS).

In my last report I noted that we continued to explore longer term arrangements for service provision with NSW FASS, including either a partnership or an ongoing professional support arrangement between the ACT and NSW. Discussions throughout 2014/15 clarified that a partnership model was likely to best meet the needs of all participants and in June 2015 the Director-General of JACS (as the funding body for the FMC) approved the opening of formal negotiations with NSW FASS on a model for the provision of future services. A working

party has been formed with NSW FASS officers and LCT staff, under my guidance and the guidance of the FASS Executive Director. I am hopeful of new arrangements being in place by mid 2016.

Toxicology Services

I noted in last year's report that poor delivery of toxicology services would be a focus for 2014/15. The ACT Government Analytical Laboratory (ACTGAL) had been taking up to three months for testing and reporting of samples, which had a flow on effect to the completion of post-mortem reports and thus finalisation of cases. Consideration was being given to purchasing all toxicology services from NSW FASS. ACT Health for ACTGAL had indicated that it could improve turnaround times and was targeting a maximum 30 day turnaround time.

I am pleased to report an improvement in the turnaround times from ACTGAL in this reporting period. In the 2014/15 financial year ACTGAL averaged 26.5 days to undertake sample testing and provide a written report; by comparison, NSW FASS averaged 12 days, however additional time is required to transport samples to the NSW facilities and can add between one to four days. Further improvement in ACTGAL turnaround times is also apparent in the 2015/16 year to date.

We will continue to monitor the sufficiency of this improved service and work with ACTGAL to drive further improvements. Discussions have commenced with ACTGAL about the possibility of undertaking rapid (one to three day) toxicology for certain specified substances, which might further obviate the need for intrusive post-mortem examinations. ACTGAL will also be consulted in respect of any arrangements with NSW FASS for pathologist and related service provision in the ACT.

WORKLOAD STATISTICS

Cases Lodged

In my last report I noted that legislative changes made in April 2014 changing the requirement for referral of deaths consistent with interstate practice had had the effect of reducing the number of deaths referred to the Coroner's Court in 2013/14. A further reduction is observed in 2014/15 but not as much as I had anticipated: see Table 1.

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

Although the intent of the April 2014 changes was to increase the scope for medical practitioners to write medical certificates in cases where they had not seen the deceased for more than three months but less than six months, and for deaths that were reportable only because they occurred within 72 hours of certain medical procedures (now changed to 24 hours), there appears a continued reluctance on the part of doctors to write certificates for these cases. This reluctance appears widespread in the ACT profession generally; we have a high proportion of cases referred to the Coroner's Court which are found to be natural cause deaths. Additional efforts will be made in 2014/15 to re-engage with the medical profession and provide education and guidance as to the matters which are properly referred to the Coroner.

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 2.

Table 2: Cases Finalised			
Type	**2014/15**	2013/14	2012/13
With a Hearing	***9***	*14*	*16*
Deaths	**9**	12	12
Fires	**0**	2	4
Disasters	**0**	0	0

By Chambers decision	***1007***	*1171*	*1375*
Deaths	**305**	317	376
Fires	**702**	854	999
Disasters	**0**	0	0
Total Cases	***1016***	*1185*	*1391*

Matters resolved without hearing constitute 97% of all inquests into deaths and 100% of inquiries into fires finalised in the 2014/15 year.

More matters were finalised in 2014/15 than were lodged, which indicates that the Coroner's Court has maintained its significant progress in reducing the length of time that families whose loved ones are subject to coronial inquests are required to wait before closure of a matter: see Table 3.

Table 3: Pending Cases			
Time Pending	**2014-15**	2013-14	2012-13
< 12 months	**84**	97	149
>12 months < 24 months	**20**	26	45
>24 months	**33**	27	40

Further efforts will be made in the forthcoming year to address the historic pending matters older than two years. I note that some of these cases involve criminal prosecutions and that the inquest cannot be finalised before conclusion of those proceedings.

Autopsy Process and Practice

The total number of admissions to the FMC in 2014/15 was 393 cases, made up of 344 ACT cases and 49 NSW cases. Medical certificates were ultimately issued in 59 ACT cases and three NSW cases. Autopsies were conducted in 215 ACT cases and 38 NSW cases, with the remaining cases either being subject to an external examination or no examination if the manner and cause of death could be established from medical records.

The median period of stay at the FMC in 2014/15 for all cases was 5 days. In cases where a post-mortem examination was undertaken, the average time between arrival and examination was 2.4 days, and from examination to discharge was 4.1 days. In interpreting these figures it should be noted that the deceased may remain at the FMC for some time if family cannot be located or for public trustee procedures to be finalised. This year there were a small number of deceased persons held for those reasons in excess of 30 days. The FMC complies with its statutory obligations to notify the Registrar of Births, Deaths and Marriages when a person remains in the care of the FMC for more than 30 days.

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 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 continued improvement on last year's figures: see Table 4.

Table 4: Post-Mortem Examinations[1]

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%)**

An option to be explored in the 2015/16 year to further drive improvement in this trend is the use of rapid toxicology in appropriate cases – such as cases of suspected overdose or deaths by fire – where obtaining information about substances found in blood may suffice to determine manner and cause of death without the need for an invasive autopsy. Discussions have commenced with ACTGAL to explore whether these services might be supplied locally.

Forecast

I expect that the number of deaths reported to the Coroner's Court will continue to decrease over 2015/16 as the effects of recent legislative changes take effect and particularly as health care professionals are better educated about the changes and the types of deaths which are properly referred to a Coroner.

I also expect the coronial fire jurisdiction will dramatically reduce now that every fire which destroys property is not automatically reportable to the Coroner's Court (see discussion later in my report about changes to our operating environment). This change reduces pressures on the Coroner's Court and brings the ACT into line with other jurisdictions, most

[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.

of which do not have a requirement to investigate all fires. It will enable focussing of effort and resources upon investigating fires that raise broader public interest and safety issues or where the cause and origin of the fire requires determination. The ability to refer fires to the Coroner remains – owners of destroyed property may request an inquiry, the Attorney-General may direct an inquiry be held and fires involving deaths will still be investigated.

COMMUNITY AND PARTICIPANT ENGAGEMENT AND EDUCATION

Coroners Investigators

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

In the ACT, investigations are conducted generally by members of the ACT Policing arm of the Australian Federal Police, including specialist areas if required. There is some blurring of the boundaries with the criminal investigation function which can be problematic, although thankfully more commonly in theory than in practice. The AFP also provides a dedicated unit – the ACT Coronial Liaison Unit – whose members who provide initial reports of deaths to the Coroner and subsequently perform coordination, liaison and investigative tasks as required. The AFP provides an excellent service to the jurisdiction.

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

Worksafe ACT and Comcare have also readily supported the coronial investigative function in relevant matters.

Support Services in the Community

All Coroners are acutely aware that grieving families can find the coronial process difficult. In 2014/15, the ACT Government funded two community support services to assist people engaged with the coronial jurisdiction:

- SupportLink was funded in 2014/15 by JACS to provide the ACT Trauma Support Service to provides support and assistance to ACT families affected by sudden and unexpected deaths, including suicide and motor vehicle fatalities (which are reportable deaths under the *Coroners Act 1997*), through direct support and referrals to other services. The service provides an immediate crisis response and ongoing practical and emotional support, information, advocacy, non therapeutic counselling and general care management to the client. Referrals to additional support systems are made via the SupportLink Integrated Services Framework for prompt response by partner agencies.
- Relationships Australia Canberra Region was funded in 2015 by ACT Health to establish the ACT Coronial Counselling Service to provide intensive therapeutic counselling, psycho-education and referral services to ACT residents who are affected by a traumatic death and are going through the coronial process. Key objectives of the program are to reduce the emotional impact of going through coronial processes for members of the ACT community and to reduce the impact of

vicarious trauma on family members, friends and the community at large. The ACT Coronial Counselling Service provides ongoing counselling services to clients who are engaged with the Service during the coronial process and for up to three months after the coronial process has been concluded, at no cost to the client. The program began seeing clients towards the end of the 2014/15 year and the effectiveness of the program will be assessed after it has been operational for some time.

These are very welcome initiatives.

SupportLink ACT and Relationships Australia Canberra Region, and their respective staffs, have engaged very constructively with the Coroner's Court. Informal feedback received by Court staff indicates the support these agencies provide is welcome and greatly appreciated by the recipients.

Direct Engagement

During the 2014/15 year, I undertook the following engagements:

- Met with NSW FASS in relation to longer term arrangements for pathologist service provision;
- Met with ACT Chief Health Officer in relation to Ebola preparedness;
- Met with Executive Director, HealthCARE Improvement Division, the Canberra Hospital and Health Service in relation to health care-related deaths;
- Met with ACT Fire and Rescue to discuss implementation of changes to the fire jurisdiction;
- Met with ACT Policing regarding investigative processes;
- Met with the DVI Commander and DVI training course;
- Met with interstate counterparts;
- Attended the Asia-Pacific 2014 Coroners Conference in Melbourne;
- Spoken to the University of the Third Age;
- Met with a number of relatives of deceased people;
- Engaged with an Australian Broadcasting Commission investigation into ACT suicide rate;
- Provided training to SupportLink and Relationships Australia staff on the coronial jurisdiction;
- Met with Victim of Crimes Commissioner in relation to the Domestic Violence Death Review Committee; and

- Met with the then Director General of the Health Directorate, Dr Peggy Brown, to discuss post-mortem procedure.

During the 2014/15 year, the FMC hosted the following groups:

- ACT Ambulance Service;
- ANU medical student groups;
- Australian Defence Force Investigative Service (ADFIS);
- Australian Federal Police cadets;
- Australian Federal Police Criminal Investigations teams;
- Canberra Hospital Social Work teams;
- Canberra Institute of Technology Forensic student groups;
- Canberra Institute of Technology nursing students;
- Disaster Victim Identification core training and refresher courses;
- Relationships Australia Canberra Region; and
- SupportLink (ACT).

During the 2014/15 year, the Coroners Unit Manager met with:

- ACT Policing;
- ACT Clinical Forensic Medical Services;
- ACT Health and the ACT Chief Health Officer;
- Counsel Assisting appointed in existing cases;
- NSW FASS;
- JACS;
- Relationships Australia Canberra Region; and
- Supportlink (ACT).

ENVIRONMENT CHANGES

Amendments to *Coroners Act 1997*

As noted in last year's report, significant amendments were made to the *Coroners Act 1997* in the 2013/14 year. The most significant amendments were effected by the *Courts Legislation Amendment Act 2014*, operative 2 April 2014, which:

- changed the requirement for an inquest into the manner and cause of death of a person who dies without having seen a doctor to extend the period of time for which the person has not seen a doctor from 3 months to 6 months;
- changed the requirement for an inquest to be held into the death of a person that occurs after medical intervention from a death occurring within 72 hours to a death occurring within 24 hours; and
- clarified the definition of post mortem examinations.

I have discussed the impact of these legislative changes earlier in my report with respect to workload and I expect the impact of these changes will continue going forward.

Amendments were made in the 2014/15 year to the *Coroners Act 1997* by the following legislation:

- The *Courts Legislation Amendment Act 2015*, which came into effect on 21 April 2015, and made amendments to:
    - simplify the reporting and inquiry requirements for fires, by introducing an own-motion coronial power to investigate fires and removing the requirement for the Coroner to investigate all fires;
    - introduce clear investigation powers for police at coronial scenes – coronial scene investigation orders and declarations; and
    - clarify certain definitions and practices relating to post mortems and coronial matters;
- The *Justice and Community Safety Legislation Amendment Act 2015*, which came into effect on 21 May 2015, and made amendments to expressly provide for a privilege against self-incrimination for witnesses to a coronial inquest or inquiry, modelled on the privilege under section 128 of the *Evidence Act 2011*, to bring the ACT in line with other jurisdictions.

Given the short period of operation of the amendments it is not possible to report on the outcomes and consequence of these changes to the Act. I note that that two coronial scene investigation orders were granted in the 2014/15 year.

I understand that further legislative amendment to better focus the reportability criteria for health care-related deaths will shortly be tabled. A targeted approach on this issue would result in a more effective use of the limited resources of the coronial jurisdiction and less unnecessary entanglement of families in matters where there is no identifiable concern warranting coronial investigation. In that vein, the legislature may wish to revisit the current situation in which a hearing is mandated following a death involving anaesthesia (s34A of the Act). There seems little current rationale for singling out this aspect of medical practice as requiring such particular scrutiny.

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 2014/15 year, there were 4 inquests into deaths in custody finalised by a Coroner:

Mark Rodney Jolliffe (CD 44 of 2010)

Cheryl Gail Mapham (CD 52 of 2013)

Jocelyn Heather Jones (CD 274 of 2013)

Maxwell Kevin Blundell (CD 122 of 2014)

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 may ultimately apply under section 90 to the Supreme Court for an order directing a hearing be held.

In the 2014/15 year, there were 1016 notices given by Coroners under subsection 34A(3), in respect of 305 deaths and 702 fires. (There were no inquires into disasters on foot or finalised in the 2014/15 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 was one application made to the Chief Coroner under section 64 in the 2014/15 year, in the inquest into the death of Paul Fennessy (CD 11 of 2010). In that matter the Chief Coroner overturned an earlier decision to dispense with a hearing and arranged for a hearing to occur; those proceedings continued into the 2015/16 year.

There were no applications to the Supreme Court made under section 90 in the 2014/15 year.

Paragraph 102(2)(c) matters – public safety 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 2014/15 year, there were reports made under subsection 57(3) to the Attorney-General in two cases: the inquest into the death of Rachel Sarah Prime (CD 34 of 2014), and the inquest into the death of Mark Rodney Jolliffe (CD 44 of 2010). Summaries of these cases, and the findings and recommendations made, can be found later in the report in the selected case notes section.

No subsection 57(3) reports were presented to the Legislative Assembly in the 2014/15 year. The subsection 57(3) report in relation to the death of Rachel Sarah Prime was tabled in the Legislative Assembly on 13 August 2015, and the report in relation to the death of Mark Rodney Jolliffe was tabled on 19 November 2015.

[I note that section 76 responses to findings about the quality of treatment, care or supervision in deaths in custody are reported separately below. However I note only the death of Mark Rodney Jolliffe constituted a death in custody, and a section 76 response was received after the reporting period.]

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 four inquests into deaths in custody finalised by a Coroner in the 2014/15 year, no findings were made in any case that the quality of care, treatment and supervision of the deceased contributed to the person's death. No section 76 response was received in either of the cases of Cheryl Gail Mapham (CD 52 of 2013) or Jocelyn Heather Jones (CD 274 of 13). A letter was received from the Minister for Justice in relation to the inquest into the death of Maxwell Kevin Blundell, dated 23 July 2015, noting that no findings or recommendations were made in respect of care, treatment or supervision; a similar letter was received from the Minister for Health in relation to the inquest into the death of Mark Rodney Jolliffe (CD 44 of 2010), dated 17 November 2015.

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 the name of the deceased person is withheld.

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

Court Reference:	CD 273/11
Age:	63 yrs
Gender:	Male
Date of Death:	4 November 2011
Place of Death:	The Canberra Hospital, Garran, ACT
Coroner:	L.A. Walker
Date of Findings:	23 January 2015

Coroner's Findings:

The deceased was Hubert Henry Jansen, born 7 November 1947, late of 71 Chantry Street, Goulburn, New South Wales.

Mr Jansen died at 10.45 p.m. on 4 November 2011 at The Canberra Hospital at Garran in the Australian Capital Territory. He died as a result of cardiac arrest caused by pulmonary artery thromboembolism related to left kidney renal cell carcinoma on a background of ischaemic heart disease.

No matter of public safety was is found to arise in connection with this inquest.

Coroner's Comments:

In retrospect, having regard to Mr Jansen's condition which was most fully disclosed at autopsy, it is unsurprising that his body was unable to cope with the demands of surgery. The situation was an impossible one. Even if the full extent of his underlying conditions had been appreciated, without surgery, Mr Jansen's prognosis was very poor.

Having regard to the totality of the evidence available in relation to Mr Jansen's treatment and care I am satisfied that there is no basis to make any adverse findings in respect to any individual.

I have considered, particularly having regard to the observations of counsel assisting, whether any recommendations could improve the issue of patient transfer between hospitals. However, I am cognisant of the fact that over-regulation of this process has the potential to remove the role of medical advocacy as the prime basis for bed allocation. Ultimately, it is for the treating team, informed by the best available medical evidence and advice and no doubt the views of patient and family to determine the urgency of any particular case and advocate for a bed accordingly. I am satisfied that there is no systemic issue which requires comment.

Court Reference: CD 35/14
Age: 36 yrs
Gender: Female
Date of Death: 13 February 2014
Place of Death: Calvary Hospital, Bruce, ACT
Coroner: P.J. Morrison
Date of Findings: 20 February 2015 (in Chambers)
Reported under 102(c)

Coroner's Findings and Recommendations:

1. *That Rachel Sarah Prime died on 13 February 2014 at Calvary Hospital, Haydon Drive, Bruce in the Australian Capital Territory;*
2. *That the cause of death was diabetic ketoacidosis due to insulin dependent diabetes mellitus;*
3. *That, pursuant to s52(4)(a)(i) of the* Coroners Act 1997 *a matter of public safety is found to arise in connection with this inquest.*
4. *Comments on matter of public safety pursuant to s52(4)(a)(ii) of the* Coroners Act 1997:
    a. *On 13 February 2014 ACT Ambulance Service was contacted for assistance for the deceased and the deceased was subsequently transported to Calvary Hospital by ACT Ambulance Service.*
    b. *The time taken for an ambulance to arrive to collect the deceased from her home was materially influenced by the priority assigned by the ACT Ambulance Service communication clinician.*
    c. *That ACT Ambulance Service communication clinician wrongly assigned a lower level of priority to the case than the circumstances warranted.*
    d. *The assignment of that lower level of priority resulted in a delay of at least 30 minutes in the ambulance reaching the scene and consequently a similar delay in the deceased arriving at hospital.*
    e. *The deceased is likely to have had better prospects of survival were it not for the*

delay in arriving at hospital.

f. The circumstances leading to the assignment of priority to the case and subsequent delay in arriving at the hospital have been the subject of review and report by ACT Ambulance Service and that report has been relied upon by me in making these findings.

5. Recommendations on matter of public safety pursuant to s57(3)(c):

That the recommendations in the Level B Case Review dated 18 September 2014 conducted by ACT Ambulance Service be implemented.

Tabling

The subsection 57(3) report in relation to the death of Rachel Sarah Prime was tabled in the Legislative Assembly on 13 August 2015.

Court Reference:	CD 274/13
Age:	76 yrs
Gender:	Female
Date of Death:	2 November 2013
Place of Death:	Adria Retirement Village, Stirling , ACT
Coroner:	R.M. Cook
Date of Findings:	1 April 2015

Reported under s102(a), (d) – death in custody

Coroner's Findings:

1. *That the deceased was Jocelyn Heather Jones, born 18 July 1937.*
2. *Ms Jones died at about 11.50 p.m. on Saturday, 2 November 2013 at the Adria Village a retirement and nursing home located at 89 Fremantle Drive, Stirling in the ACT.*
3. *Ms Jones died as a result of severe congestive Cardiac failure and rheumatic mitral valve disease.*
4. *No matters of public safety arose in connection with this inquest.*
5. *I make no findings to the effect that the quality of care, treatment and supervision of the deceased contributed to her death.*

Section 76 Response

Nil received.

Court Reference: CD 60/14
Age: 86 yrs
Gender: Male
Date of Death: 14 March 2014
Place of Death: The Canberra Hospital, Garran, ACT
Coroner: R.M. Cook
Date of Findings: 12 June 2015

Death under anaesthetic – mandatory hearing

Coroner's Findings:

1. *The deceased was Ray Pulver, born 27 September 1927.*
2. *Mr Pulver died at about 11.53 a.m. on Friday, 14 March 2014 at The Canberra Hospital following admission to the Emergency Department on 12 March 2014.*
3. *Mr Pulver died as a result of blood loss due to a bleeding perforated Duodenal Ulcer. Other significant conditions contributing to death but not related to Mr Pulver's condition, was a recent coronary artery bypass graft surgery and aortic valve replacement. Death was due to natural causes.*
4. *No matters of public safety arose in connection with this inquest.*
5. *I make no findings to the effect that the quality of care, treatment and supervision of the deceased contributed to his death.*

Court Reference: CD 311/13
Age: 46 yrs
Gender: Male
Date of Death: 18 December 2013
Place of Death: Rivett, ACT
Coroner: L.A. Walker
Date of Findings: 15 June 2015

Coroner's Findings:

(a) The deceased was Peter Zovak.
(b) He died on 18 December 2013 at Streeton Drive, Rivett in the Australian Capital Territory.
(c) The manner and cause of death was asphyxia by hanging – suicide.

58. Peter Zovak did not receive an adequate level of mental health care.

59. Whilst the multidisciplinary team decision to close Peter's case on 10 December 2013 may have been a little premature, it was not unreasonable on the evidence 11 then available.

There had been some post-discharge follow-up through which Peter appeared unaffected by those symptoms which had lead to him attending hospital in the first place. He indicated that he did not want follow-up but that he knew how to seek it if he did and he had family support as evidenced by Nedan taking him to hospital in the first instance.

60. However, the service's failure to respond to Peter's need for assistance on 12 December 2013 was not reasonable. Although the provisional diagnosis for Peter on discharge from hospital was drug induced psychosis/delirium, it was further recorded as possible first episode psychosis with no organic features found to explain it. In the context of a first engagement with mental health that must have been far from definitive.

61. The information provided to Mr Gunasekera-Ranga on 12 December 2013 was strongly indicative of significant ongoing mental health symptoms. It was, or should have been, known to him that Peter did not have a relationship with a general practitioner at all, never mind one with a modicum of expertise in mental health. Mr Gunasekera-Ranga made a serious error of judgment when he declined the call for help directly from Peter's brother and indirectly from Peter himself.

62. However, as the submissions of all parties to these proceedings recognise, it is speculative to infer that this failure contributed to Peter's death. It no doubt represents a lost opportunity to influence the outcome of Peter's illness but it is entirely speculative what, if any, difference a more proactive response by Mr Gunasekera-Ranga following Nedan's call on 12 December 2013 would have produced.

63. Consequently, I make no finding of contribution to Peter's death from the failures of ACT Mental Health.

64. I am, however, able to make comment based on issues of public safety arising in connection with the inquest. They are more limited than the recommendations sought by Peter's family in light of the considerations as to the scope an inquest detailed above.

Coroner's Comments:

65. That ACT Health should implement and continue to monitor those measures detailed in the "Clinical Recommendations Action Plan – Review Mental Health Triage May 2014".

66. It would be useful for ACT Mental Health to review the Crisis and Assessment Treatment Team role having regard to the emphasis placed on immediate risk of harm as opposed to the broader requirement for an community outreach mental health system and consider whether the Team as it is presently structured is best equipped to meet community need.

67. ACT Mental Health should consider making it a mandatory requirement in dealings with patients that they be positively requested to indicate whether they consent to the service communicating with one or more nominated family members or carers in respect to the

patient's mental health with a concomitant requirement to record that consent in the service's electronic data system.

[Chief Coroner Walker's full reasons for findings are published on the Court's website.]

Court Reference: CD 52/13
Age: 59 yrs
Gender: Female
Date of Death: 15 February 2013
Place of Death: Florey, ACT
Coroner: K.M. Fryar
Date of Findings: 17 June 2015
Reported under s102(a), (d) – death in custody

Coroner's Findings:

Cheryl Gail Mapham died at 23 Eddy Crescent, Florey in the Australian Capital Territory on 15th February 2013. The manner and cause of death was breast cancer with liver metastases, which Mrs Mapham had suffered from for a period of years.

No matter of public safety arises in relation to Mrs Mapham's death.

There are no matters in relation to the quality of care, treatment or supervision of Mrs Mapham that contributed to the cause of her death.

I make no recommendations or other comments.

Section 76 Response

Nil received.

Court Reference: CD 124/14
Age: 54 yrs
Gender: Male
Date of Death: 10 June 2014
Place of Death: The Canberra Hospital, Garran, ACT
Coroner: P.G. Dingwall
Date of Findings: 26 June 2015
Reported under s102(a), (d) – death in custody

Coroner's Findings:

Maxwell Kevin Blundell died at The Canberra Hospital, Yamba Drive, Garran in the Australian Capital Territory on 10th June 2014. The manner and cause of death was:

1. DIRECT CAUSE
(a) Ischaemic heart disease due to
2. ANTECEDENT CAUSES
(b) Coronary atherosclerosis

No matter of public safety arises in relation to Mr Blundell's death.

There are no matters in relation to the quality of care, treatment or supervision of Mr Blundell that contributed to the cause of his death.

I make no recommendations or other comments.

Section 76 Response

A letter was received from the Minister for Justice in the inquest into the death of Maxwell Kevin Blundell, dated 23 July 2015, noting that no findings or recommendations were made in respect of care, treatment or supervision.

Court Reference: CD 44/10
Age: 37 yrs
Gender: Male
Date of Death: 15 February 2010
Place of Death: City Hill, Canberra City, ACT
Coroner: P.G. Dingwall
Date of Findings: 30 June 2015
Reported under s102(a), (c), (d) – death in custody

Coroner's Findings and Recommendations:

1. As required by s 52 of the Act I find that :

- *the deceased was Mark Rodney Jolliffe, born on 31 October 1972;*
- *the deceased died at some time between 6.25pm on 14 February, 2010 and 7.15am on 15 February, 2010 on City Hill, Canberra City in the Australian Capital Territory; and*
- *the deceased died as a result of hanging, which was self-inflicted with the intention of taking his own life.*

Findings about Quality of Care, Treatment and Supervision

2. *Notwithstanding the number of important issues raised by the deceased's family, there is no evidentiary basis for the making of a finding, under s 74 of the Act, that the quality of care, treatment and supervision provided to the deceased by the ACT contributed to the cause of his death.*

Recommendations

3. *Pursuant to s 57 of the Act, in the interests of public health and safety, I recommend to the Attorney-General that:*

   - *If Mental Health ACT team meetings are not held before every decision is made to apply for a psychiatric treatment order, or the continuation of such an order, they be held before every such decision is made and that all such team meetings be clearly recorded in the patient notes.*
   - *Consideration be given by the Executive and the Legislative Assembly to the making of all necessary statutory amendments so as to mandate, in the case of a person in respect of whom a mental health order has been made under the* Mental Health (Treatment and Care) Act 1994*, the disclosure of that person's mental health records to a person appointed as the person's attorney under the* Powers of Attorney Act 2006*, or corresponding Act of a State or other Territory, or, if there is no such attorney, to the closest living relative or relatives of the person who demonstrate a legitimate interest in his or her welfare and a wish to be involved in his or her treatment, care and supervision.*
   - *Where the ACT Civil and Administrative Tribunal is conducting proceedings in relation to an application for the making of a mental health order in respect of a person, it be required to notify any known person appointed as the person's attorney under powers of attorney legislation and all known close relatives of the person who are, or are likely to be, concerned and interested in the person's treatment, care and supervision.*
   - *The relevant bodies in the Australian Capital Territory monitor the progress of the study into suicides occurring in Victoria between 2009 and 2010 being conducted by the Coroner's Court of Victoria and the University of Melbourne and that its report be closely considered to determine whether any recommendations made in it should be implemented in the Australian Capital Territory, and whether a similar study should be conducted in the Australia Capital Territory and the direction that it should take.*

<u>Tabling</u>

The subsection 57(3) report in relation to the death of Mark Rodney Jolliffe was tabled in the Legislative Assembly on 19 November 2015.

Section 76 Response

A letter was received from the Minister for Health in the inquest into the death of Mark Rodney Jolliffe, dated 17 November 2015, noting that no findings or recommendations were made in respect of care, treatment or supervision.

[Coroner Dingwall's full reasons for findings are published on the Court's website.]
