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

Dear Attorney,

Report pursuant to s.102 *Coroners Act 1997*

Attached is my report to you pursuant to s.102 of the *Coroners Act 1997.* This report relates to the period 1 July 2010 to 30 June 2011. Of course, I was not Chief Coroner during this period. Consequently, I have provided on this occasion only the core information required. The cases reported on have been deidentified. I am happy to provide further detail if required.

I hope to be in a position to provide a more fulsome report to you in future years.

I certainly expect that there will be some developments. I will be reviewing the role of the new Forensic Medical Centre which opened in September and have been in discussions with a new forensic pathologist who may be available to assist with the work there. Serious consideration needs to be given to the number of post mortems taking place and the basis for making those decisions.

Pending legislative change may have some impact on our work.

Further, the Court must address the conclusion of the case management trial which took place under the leadership of former Chief Magistrate John Burns and Magistrate Peter Dingwall.

Mr Dingwall has chosen to step back from his special role in relation to the coronial function and I am presently reflecting on how best to meet the workload in this jurisdiction.

I note the pending inquest into the death of Mr Nathan Doherty following his shooting by an officer of the Australian Federal Police will commence late February 2012. I will be hearing the matter, assisted by Mr Shane Gill of counsel. I anticipate that this may take about four weeks hearing time.

There is also a significant issue regarding organ donation which needs close attention. I am currently consulting with Dr Imogen Mitchell in her capacity as DonateLife organiser.

As these are but a few of the issues arising in the coronial jurisdiction, you may expect to hear more in my next report.

Finally, I note that the report must be provided within six months of the end of the financial year. Unfortunately, this fact only came to my attention after the Court stand-down period commenced, thus the 'eleventh hour' filing of this particular report by email. I will forward an hard copy to you early in the new year.

Yours faithfully,

Lorraine Walker
Chief Coroner

Annual Report of the Chief Coroner to the Attorney-General pursuant to s.102 of the *Coroner Act 1997* 1 July 2010 to 30 June 2011

The following report addresses those matters which the Chief Coroner must report to the Attorney-General pursuant to s.102 of the *Coroners Act 1997.*

s.102(2)(a) Deaths in Custody

Case 1

Court Reference: CD 295/07
Age: 43 yr old
Gender: Male
Date of Death: 21/11/2007
Place of Death: Conder
Coroner: M.K. Doogan

Findings:

"(The deceased) died at about 8.30pm on 21 November 2007 at his residence in Conder in the Australian Capital Territory. The cause of death was choking on a bolus of food which was part of a sandwich eaten immediately prior to death."

Case 2

Court Reference: CD 87/09
Age: 79 yr old
Gender: Female
Date of Death: 31/01/2009
Place of Death: The Canberra Hospital
Coroner: J.D. Burns

Findings:

"I find that the deceased died at The Canberra Hospital, Garran in the Australian Capital Territory at 6.56 a.m. on 31 March 2009. The cause of death was pulmonary thromboembolism."

Case 3

Court Reference: CD 59/10
Age: 45 yr old
Gender: Male
Date of Death: 8-9/1/2010
Place of Death: Oaks Estate
Coroner: P.G. Dingwall

Findings:

"The deceased was (name) born 13 February 1964.

The deceased died between 3.30 p.m. on 8 January 2010 and 11.30 a.m. on 9 January 2010 at Unit 5, 20 George Street, Oaks Estate in the Australian Capital Territory.

The deceased's death was caused by liver failure consequent upon hepatitis C.

In my opinion no aspect of the care, treatment and supervision of the deceased provided to the deceased by A.C.T. Mental Health contributed to the cause of the deceased's death."

Case 4

Court Reference: CD 203/10
Age: 43 yr old
Gender: Male
Date of Death: 27/7/2010
Place of Death: Wanniassa
Coroner: M.K. Doogan

Findings:

"(The deceased) born 8 July 1967 died on 27 July 2010 sometime between 8.00am and 10.30 am at his home in Canberra in the Australian Capital Territory.

The cause of death was morphine toxicity as a result of an accidental overdose of the drug which was self-administered, and possibly asphyxia caused by inhaled vomitus."

Case 5

Court Reference: CD 232/10
Age: 72 yr old
Gender: Female
Date of Death: 21/8/2010
Place of Death: Jindalee Nursing Home
Coroner: P.G. Dingwall

Findings:

"The deceased was (name), born on 31 March 1938.

That the deceased died on 21 August 2010 at Jindalee Nursing Home, 227 Goyder Street, Narrabundah in the Australian Capital Territory.

The deceased died as a result of respiratory failure due to chronic obstructive airways disease cor pulmonale.

I make no finding that any aspect of the quality of care, treatment and supervision of the deceased contributed to the cause of death."

s.102(2)(b) Notices given under s.14(3)

Of the 1,140 matters finalised in the relevant period, 1,120 matters were dispensed with without conducting an hearing, that is they were disposed of by the Coroner in chambers.

s.102(2)(c) Recommendations made under s.57(3)

Section 57(3) of the *Coroner's 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.

No recommendations were made in the relevant period.

s.102(2)(d) Responses of agencies under s76

Pursuant to s.76, no agency responses were received during the relevant period.

The following is a numerical snapshot of the relevant period

1 July 2010 – 30 June 2011	
MATTERS LODGED:	
Deaths:	317
Fires:	861
Total:	1178
MATTERS FINALISED:	1140
By hearing:	20
Dispensed with (i.e. dealt with in Chambers)	1120

Lorraine Walker
Chief Coroner
31 December 2011