CANBERRA

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Mr Gordon Ramsay 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 2016.

Yours sincerely

Lorraine Walker
Chief Coroner

December 2016

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Coroners Act 1997 (excerpt)

s102 Annual report of court

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

(2) The report must include particulars of—

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

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

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

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

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

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

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

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

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

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

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

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

(9) If the Chief Coroner fails to give a report to the Attorney-General in accordance with this section, the Chief Coroner must give the Attorney-General a written statement explaining why the report was not given to the Attorney-General.

(10) The statement must be given to the Attorney-General within 14 days after the end of the period within which the report was required to be given to the Attorney-General.

(11) The Attorney-General must present a copy of the statement to the Legislative Assembly within 3 sitting days after the day the Attorney-General receives the statement.

STAFFING

Coroners

The ACT 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 2015/16. 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.

As I noted in last year's report, the appointment of the Registrar of the Coroners Court as a Deputy Coroner and delegating most of fire inquiry work to the Deputy Coroner proved efficient and beneficial. In 2015/16 we saw the full effect of the legislative change in April 2015 to make reporting of fires to the Coroner discretionary rather than mandatory, and to allow Coroners an own motion power to inquire into a fire. After receiving over 1,000 fire matters each year for the last three years, this year we received one fire referral. The Deputy Coroner continues to work with Police and Fire authorities to ensure that appropriate fire matters are referred for inquiry.

Last 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. I explained my reasons for this view in last year's annual report, but the reasons include improved efficiency and timeliness, the development of expertise, and improved coordination and oversight of the jurisdiction. Regrettably I have not received a formal response from Government in relation to this issue. I reiterate my recommendation that serious consideration be given to establishing a dedicated Coroner appointment for the ACT.

It is also worth remembering 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. In 2015/16 the ACT Coroner was notified of two deaths occurring within the Jervis Bay Territory, and one death occurring in the Australian Antarctic Territory. Costs in relation to these inquests are billed back to the Commonwealth Government on a cost-recovery basis. A priority in the forthcoming year for the Court will be examining the coronial needs for each of the Territories and updating and putting in place processes and authorisations to appropriately discharge the Court's responsibilities in this regard.

I note that Coroner Peter Dingwall retired this year. The Court wishes to acknowledge Coroner Dingwall's contribution. He had a special interest in coronial matters and was particularly well regarded for his engagement with families and his belief in the significant role the coronial jurisdiction can play in enhancing public safety.

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.

In last year's report I noted that I was not yet in a position to comment on the impact of the newly created Legal Manager position given the incumbent assumed the role in May 2015. I am pleased to note that in general, cases are progressing more efficiently and quickly – over 12 months we have seen a 10% improvement in our KPI for days to finalisation of coronial cases; we are holding more hearings – a year on year increase of 78%; and our processes are being reviewed and improved over time. I am particularly pleased to note that our focus on attending to older cases has resulted in the number of cases pending from 2014/15 and older reducing by 63%, and while this has come at the cost of a short term increase in the number of short term pending cases, we are still turning cases around on average quicker than we ever have before.

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.

The introduction of this role has revolutionised coronial service delivery in the ACT. The present incumbent, Ms Sarah Baker-Goldsmith, holds a rare combination of skills, being an excellent lawyer, an excellent administrator and a very dedicated worker. Ms Baker-Goldsmith has supported the Chief Coroner enormously by accepting a significant devolution of responsibility for supporting individual Coroners with their case load resulting in moving it more efficiently through the Court, developing policy and process initiatives, restructuring pathology services and liaising with stakeholders, in addition to functioning as a very competent counsel assisting in a number of matters.

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 10 hearings (and countless directions hearings) in the 2015/16 year.

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

A number of cases were also briefed to the private bar in 2015/16 due to the complexity of the matter or the capacity of our in-house practitioner. In such matters our in house practitioner performing the role of instructing solicitor, which enables the costs to be kept down and has proven beneficial to the appointed lead Counsel.

FACILITIES AND SERVICES

FMC

In 2015/16 the Forensic Medicine Centre (FMC) completed Standard Operating Procedures for the facility. Those procedures will be periodically reviewed and updated to meet best practice and to remain consistent with industry standards.

FMC staff continue to build on professional relationships with other Forensic Mortuaries and Specialist staff including Forensic Pathologists from Queensland, New South Wales and South Australia who offer their services to assist the ACT when their own operational requirements permit. The Mortuary Manager has been invited to attend the Mortuary Managers Working Group in Melbourne in July with a view to obtaining full membership later this year. This meeting is part of the Australian and New Zealand Policing Advisory Agency (ANZPAA) and the role of the meeting is to consider forensic science issues within the policing and justice sectors of Australia and New Zealand which can then be advanced through ANZPAA.

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. The FMC in conjunction with AFP Specialist Operations participated in a Post Blast Scene Examination and Management Workshop involving a suicide bomber scenario and pig carcass. 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.

I noted in last year's report the considerable saving on power consumption at the FMC due to the establishment of solar power as an energy source, reporting a 20% decrease in power consumption as between 2013/14 and 2014/15, even with only half of the panels being available for six months. I am pleased to be able to report that this financial year there has been a 29% reduction in electricity costs with a full complement of solar panels. Additional energy efficiencies will be explored this coming year.

Pathologist Services

Dr Sanjiv Jain continued in 2015/16 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. I wish to acknowledge specifically the assistance provided by Professor Johan Duflou, Dr Beng Beng Ong and Dr Nathan Milne. We continue

to be grateful for the assistance provided by the Victorian Institute of Forensic Medicine (VIFM) and the NSW Forensic and Analytical Science Service (FASS).

In my last report I noted that negotiations were ongoing with NSW FASS in relation to a partnership model for the long term provision of pathologist services to the FMC. In May 2016, NSW FASS provided an updated business proposal which was currently under active consideration by the Court and Government. I was hopeful of new arrangements being in place some time before the end of this financial year. However NSW FASS has been unable to access the level of resourcing required to progress this arrangement at present. Recruitment of forensic pathologists is very difficult given so few medical practitioners choose this area of specialisation. The ACT is exposed to the risk of have no or very limited local pathology support. The Court is working to put in place sustainable interim solutions whilst still aiming for a better long term arrangement.

ACT Health, and specifically the ACT Government Analytical Laboratory (ACTGAL) and ACT Pathology, will be consulted in respect of any arrangements with NSW FASS for pathologist and related service provision in the ACT.

Toxicology Services

I noted my reports for the previous two years that poor delivery of toxicology services was a key area of focus for the Court. Prior to 2013/14 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, but this action was stayed in the light of commitments from ACTGAL that it could improve turnaround times and was targeting a maximum 30 day turnaround time.

I am pleased to report ACTGAL continues to meet its target for turnaround times in this reporting period, and has managed a slight improvement from last year: see Table 1.

Table 1: Toxicology Timeframes

Type	**2015/16**	2014/15	2013/14
Average days	**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. By way of comparison, in 2015/16 NSW FASS averaged 15.4 days, however additional time is required to transport samples to the NSW facilities and can add between one to four days.

In last year's report I noted that discussions had 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. After negotiations between the FMC and ACTGAL a limited pilot program commenced in

December 2015 but results to date have been mixed. Since the commencement of the pilot to 30 June 2016, 17 cases were identified by the FMC where rapid toxicology would be of assistance to the post-mortem examination. In 11 of those cases ACTGAL were unable to assist for reasons including insufficient staffing and resourcing or because of technological limitations; ACTGAL does not have the capability or technology to provide rapid results for opioids, and cannot provide rapid results for different classes of drugs where multisubstance overdose is suspected, both of which constitute a significant proportion of the cases in which rapid toxicology would obviate the need for an intrusive autopsy. Nevertheless this capability, even as limited as it is, is still a pleasing improvement to toxicology services in the ACT and I encourage further development in this regard.

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. However, the number of referrals appears to have plateaued when the last three years are considered together: see Table 2.

Table 2: Cases Lodged

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

The observations I made in last year's report in relation to the reluctance on the part of doctors to write certificates for cases which are subsequently found to be natural cause deaths remains true. I was hopeful that the changes to the health-care related deaths jurisdictional ground which came into effect towards the middle of this reporting period would also have the effect of reducing the number of reports, but that does not appear to have been the case. That said, I acknowledge the increased difficulty for doctors in a causation-based criterion as compared to the previous time-based criterion for referral. Additional efforts will be made in 2015/16 to re-engage with the medical profession and provide education and guidance as to the matters which are properly referred to the Coroner, as discussed later in my report in the context of environment changes.

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 3.

Table 3: Cases Finalised

Type	**2015/16**	2014/15	2013/14	2012/13
With a Hearing	***16***	*9*	*14*	*16*
Deaths	**16**	9	12	12
Fires	**0**	0	2	4
Disasters	**0**	0	0	0

By Chambers decision	***234***	*1007*	*1171*	*1375*
Deaths	**234**	305	317	376
Fires	**0**	702	854	999
Disasters	**0**	0	0	0
Total Cases	***250***	*1016*	*1185*	*1391*

Matters resolved without hearing constitute 94% of all inquests into deaths finalised in the 2015/16 year.

The expected reduction in the coronial fire jurisdiction is now fully evidenced. This change reduces pressures on the Coroner's Court and brings the ACT into line with other jurisdictions, most 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.

This year more matters were lodged than were finalised in the reporting period, which is demonstrated in the increase in the number of cases pending in 2015/16 as against 2014/15: see Table 4.

Table 4: Pending Cases

Time Pending	**2015/16**	2014/15	2013/14	2012/13
< 12 months	**108**	84	97	149
> 12 months < 24 months	**23**	20	26	45
> 24 months	**27**	33	27	40

The increase in cases are in the short term pending (less than 12 months) category. This is due to the increased focus I foreshadowed in last year's report upon resolving older cases. By definition, the cases pending for less than 12 months at the end of 2015/16 are cases that were received this year. Roughly speaking then, of the 137 cases which were pending at the end of 2014/15, only 50 of those cases remain pending in 2015/16 (being those that are pending for more than one year). Continued efforts will be made in the forthcoming year to address the historic pending matters, and particularly those 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.

However, this focus on resolving older cases has not impacted upon the timely resolution of newer cases: see Table 5.

Table 5: Time to Closure		
	2015/16	2014/15
Median days to finalisation (target)	**75 (85)**	83 (153)

This statistic is comparatively recent and this data has only been collected for the last two financial years. It demonstrates that notwithstanding the increased number of short term pending cases, recent reportable deaths continue to be dealt with expeditiously, and 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.

Autopsy Process and Practice

The total number of admissions to the FMC in 2015/16 was 420 cases, made up of 350 ACT cases and 70 NSW cases. Medical certificates were ultimately issued in 67 ACT cases and seven NSW cases. Autopsies were conducted in 207 ACT cases and 41 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 2015/16 for all cases was five days. In cases where a post-mortem examination was undertaken, the average time between arrival and examination was three days, and from examination to discharge was two 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, for identification to be confirmed, or for public trustee procedures to be finalised.

This year, as frequently occurs, 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.

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

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 2015/16 the facility achieved a KPI of 93.6%. Again, this result has been achieved with the majority of cases being conducted on weekends and after hours, as the usual consulting pathologist is only available on average two days a week.

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 our proportion of cases subject to external examination remains stable: see Table 7.

Table 7: 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%)
2015/16	**279**	**207**	**72 (25.8%)**

I believe there are further opportunities for improvement upon the steady percentage figure with respect to limiting invasive examinations. Further improvements however are likely to be driven by changes to technological advancements such as greater availability of rapid toxicology testing on multiple drug families. Process enhancements such as pathologist-led medical reviews may also support further improvements.

Forecast

I would like to see the number of deaths reported to the Coroner's Court continue to decrease over 2016/17 as health care professionals are better educated about the changes and the types of deaths which are properly referred to a Coroner. Our process of engagement with the professions in this regard has markedly increased and will be a key focus of 2016/17.

The forthcoming year will bring a number of inquest hearings of significant complexity. Some of these are as the result of new complex referrals (for example, the Antarctic death

[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 Captain Wood, the death of Mr Smith-Brown in the context of a police pursuit); some are as a result of our increased focus on clearing the backlog of historic cases, where the delay directly reflects the time required to appropriately consider and deal with the matter; and some are as the result of the conclusion of related criminal proceedings which reinvigorate the inquest process (for example, the workplace deaths of Mr Catanzariti and Mr Vickery). These matters will bring timing and resourcing challenges to the Court which we must, and will, find a way to bear.

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 2015/16, the ACT Government funded two community support services to assist people engaged with the coronial jurisdiction:

- 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 feedback from clients is uniformly positive.
- In 2015/16, SupportLink Australia was contracted to provide a limited ACT Trauma Support Service which would provide on-call immediate crisis care and some short-term practical support to persons affected by unexpected traumatic deaths which

fall within the coronial jurisdiction. The Coroner's Court has contributed to a review undertaken by the Directorate to identify what, if any gaps exist in the support for those affected by sudden and unexpected death available in the ACT now that the Coronial Counselling Service is established.

SupportLink ACT and Relationships Australia Canberra Region, and their respective staffs, engaged constructively with the Coroner's Court in the last year. There is a clear ongoing need for coronial counselling services.

Direct Engagement

During the 2015/16 year, I undertook the following engagements:

- Met with NSW FASS in relation to longer term arrangements for pathologist service provision;
- 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 National Judicial College of Australia Council Meeting;
- Attended the International Chief Coroners Conference in London in April 2015, and as part of that visit, undertook a fact finding visit to the Leeds City Council and Children's Court; and
- Met with a number of relatives of deceased people;

During the 2015/16 year, the FMC hosted the following groups:

- ANU medical student groups;
- Australian Defence Force Investigative Service (ADFIS);
- Australian Federal Police cadets;
- Australian Federal Police Criminal Investigations teams;
- ACT Policing Communications staff;
- Canberra Institute of Technology Forensic student groups;
- Disaster Victim Identification core training and refresher courses;
- St. John's Ambulance volunteers;
- Relationships Australia Canberra Region; and
- SupportLink (ACT).

During the 2015/16 year, the Coroners Unit Manager met with:

- Family members of deceased persons;
- Experts and witnesses engaged in inquests;
- Investigators;
- Researchers;
- Local funeral directors;
- External Counsels Assisting;
- Internal Counsels Assisting from other jurisdictions;
- The Queanbeyan Coroner;
- ACT Policing;
- ACT Disaster Victim Identification Team;
- ACT Fire and Rescue;
- ACT Health;
- DonateLife;
- ACTGAL;
- NSW FASS;
- JACS;
- AHPRA;
- The National Institute of Forensic Science;
- The ACT Domestic and Family Violence Review Team;
- The ACT Government Solicitor;
- Headspace;
- The National Coronial nformation Systen;
- 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 2014/15 year, as follows:

- 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.

I have discussed the impact of the former legislative changes earlier in my report with respect to resourcing and workload and I expect the impact of these changes will continue going forward. Coronial scene investigation orders have proven themselves a useful tool for investigators and these orders are now routinely made by Coroners. The express privilege against self-incrimination has also been utilised in a number of recent hearings.

Amendments were made in the 2015/16 year to the *Coroners Act 1997* by the following legislation:

- The *Red Tape Reduction Legislation Amendment Act 2015*, which came into effect on 14 October 2015, and amended the requirement to give notice of a hearing to allow notice to be given either by notice published in a daily newspaper or by publication of a notice on an ACT government website;
- The *Courts Legislation Amendment Act 2015 (No 2)*, which came into effect on 10 December 2015, and made amendments to:
    - require a separate appointment for special magistrates to act as coroners, although current special magistrates will continue to be coroners;
    - change the reportability basis for health care-related deaths from a time based criterion to a causation based criterion;

  - provide protection from civil and criminal liability, and breach of professional ethics and rules of conduct, for persons who disclose information to a coroner; and
  - correct a typographical error in subsection 102(9) to correct the title of the Chief Coroner;

- The *Mental Health Act 2015*, which came into effect on 1 March 2016, and made consequential amendments to the *Coroners Act 1997* to correctly refer to the new mental health legislation;
- The *Crimes (Sentencing and Restorative Justice) Amendment Act 2016*, which came into effect on 2 March 2016, and made a consequential amendment to reflect that periodic detention is no longer a sentencing option in the ACT; and
- The *Justice and Community Safety Legislation Amendment Act 2016*, which came into effect on 29 June 2016, and made amendments to:
  - change the tabling process of section 57 reports in the Legislative Assembly to remove that responsibility from the Attorney-General to the Minister with portfolio responsibility for the matters reported on by the coroner; and
  - extend the timeframe for providing the coroner with a custodial agency's report to coronial findings in deaths in custody to align with the section 57 process, where that process has also been enlivened by the coroner.

Given the short period of operation of the amendments it is not possible to fully report on the outcomes and consequence of these changes to the Act, but there are two comments I would make here.

Firstly, the rationale behind the amendment to better focus the reportability criteria for health care-related deaths was to better target coronial resources on matters where independent review and examination of deaths is warranted, leading to resource efficiencies and to prevent unnecessary entanglement of families in matters where there is no identifiable concern warranting coronial investigation. Although the provision has only been in for approximately half a year, and it is not possible to definitively divine its impact on the number of matters reported, I confess that I had expected more of a trend reduction in numbers than has appeared to have taken place. I am satisfied that the policy intention behind the amendment is sound but I consider perhaps doctors are conservative in their opinions as to the impact of surgery undertaken in close proximity to death, akin to the general conservativeness I noted in last year's report in relation to writing death certificates. As noted earlier in my report, I intend to undertake outreach with general practitioners and hospital doctors in the next year to educate them on the types of matters which are required to be referred to the Coroner's Court.

Secondly, the most recent amendments made by the *Justice and Community Safety Legislation Amendment Act 2016* were not amendments sought by me, or by Coroners, or by the Courts Administration, but originated from and were driven by the Directorate.

I understand that the Directorate intends to put forward further legislative amendment in the new Legislative Assembly to address the concern I raised in last year's report, and which also has been prosecuted by Coroner Peter Morrison in a number of recent cases, some of which are reported at the end of this Report, in relation to mandated hearings following deaths involving anaesthesia (paragraph 34A(2)(b) of the Act). As the original policy intention underlying the need for mandatory hearings in these deaths has been overtaken by clinical improvements in anaesthesia, I consider that this is a welcome step and will lead to the better allocation of coronial and police resources on matters deserving of coronial attention. I note that where deaths appear to be attributable in some way to the administration of anaesthetics or anaesthesia may have contributed to death, those deaths will continue to be reportable to a coroner under the new causation criterion for health care-related deaths, and a coroner retains a discretion to hold hearings in such cases if considered appropriate.

I also note that in this reporting period, the *Transplantation and Anatomy Act 1978* was amended to enable the coroner to provide direction prior to death that a coroner's consent is not required for organ donation to occur following death (thereby bringing ACT legislation into line with other jurisdictions, and allowing prompt collection of organs after death), and to simplify the wording describing the circumstances where a coroner may be required to hold an inquest into the death of a person. These amendments were effective 18 March 2016. I remain fully supportive of organ donation in appropriate cases, which is to say, cases in which the removal of organs would not adversely impact on the coronial process and the statutory findings a coroner is required to make.

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 2015/16 year, there were 7 inquests into deaths in custody finalised by a Coroner:

Chi Fay Choy (CD 27 of 2015)

Jacques Filiatrault (CD 6 of 2014)

Mark I'Anson (CD 169 of 2015)

MP * (CD 181 of 2013)

Justin Lee Monfries (CD 286 of 2014)

Christina Savvas (CD 250 of 2013)

Ben Wunderlich (CD 50 of 2014)

* In the matter of MP, the Coroner made a non-publication order prohibiting publication of the name of the deceased.

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 2015/16 year, there were 234 notices given by Coroners under subsection 34A(3), in respect of 234 deaths. (There were no inquires into fires or disasters on foot or finalised in

the 2015/16 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, nor any applications to the Supreme Court made under section 90, in the 2015/16 year. However, a section 90 application to the Supreme Court was made after the conclusion of this reporting period in respect of the inquest into the death of Corrina Medway (CD 127 of 2011). A more fulsome report will be made in next year's Annual Report.

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 went to hearing in the 2015/16 year before Coroner Margaret Hunter and findings are anticipated to be handed down in December 2016.

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 2015/16 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 John Cardar Throckmorton (CD 215 of 2015) was tabled on 4 August 2015, 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 2015. 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 2015/16 year relating to coronial reports made in the previous year. The subsection 57(3) report in relation to the death of Rachel Sarah Prime (CD 34 of 2014) was tabled in the Legislative Assembly on 13 August 2015, and the report in relation to the death of Mark Rodney Jolliffe (CD 44 of 2010) was tabled on 19 November 2015.

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

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 seven inquests into deaths in custody finalised by a Coroner in the 2015/16 year, in only the case of MP (CD 181 of 2013) were findings were made in any case that the quality of care, treatment and supervision of the deceased contributed to the person's death. In relation to that matter, a letter was received from the Minister for Corrections, dated 22 July 2016, attaching the ACTCS response to the Coroner's findings. Further details as to this response are included with the case summary later in this report. Additionally, a letter was received from the Minister for Health, dated 23 February 2016, acknowledging the coronial report and stating "*ACT Health has a collaborative working relationship with the Justice and Community Safety Directorate and will continue to work in an integrated manner in the provision of health services to detainees*".

There is no indication on the relevant files that any section 76 response was received in the cases of Chi Fay Choy (CD 27 of 2015), Jacques Filiatrault (CD 6 of 2014), Justin Lee Monfries (CD 286 of 2014), and Christina Savvas (CD 250 of 2013).

A letter was received from the Director-General of the ACT Health Directorate in relation to the inquest into the death of Ben Wunderlich (CD 50 of 2014), dated 27 November 2015, noting that no findings or recommendations were made in respect of care, treatment or supervision.

A letter was received from the Minister for Health in relation to the inquest into the death of Mark I'Anson (CD 169 of 2015), dated 23 February 2016, noting that no findings or recommendations were made in respect of care, treatment or supervision.

In relation to 2014/15 matters, I note the following correspondence was received in this reporting period: a letter was received from the Minister for Justice in relation to the inquest into the death of Maxwell Kevin Blundell (CD 124 of 2014), 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/courts2/coroners_court/selected-findings .

Court Reference: CD 250/2013
Age: 44 years
Gender: Female
Date of Death: 4 October 2013
Place of Death: Fadden, ACT
Coroner: B.C. Boss
Date of Findings: 3 July 2015

Mandatory hearing – death in custody

Reported under 102(a), (d)

Coroner's Findings:

Christina Savvas died at 22 Appel Crescent, Fadden, in the Australian Capital Territory on 4 October 2013. The manner and cause of Ms Savvas's death was

1. DIRECT CAUSE
   (a) Metastatic breast cancer (1 year)
2. OTHER SIGNIFICANT CONDITIONS contributing to the death but not related to the disease or condition causing it
   (a) Psychotic illness

No matter of public safety arises in relation to Ms Savvas' death.

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

I make no recommendations or other comments.

Court Reference: CD 236/2014
Age: 72 years
Gender: Male
Date of Death: 12 October 2014
Place of Death: The Canberra Hospital, Garran
Coroner: K.M. Fryar
Date of Findings: 12 August 2015
Mandatory hearing – death under anaesthetic

Coroner's Findings:

John Douwe Jongebreur died at The Canberra Hospital, 1 Dann Close, Garran in the Australian Capital Territory on 12 October 2014.

The manner of death was: Cardiogenic shock. The cause of death was: Acute myocardial infarct.

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

I make no recommendations or other comments.

Court Reference: CD 27/2015
Age: 35 years
Gender: Male
Date of Death: 23 January 2014
Place of Death: Symonston, ACT
Coroner: L.E. Campbell
Date of Findings: 13 August 2015
Mandatory hearing – death in custody
Reported under 102(a), (d)

Coroner's Findings:

1. The deceased was Chi Fai Choy born on 11 October 1978.
2. The deceased died on 23 January 2014 at the Sundowner Motel Resort, 205 Narrabundah Lane, Symonston in the Australian Capital Territory.
3. The manner and cause of death was heroin toxicity.
4. No matter of public safety arises in relation to Mr Choy's death.

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

6. I make no recommendations or other comments.

Court Reference: CD 8/2010
Age: 39 years
Gender: Male
Date of Death: 4 January 2010
Place of Death: The Canberra Hospital, Garran
Coroner: P.G. Dingwall
Date of Findings: 21 August 2015
Hearing held

Coroner's Findings:

As required by s 52 of the act I find that:

- the deceased was James William Horton, born on 15 November 1970;
- the deceased died on 4 January 2010 at The Canberra Hospital, Garran in the Australian Capital Territory; and
- the deceased died as a result of blood loss caused by the laceration of his right lung following a waterway collision between a jet ski driven by him and a motor powered ski boat on Molonglo Reach, Fyshwick in the Australian Capital Territory.

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

Recommendations

However, in the interests of public health and safety generally, I recommend that:

- Consideration be given to dividing Molonglo reach into two separate sections to cater for the differing types of watercraft which regularly use the area and their differing activities. One possibility is to confine slower and less manoeuvrable vessels, such as water ski boats towing people on water skis, wakeboards and ski biscuits, to the wider section of Molonglo Reach between the northern and southern boat ramps and confine the faster and more manoeuvrable vessels, such as jet skis, to the narrower section to the south of the southern boat ramp.

- Consideration be given to carrying out further work to widen the two bends on Molonglo Reach to the north and south of the area where the collision occurred by the removal of vegetation on the river banks.
- Consideration be given to the placement of navigation buoys and relevant signage on Molonglo Reach from the approach to, and through, the two bends referred to above so as to assist watercraft to maintain a course to the port side of the centre of the river.
- If not already in place, consideration be given to developing a more regimented approach to the management of Molonglo Reach, including regular risk assessments, protocols and arrangements for identifying and removing hazards prior to and during the waterskiing season, and a greater monitoring of use of the area by recreational watercraft by either the relevant Australian Capital Territory Department or the Australian Federal Police.
- If not already in place, consideration be given to developing a more streamlined and effective method for booking Molonglo Reach for use by recreational watercraft so as to ensure that the number of users at any one time is limited to a safe number.
- A review of the relevant legislation be carried out to ensure that it is adequate and carries sufficient deterrents for the unlawful use of Molonglo Reach, and that members of the Australian Federal Police have sufficient powers to enforce relevant safety legislation, including the issuing of infringement notices and the carrying out of random alcohol and drug testing.

Court Reference: CD 286/2014
Age: 26 years
Gender: Male
Date of Death: 17 December 2014
Place of Death: The Canberra Hospital, Garran
Coroner: R.M. Cook
Date of Findings: 29 September 2016
Mandatory hearing – death in custody
Reported under 102(a), (d)

Coroner's Findings:

1. The deceased was Justin Lee Monfries, born 14 March 1988.
2. Mr Monfries died at about 3:00 PM on Wednesday, 17 December 2014 at The Canberra Hospital, Garran following his admission on 18 November 2014 having experienced

difficulty in breathing caused by hypersensitivity pneumonitis while incarcerated at the Alexander Maconochie Centre.

3. Mr Monfries died as a result of respiratory failure from interstitial pneumonia an incurable progressive inflammatory lung disease.

4. Death was due to natural causes.

5. No matters of public safety arose in connection with this inquest.

6. 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 50/2014
Age: 35 years
Gender: Male
Date of Death: 3 March 2014
Place of Death: Giralang, ACT
Coroner: B.C. Boss
Date of Findings: 3 November 2015
Mandatory hearing – death in custody
Reported under 102(a), (d)

Coroner's Findings:

The deceased was Ben Wunderlich, born 9 November 1978.

Mr Wunderlich died at 2 Wanaga Place, Giralang in the Australian Capital Territory on 3 March 2014 and the cause of his death was ultimately hypoxia.

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

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

Court Reference: CD 133/2013
Age: 70 years
Gender: Male
Date of Death: 28 May 2013
Place of Death: The Canberra Hospital, Garran

Coroner: B.C. Boss
Date of Findings: 3 November 2015
Mandatory hearing – death under anaesthetic

Coroner's Findings:

Abdo Abdel-Massih died on 28 May 2013 at The Canberra Hospital, 1 Dann Close, Garran. The manner and cause of Mr Abdel-Massih's death was as follows:

1. DIRECT CAUSE
   (a) Sepsis, Pneumonia & Congestive Cardiac Failure
   (due to (or consequences of)
   (b) Acute on Chronic Renal Failure
   (due to (or consequences of)
   (c) Severe Generalized Atherosclerosis
2. OTHER SIGNIFICANT CONDITIONS contributing to the death but not related to the disease or condition causing it
   (a) Previous myocardial infarction
   (b) Bilateral leg amputations for vascular disease
   (c) Hypertension
   (d) Abdominal aortic aneursym repair

No matter of public safety arises in relation to Mr Abdel-Massih's death. I make no recommendations or other comments.

Court Reference: CD 118/2015
Age: 65 years
Gender: Male
Date of Death: 8 June 2015
Place of Death: The Canberra Hospital, Garran
Coroner: P.J. Morrison
Date of Findings: 16 November 2016
Mandatory hearing – death under anaesthetic

Coroner's Findings:

Terry Norman Ellis died on 8 June 2015 at The Canberra Hospital, 1 Dann Close, Garran. The manner and cause of Mr Ellis's death was as follows:

1. DIRECT CAUSE
   (b) Haemopericardium
2. ANTECEDENT CAUSES

(a) Ruptured dissection of aorta

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

I have commented and made a recommendation in another matter about the statutory necessity of holding a hearing where death occurs while under anaesthetic, but in circumstances which ordinarily would suggest a hearing should be dispensed with.

In the inquest into the death of Ursula Hanel, CD 244 of 2012, in which I delivered findings on 29 October 2013, I recommended that section 34A of the *Coroners Act 1997* be reviewed in relation to the limitations on the power of a Coroner to dispense with a hearing.

It does not appear that this review has taken place. I can say that section 34A has not been altered since I had cause to consider it in Hanel.

I remain of the view that section 34A should be reviewed, and I reiterate my recommendation, first made in Hanel, for such a review. I attach to these findings a copy of the findings I made in Hanel and a copy of the Wright Committee report referred to therein.

Court Reference:	CD 109/12
Age:	38 years
Gender:	Male
Date of Death:	4 May 2012
Place of Death:	Bonython, ACT
Chief Coroner:	L.A. Walker
Date of Findings:	25 November 2015

Coroner's Findings:

(1) The deceased died at … Bonython in the Australian Capital Territory on 4 May 2012.

(2) The manner and cause of death was a fatal cardiac arrythmia related to underlying severe cardiomegaly and interstitial fibrosis related to underlying primary cardiomyopathy.

(3) A matter of public safety was not found to arise in connection with the inquest.

I note that the experts who provided opinions for my assistance advise that that there is no established clinical pathway for people suffering the conglomeration of symptoms experienced by [the deceased]. Their opinion is to be provided to the Royal Australian College of Physicians for its consideration.

Court Reference: CD 169/2015
Age: 54 years
Gender: Male
Date of Death: 20 August 2015
Place of Death: Mawson, ACT
Coroner: B.C. Boss
Date of Findings: 4 December 2015
Mandatory hearing – death in custody
Reported under 102(a), (d)

Coroner's Findings:

Mark Roland I'Anson died at 26/4 Wilkins Street, Mawson, in the Australian Capital Territory on 20 August 2015. The manner and cause of Mr I'Anson's death was as follows:

1. DIRECT CAUSE
   (c) Cardiomegaly
2. ANTECEDENT CAUSES
   (e) Bullous emphysema

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

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

I make no recommendations or other comments.

Court Reference: CD 127/2011
Age: 32 years
Gender: Female
Date of Death: 22 May 2011
Place of Death: The Canberra Hospital, Garran
Coroner: M.A. Hunter
Date of Findings: 18 December 2015
Hearing held

Coroner's Findings:

I find that Corinna Anne Medway born 21 June 1978, died at the Canberra Hospital Intensive Care Unit, 1 Dann Close, Garran, in the Australian Capital Territory at 17:03 hours on 22 May 2011.

I further find that the cause of her death was a massive post partum intra cerebral haemorrhage of a spontaneous hypertensive origin.

Recommendations:

In my view recommendations as to a matter of health and safety arise in this inquest:

A. That all nursing staff, midwives, general medical practitioners and specialist obstetricians involved in the treatment and care of pregnant women undertake specific training with respect to pregnancy induced hypertension (pre-eclampsia) and the risks that condition presents to pregnant women antenatally and post partum. This training should include familiarity with the SOMANZ guidelines in place at the time and the WHO recommendations regarding treatment and care of patients with pregnancy induced pre-eclampsia.

B. That literature such as the Pre-eclampsia Foundation Brochure (which sets out the risks of pre-eclampsia to pregnant women) be provided by practitioners who have the care and treatment of pregnant women to all pregnant women under their care.

C. That a patient's complete notes should be sent with the patient at the time of their discharge from the birthing suite onto the ward.

D. The taking of contemporaneous notes is to be encouraged when any significant event occurs. In my view this should be routine for all staff treating a patient, including the medical staff.

Note: an application under section 90 has been made to the Supreme Court in respect of this matter, but outside the reporting period. This will be more fully reported on in next year's Annual Report.

Court Reference: CD 181/2013
Age: 30 years
Gender: Male
Date of Death: 16 July 2013
Place of Death: Alexander Maconochie Centre
Coroner: B.C. Boss
Date of Findings: 18 December 2015
Mandatory hearing – death in custody
Reported under 102(a), (d)

Coroner's Findings:

Pursuant to section 52, I find that [MP] died on 16 July 2013 at the Alexander Maconochie Centre, a corrections centre, where he was being held on remand. He died as a result of hanging. I am satisfied on the evidence that he took his own life.

Recommendations

In my findings I have made references to a number of matters concerning policy and procedure in place at the AMC at the time that were raised at the hearing particularly by Professor Ogloff. I make no formal finding as to those matters. Clearly procedures concerning the management of mentally ill offenders were undergoing significant change at the time of [MP]'s death. However, as noted above, it is beyond the scope of this Inquest to make findings as to those changes and the effectiveness of the implementation.

I recommend that ACT Corrective Services engage a suitably qualified expert to provide a report to the Attorney-General as to the effectiveness of changes to practice and procedures relating to the management of "at risk" detainees that have been made since October 2012, and to report on the implementation of the recommendations made in the internal review into [MP]'s death.

Note: the Coroner made a non-publication order prohibiting publication of the deceased's name.

Responses

A letter was received from the Minister for Corrections in relation to the inquest into the death of MP (CD 181 of 2013), dated 22 July 2016, attaching the ACTCS response to the Coroner's findings. The letter advised that ACTCS has acted promptly on the Coroner's recommendation and engaged Professor James Ogloff to undertake a review of the effectiveness as to changes to practices and procedures, and to report on the implementation of the recommendations of the internal review. A copy of Professor Ogloff's report was included. The letter went on to say, *"[w]hile the report found that ACTCS complies with international standards of best practice, it also made 10 recommendations for further improvement*". The letter also enclosed a report outlining the progress made against the Professor's recommendations.

Additionally, a letter was received from the Minister for Health in relation to the inquest into the death of MP (CD 181 of 2013), dated 23 February 2016, acknowledging the coronial report and stating "*ACT Health has a collaborative working relationship with the Justice and Community Safety Directorate and will continue to work in an integrated manner in the provision of health services to detainees*".

Court Reference:	CD 189/2015
Age:	54 years
Gender:	Female

Date of Death: 15 September 2015
Place of Death: The Canberra Hospital, Garran
Coroner: P.J. Morrison
Date of Findings: 14 January 2016
Mandatory hearing – death under anaesthetic
Reported under 102(b)

Coroner's Findings:

Gail Maree Cleathero died on 15 September 2015 at The Canberra Hospital, 1 Dann Close, Garran. The manner and cause of Ms Cleathero's death was as follows:

1. DIRECT CAUSE
   (b) Blood loss, due to
   (c) Cardiac valve replacement surgery complicated by left ventriculo pericardial fistula
2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT
   (a) Severe rheumatic heart valvular disease

No matter of public safety arises in relation to Ms Cleathero's death.

Recommendations

This hearing is one where a hearing was not necessary to determine the manner and cause or death or for any other purpose.

Ordinarily I would have dispensed with a hearing. I was unable to do so in this case because the express terms of section 34A(2)(b) of the *Coroners Act 1997* prevent me from doing so when a person dies under or as a result of the administration of an anaesthetic administered in the course of a medical, surgical or dental operation.

As I noted in the recent inquest into the death of Terry Ellis, CD 118 of 2015, also a matter where I was required to hold a hearing because the death occured under anaesthetic, the public resources utilised in the preparation for and holding of a hearing which is otherwise unnecessary could be better utilised elsewhere.

In the inquest into the death of Ursula Hanel, CD 244 of 2012, in which I delivered findings on 29 October 2013, I commented on a review conducted in 1935 of the equivalent of section 34A in the *Coroners Act 1887* of the United Kingdom and recommended that section 34A of the Territory's *Coroners Act 1997* be similarly reviewed with a view to giving a Coroner a power to dispense with a hearing in cases such as this.

I remain of the view that section 34A should be reviewed, and I reiterate my recommendation, first made in Hanel, for such a review. I note that a copy of the findings I made in Hanel, and a copy of the Wright Committee report referred to in those reasons, was

forwarded to the Attorney-General as part of the findings and recommendation I made in the Ellis inquest on 16 November 2015.

Court Reference: CD 6/2014
Age: 52 years
Gender: Male
Date of Death: 4 January 2014
Place of Death: Reid, ACT
Coroner: P.G. Dingwall
Date of Findings: 5 March 2016
Mandatory hearing – death in custody
Reported under 102(a), (b)

Coroner's Findings:

Jacques Filiatrault died at Unit 14, Block 7, Bega Court, Ballumbir Street, Reid, in the Australian Capital Territory on 4 January 2014.

The manner and cause of Mr Filiatrault's death was a self inflicted stab wound by knife to the abdomen.

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

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

I make no recommendations or other comments.

Court Reference: CD 215/2015
Age: 62 years
Gender: Male
Date of Death: 21 October2015
Place of Death: The Canberra Hospital, Garran
Coroner: K.M. Fryar
Date of Findings: 5 May 2016
Reported under 102(b)

Coroner's Findings:

1 That John Cardar Throckmorton died on 21 October 2015 at The Canberra Hospital, 1 Dann Close, Garran, in the Australian Capital Territory;

2 That the cause of death was ischaemic heart disease;

3 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.

4 Comments on matter of public safety pursuant to s 52(4)(a)(ii) of the *Coroners Act 1997*:

a. On 21 October 2015 the ACT Ambulance Service was contacted for assistance for the deceased and the deceased was subsequently transported to Calvary Hospital by ACT Ambulance Service. After assessment at Calvary Hospital, the deceased was subsequently transferred to The Canberra Hospital, where he died.

b. At the time ACTAS paramedics first attended upon the deceased, he was experiencing a ST elevation myocardial infarction (STEMI). A decision was taken to transport the deceased to the closest Emergency Department, which was Calvary Hospital. However, under the relevant ACTAS Clinical Management Guideline in force at the time, the attending paramedics should have consulted with The Canberra Hospital about whether the deceased should have been transported in the first instance to The Canberra Hospital where cardiac catheterisation facilities are available. ACTAS has agreed that the Guidelines at that time were unclear.

c. The medical practitioner who performed a post mortem examination of the deceased at my direction has advised me that he doubts whether the delay in transport of the deceased to The Canberra Hospital contributed to any significant degree to the death of the deceased. I note also that the deceased's family have commented favourably about the treatment and care by the attending paramedics and that they hold no concerns in that regard. However, it is clear that in other cases, a delay in transporting a patient in a similar condition to the deceased to The Canberra Hospital may impact on the patient's prospects of survival.

d. The circumstances surrounding the deceased's transport by ambulance on the day of his death have been the subject of review and report by the ACT Ambulance Service and that report has also been relied upon by me in making these findings. As a result of that review, ACTAS has reviewed and amended its Clinical Management Guidelines and relevant checklists and flowcharts to clarify the appropriate management of patients presenting with similar symptoms to the deceased, and a copy of the amended Guidelines have been issued to all ACTAS staff.

e. On the basis of the actions now taken by ACTAS I am satisfied that the risks to public safety identified in this inquest have been appropriately ameliorated. I see no need to make a formal recommendation.

Court Reference:	CD 226/2012
Age:	81 years
Gender:	Male
Date of Death:	26 August 2012
Place of Death:	Jindalee Nursing Home, Narrabundah
Coroner:	B.C. Boss
Date of Findings:	9 May 2016

Hearing held

Coroner's Findings:

The deceased was Aladar Vidak, born 17 April 1931, formerly of Narrabundah in the Australian Capital Territory.

Mr Vidak died on 26 August 2012 at the Jindalee Nursing Home, 277 Goyder Street, Narrabundah in the Australian Capital Territory.

Mr Vidak died as a result of asphyxia caused by aspiration of vomitus. This was significantly attributed to the presence of a blood alcohol level of 0.249 grams per 100ml of ethyl alcohol.

This inquiry has been unable to determine how the alcohol came to be in Mr Vidak's system and the matter was referred back to the Australian Federal Police. The police have advised this Court that there are no further fruitful avenues of enquiry and they will not be investigating the matter further.

It remains unresolved as to how the deceased acquired the blood alcohol level which ultimately caused his death.

Recommendations

I make the following recommendation pursuant to my common law powers as a Coroner: *That CCTV or other methods be put in place in nursing homes so that residents can be continuously monitored for their safety.*

Court Reference: CD 110/2015
Age: 66 years
Gender: Male
Date of Death: 30 May 2015
Place of Death: The Canberra Hospital, Garran
Coroner: P.J. Morrison
Date of Findings: 20 May 2016
Mandatory hearing – death under anaesthetic

Coroner's Findings:

Jorma Risto Paavilainen died on 30 May 2015 at The Canberra Hospital, 1 Dann Close, Garran. The manner and cause of Mr Paavilainen's death was ischaemic heart disease.

No matter of public safety arises in relation to Mr Paavilainen's death. This inquest is one where a hearing was not necessary to determine the manner and cause or death or for any other purpose. Ordinarily I would have dispensed with a hearing. I was unable to do so in this case because the express terms of section 34A(2)(b) of the *Coroners Act 1997* prevent me from doing so when a person dies under or as a result of the administration of an anaesthetic administered in the course of a medical, surgical or dental operation. At the time of his death Mr Paavilainen was under anaesthetics for day surgery to debride pressure wounds on his hips.

As I have noted in a number of recent inquests the public resources utilised in the preparation for and holding of a hearing which is otherwise unnecessary could be better utilised elsewhere.

I remain of the view that section 34A should be reviewed, and I reiterate my recommendation for such a review.

Court Reference: CD 15/2009
Age: 57 years
Gender: Male
Date of Death: 13 January 2009
Place of Death: Evatt, ACT
Coroner: P.G. Dingwall
Date of Findings: 29 June 2016
Hearing held

Coroner's Findings:

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

- the deceased was Blackfella Gowen (formerly known as Geoffrey William Gowen), born on 13 January 1952;
- the deceased died between 4.45am and 4.55am on 13 January 2009 at McClure Place, Evatt in the Australian Capital Territory; and
- the deceased died as a result of massive neck and chest injuries which he sustained when the jib of the Palfinger PK 9501 model hydraulically operated knuckle-boom type vehicle loading crane he was operating, and which was mounted on the back of an ACCO make flat-bodied truck, came into contact with, and exerted great force against, his upper back, causing his chest and neck to be crushed against the control panel and other parts of the crane located on the passenger side of the truck.

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

I formalise my interim finding, made on the last hearing date, that no adverse comment is made in respect of Sonnie Pty Ltd, trading as Palfinger Australia.

Recommendations

I am aware that a great deal of work has been undertaken by Worksafe ACT in relation to the level of training that should be required before a person is permitted to operate a HIAB such as the one that caused Mr Gowen's death, particularly in light of the fact that prior to his death an operator of a HIAB with a lifting capacity of less than 10 tonnes was not required to hold an operator's licence issued by an appropriate licensing authority. In view of the fact that the training provided to Mr Gowen was clearly inadequate, it is my view, given the dangers posed to life and limb through the operation of HIABs, that the assessment of an employee's competency should not be left to employers but, instead, be assessed by an independent and qualified person.

Accordingly I recommend that formal training and licensing be required for any operator of a HIAB with a lifting capacity of less than 10 tonnes. I note that formal training and licensing is required for operators of such cranes with a lifting capacity above 10 tonnes.

Other Action

I make no recommendations concerning the design of the Palfinger VLC involved in this matter. However, I will forward a copy of these reasons and copies of the reports of Mr O'Brien, Dr Shane Richardson, Mr John Weir, Mr Mario La Rocca and Mr Nathan Jess, together with the transcript of their evidence, to Standards Australia for its consideration of

the issue and to the manufacturer of the Palfinger VLC with a request that it consider enhancing the design of the crane so as to ensure that a "drop event" does not occur if the crane is operated other than in accordance with the manufacturer's instructions. I will also request that consideration be given to improving the clarity of the instruction manual and the instructions displayed on the control panel of the crane.
