CANBERRA

Office of the Chief Magistrate
Law Courts of the Australian
Capital Territory
Canberra City, A.C.T.
G.P.O. Box 370

Mr S Corbell MLA
Attorney General
ACT Legislative Assembly
GPO Box 1020
Canberra ACT 2601

Dear Attorney General

Attached is the Annual Report of the Chief Coroner of the Australian Capital Territory. This report is furnished pursuant to section 102 of the *Coroners Act 1997* and is for the financial year 1 July 2009 to 30 June 2010.

Yours sincerely

J D Burns
Chief Magistrate and Chief Coroner
24 December 2010

CHIEF CORONER

OF THE

AUSTRALIAN CAPITAL TERRITORY

ANNUAL REPORT

2009 – 2010

CHIEF CORONER

OF THE

AUSTRALIAN CAPITAL TERRITORY

ANNUAL REPORT

2009 - 2010

INTRODUCTION

Section 102 of the Coroners Act 1997 ("the Act") provides :

> *"(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 those reports; and*
>
> *(b) notices given under section 14 (3); and*
>
> *(c) recommendations made under section 57 (3); and*
>
> *(d) responses of agencies under section 76, 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. ..."*

This report is furnished under the Act and is for the financial year 1 July 2009 to 30 June 2010.

Section 13 of the Act sets out the circumstances under which a coroner shall hold an inquest. Section 14 enables a coroner to dispense with a formal hearing if the coroner is of the opinion that the cause of death is sufficiently disclosed in the material supplied by the investigating officers and that a hearing is unnecessary.

Under such circumstances, a coroner is obliged to furnish written notice to the Chief Coroner stating reasons for doing so (section 14(3)).

Section 57 of the Act permits a coroner to make recommendations to the Attorney-General on any matter relating to public health or safety or the administration of justice following an inquest.

Section 76 requires custodial agencies to respond in writing to a coroner's findings with respect to a death in custody.

This report includes statistics concerning these sections

Deaths in Custody

In the reporting year, there were six reports of deaths in custody delivered by the court. Particulars of those deaths follow :

Andrej Nagy

Court Reference:	CD 25/04
Age:	32 year old
Gender:	Male
Date of Death:	18 January 2004
Place of Death:	Psychiatric Services Unit, The Canberra Hospital, Garran
Coroner:	R.J. Cahill/P.G. Dingwall
Date of Report:	12 May 2010

Findings:

"The deceased was Andrej NAGY.

1) *The deceased died on 18 January 2004 in the Seclusion Suite of the Psychiatric Services Unit at The Canberra Hospital, Garran in the Australian Capital Territory.*

2) *The deceased died as a result of hypoxia caused by positional asphyxia and obesity and contributed to by the presence of a therapeutic level of the drug Zuclopenthixol.*

3) *At the time of his death the deceased was subject to an authorisation of involuntary detention and care at an approved*

mental health facility made pursuant to section 41, Mental Health (Treatment and Care) Act 1994 and, accordingly, his death was a death in custody as defined by section 3C, Coroners Act 1997.

4) *In my opinion, the quality of care, treatment and supervision of the deceased did not contribute to the cause of his death."*

Lolesio Smith

Court Reference: CD 56/06

Age: 44 year old

Gender: Male

Date of Death: 27 February 2006

Place of Death: The Canberra Hospital, Garran following incident in Turner ACT

Coroner: R.J. Cahill/J.D. Burns

Date of Report: 7 May 2010

Findings:

"The deceased was Lolesio Smith. He died at the Canberra Hospital on 27 February 2006. The cause of death was self-inflicted gunshot injury to the head.

1. *This is a coronial hearing commenced by the former Chief Coroner. The evidence establishes that the deceased died on 27 February 2006. The evidence is very clear as to the identity of the deceased, and the manner and cause of his death.*

2. *The former Chief Coroner determined to conduct a hearing into the death. This hearing took place on 15 March 2007. Apparently, no person sought leave to appear on the hearing except Ms Margaret Hunter of the office of the Director of Public Prosecutions who appeared as counsel assisting the coroner. The former Chief Coroner heard evidence from the investigating officer, Detective Constable Swain, through whom the brief of evidence was tendered. The former Chief Coroner then reserved his decision in the matter, but did not publish his findings or any reasons before he retired in November 2009. On behalf of the court I express my regrets to the family of the deceased for the delay in concluding this matter.*

3. *The evidence clearly establishes that the deceased was Lolesio Smith. He died on 27 February 2006 at the Canberra Hospital. The cause of death was a self-inflicted gunshot injury to the head.*

4. *The evidence establishes that the deceased was a resident of 10 Hale Crescent Turner in the ACT. Police were called to that residence on the morning of 26 February 2006 because of a domestic dispute at those premises. When police arrived they spoke to the wife of the deceased who complained that the deceased had assaulted her, and requested assistance in removing the deceased from the house. Police spoke to both the deceased and his wife to attempt to ascertain what had happened. As the process continued, the deceased walked out of the premises and produced an improvised firearm, described as a 'pen gun'. Police attempted to convince the deceased to drop the weapon, but he placed the weapon against his head and discharged it.*

5. *The deceased was conveyed to the Canberra Hospital but died the next day.*

6. *There are no issues surrounding the death, or the conduct of the police, which require comment or examination."*

Richard Henry Schaeffer

Court Reference: CD 88/08

Age: 35 year old

Gender: Male

Date of Death: 22 April 2008

Place of Death: Private residence Bruce ACT

Coroner: M.K. Doogan

Date of Report: 18 Aug 2009

Findings:

"RICHARD HENRY SCHAEFFER born 10th July 1972 died between 6.00 a.m. and 9.00 a.m. on Monday 21st April 2008 in Canberra.

The cause of death was asphyxia due to hanging which was an act of suicide.

Minister for Health's Response (Undated):

> *"I note that you did not make any recommendations in this matter, and did not form the opinion that the quality of care, treatment and supervision of Mr Schaeffer, by ACT Health staff, contributed to his death.*
>
> *Your formal findings in respect to the death of Mr Schaeffer have been forwarded to the Director of Mental Health ACT for notification."*

Pierre Eiben

Court Reference: CD 199/08

Age: 24 year old

Gender: Male

Date of Death: 5 August 2008

Place of Death: The Canberra Hospital

Coroner: K.M. Cush

Date of Report: 17 June 2010

> *Findings:*
>
> *"I formally find that Pierre Eiben, who was then aged 24 years, died at The Canberra Hospital at 10:25am on 5 August 2008 as a consequence of a self inflicted gun shot wound to the head which occurred on 4 August 2008 while the deceased was seated alone in a motor vehicle in the suburb of Monash in the Australian Capital Territory. ...*
>
> *In regard to the evidence placed before me I could not conclude that there were any acts or omissions by the Australian Federal Police, The Canberra Hospital, Mental Health or the CATT which caused or contributed to the death of Pierre Eiben or which were in any relevant way connected to his death."*

Minister for Health's Response 28 June 2010:

> *"I note that you did not make any recommendations in this matter, formed the opinion that there were no acts or omissions by the Canberra Hospital, or Mental Health ACT which caused or contributed to the death of Mr Eiben or which were in any relevant way connected to his death.*

Your formal findings in respect to the death of Mr Eiben have been forwarded to the Director, Mental Health ACT for notification."

Andreas Bulig

Court Reference: CD 220/09

Age: 44 year old

Gender: Male

Date of Death: 12 August 2009

Place of Death: Alexander Maconochie Centre, Hume

Coroner: L.E. Campbell

Date of Report: 10 May 2010

Findings:

"Andreas Bulig (known to his family as Andrew) died at the Alexander Maconochie Centre, Hume between 2:00 am and 5:14 am on 12 August 2009 of acute non traumatic aortic dissection with haemopericardium.

Comments

It would be a matter of grave concern if Custodial Officers were not undertaking observations of inmates as they are required to do by their employer. Certainly this is something which the public would require to Government to take seriously.

However the absence of any suggestion that an omission by a Corrections Officer to undertake observations as required caused or contributed to the death of Mr Bulig means that I am not empowered to conduct an investigation into the work practices at Alexander Maconochie Centre. In any event it appears that an internal review undertaken by that organisation into the matters has been thorough and productive.

Further, it is clear that Mr Bulig's death had nothing to do with the claims originally made that he did not have access to medication to manage his

epilepsy. He was receiving treatment for this and his medication dosage was being monitored. He died from an unrelated condition.

I am satisfied that there was nothing in the quality of care, treatment or supervision of Mr Bulig while an inmate at the Alexander Maconochie Centre which contributed to his cause of death."

Attorney-General's Response 25 June 2010:

"As you are aware, a full internal investigation was conducted by ACT Corrective Services into this incident. From this investigation, a number of recommendations were made. These included the review of the Alexander Maconochie Centre Observations, Muster and Headchecks Policy and Procedure, *a review of the night shift post duties and training to ensure officers were aware of amendments made to these documents.*

The implementation of these recommendations will assist in ensuring the future safety of all prisoners."

Marie Gloria Host

Court Reference: CD 86/09

Age: 81 year old

Gender: Female

Date of Death: 28 March 2009

Place of Death: The Canberra Hospital, Garran

Coroner: J.D. Burns

Date of Report: 1 September 2009

Findings:

"MARIE GLORIA HOST died at approximately 8.16 p.m. on 28th March 2009 at The Canberra Hospital, Garran in the Australian Capital Territory. The cause of death was cardiac arrest due to congestive heart failure."

Recommendations to the Attorney-General

Section 57(3) of the *Coroners Act* allows a Coroner to make recommendations to the Attorney-General on any matter connected with an inquest including matters relating to public health or safety.

Khaled Kanj

Court Reference: CD 13/05

Coroner: R.J. Cahill

Date of Report: 29 October 2009

Findings

- *"Kaled Kanj, aged two years, died in the Emergency Department of the Calvary Hospital, Belconnen on 12 January 2005. The death occurred most probably between 13:50 and 14:00, and the life was pronounced extinct at 14:25 hours.*

- *The manner of his death was that he attended the swimming pool at Canberra International Sports & Aquatic Centre, Belconnen in the afternoon of 12 January 2005, along with his sisters and mother, Ms Jasmina Kanj. Not long after, Ms Kanj lost sight of Kaled as she also had responsibility of her 9-month-old baby. Soon thereafter, Kaled was observed floating face down in the water. The life guard retrieved Kaled and commenced cardiopulmonary resuscitation (CPR) which was then continued by two nurses who happened to be present at the pool at the time. Kaled was then taken to the Calvary Hospital Emergency Department where, even after efforts to resuscitate him, he succumbed to death.*

- *The cause of Kaled Kanj's death was drowning (immersion)."*

RECOMMENDATIONS

"I make the following recommendations arising from the Eccleston report, some of which may have already been covered by the recommendations implemented by the CISAC:

(a) All public pools in the ACT must have an audit by the Royal Life Saving Society of Australia and implement any recommendations in respect of that audit.

(b) Risk assessments should be done especially when there is large numbers in the CISAC swimming pool and the assessments should be recorded. Recommended minimum ratio of lifeguards to people in the water is 1:100, but a risk assessment should be completed to vary this ratio taking into consideration a range of factors such as weather, holidays, size, number and layout of pools, surface reflection, average attendance, anticipated attendance, swimming capabilities, special needs individuals and groups, the number and distribution of users, and recreational activities (programmed or spontaneous). All areas of the pool, including the pool floor must be scanned and scrutinised on a regular basis.

(c) Signage in relation to parental or adult supervisor responsibility must be well signposted in large lettering. It should be posted prominently in areas of danger to encourage adults to keep their children at arms length, and posted at reception on the "Conditions of entry" and then, on entry to the aquatics area on the "Aquatic Rules". It should state that "Children under 10 must be supervised by an adult at all times when in the aquatics area".

(d) Signage in relation to pool behaviour should also be prominent and should be in an area where it is able to be well visualised such as the entry turnstiles and also on the pool deck.

(e) Educational pamphlets should be available at the entry to the pool.

(f) Depth indicators should be displayed in the area where depth is changing with signage such as 'DEPTH INCREASES – 0.6 TO 1.2M PARENTS KEEP CHILDREN AT ARMS LENGTH'.

(g) Sufficient lifeguards should be provided to ensure that all the areas of water and people therein can be supervised easily without obstruction from any object. Blind spots and areas where there is sun glare must be considered when deploying lifeguards.

(h) Where the whirlpool entry is restricted by a lane rope, there should be a sign posted to indicate that the area is closed. Preferably, the sign can read as "No Access beyond this point. Whirlpool Closed to Public: No Swimming in this area"

(i) Consideration should be given to

(i) recording every incident which resulted in the intervention of a lifeguard;

(ii) setting a limit to the number of users of different areas of the pool and that limit be effectively monitored by staff;

(iii) having at least two lifeguards constantly moving in the area between the shallower and deeper area of the pool, giving particular attention to children who cannot swim;

(iv) highlighting changes in gradient of the pool floor with a contrasting colour, in particular area between the toddler/leisure pool and the area outside of it; and

(v) providing a minimum of four training sessions per year to lifeguards at quarterly intervals, directly related to the aquatic facility of which the lifeguard is employed, and the training should include, but not limited to,

- *revision and practice of emergency procedures*
- *practice of initiative assessment of and response to simulated incidents*
- *revision of lifesaving skills*
- *resuscitation*
- *oxygen equipment*
- *first aid*
- *retrieving a person from the deepest part of the pool*
- *special needs populations;*
- *public relations; and*
- *practical water work."*

Meg Malaika

Court Reference: CD 71/06

Coroner: R.J. Cahill/J.D. Burns

Date of report: 30 April 2010

Findings

"The deceased was Meg Malaika, aged 39 years. She died at midnight on 18 March 2006 in the Canberra Hospital at Garran in the Australian Capital Territory.

The cause of Ms Malaika's death was heart failure connected to a massive pulmonary embolus as a result of deep vein thrombosis."

RECOMMENDATIONS

"I recommend that the Canberra Hospital review its practices with regard to prescribed but not administered, or keeping records of drugs prescribed and administered to patients so as to minimise the possibility that drugs may be administered and not recorded and consider implementing a requirement that two responsible persons must sign the records of the hospital to confirm that prescribed medication has been administered."

Statistics

1 July 2009 – 30 June 2010

MATTERS LODGED:

Deaths:	345
Fires:	1219
MATTERS FINALISED:	1568
Matters finalised by hearing:	35
Matters dispensed with (i.e. dealt with in Chambers)	1533