ACT CORONERS COURT

ANNUAL REPORT 2019/20

[Coroners Act, section 102]

Issued at the direction of
Chief Coroner Lorraine Walker

24 December 2020

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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.

References in this report to legislation or to 'the Act' are to the *Coroners Act 1997* unless otherwise stated.

WORKLOAD STATISTICS

Cases Lodged

The number of referrals received increased again this year: see Table 1.

Table 1: Cases Lodged								
Type	**2019/20**	2018/19	2017/18	2016/17	2015/16	2014/15	2013/14	2012/13
Deaths	**346**	313	305	299	291	290	295	324
Fires	**0**	2	3	0	1	683	846	1014
Disasters	**0**	0	0	0	0	0	0	0
Total Cases	**346**	**315**	**308**	**299**	**292**	**973**	**1141**	**1338**

This represents an increase of cases lodged of 9.8%, which cannot be explained by population growth alone. It is difficult to assess the reason for the increase in admissions.

Notably, the Court received reports of:

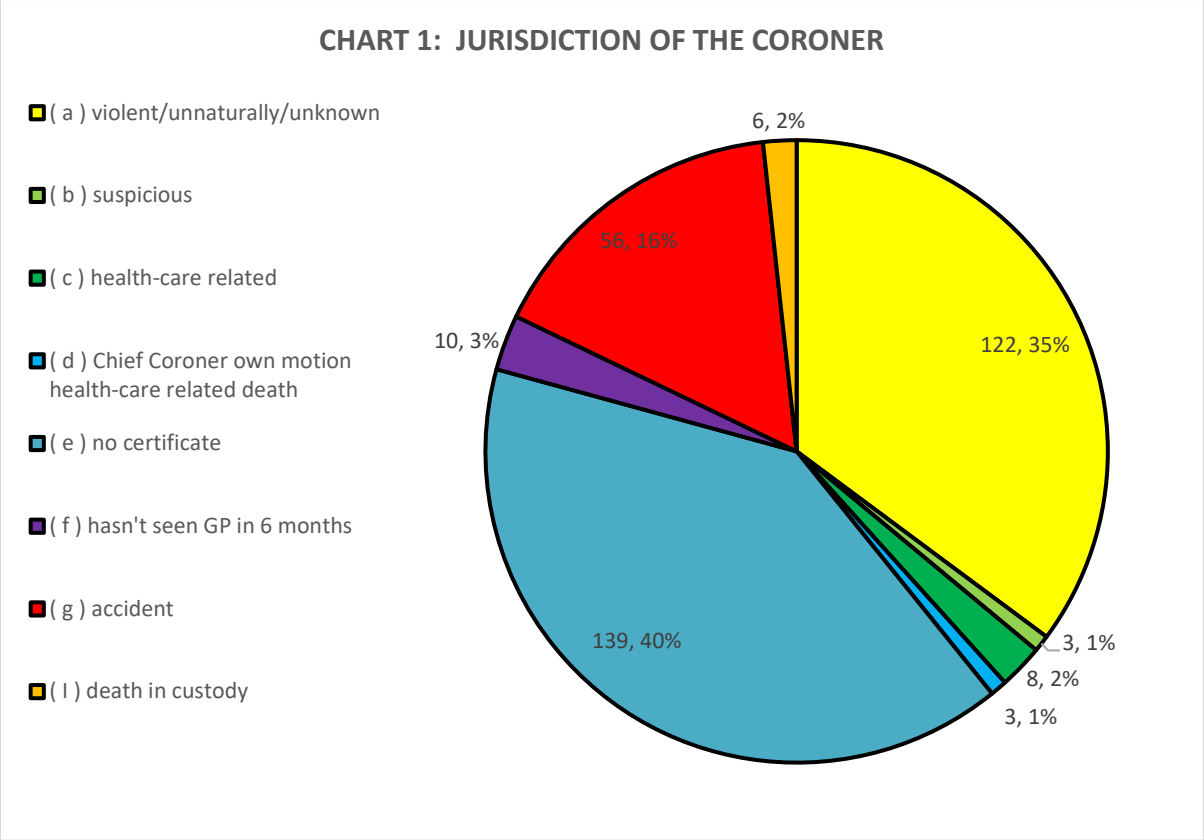
- 76 deaths of NSW residents which occurred within the ACT (16.17% of the total)- this represents a significant increase compared to 31 cases in the previous financial year.
- 1 death that occurred within the Jervis Bay Territory.

Type of Referral

This is the fourth year the Court has collected statistics on the head of jurisdiction under which matters have been referred, that is, the paragraph or paragraphs of subsection 13(1) of the Act under which the matter has been reported to a Coroner: see Table 2 and Chart 1.

Table 2: Jurisdiction of Coroner				
	2019/20	**2018/19**	2017/18	2016/17
(a) - violent/unnatural/unknown[1]	**122 (35%)**	86 (27%)	101 (32%)	61 (19%)
(b) - suspicious	**3 (1%)**	1 (0.3%)	5 (2%)	10 (3%)
(c) - health-care related death	**8 (2%)**	28 (9%)	17 (5%)	21 (6%)
(d) - Chief Coroner own motion health-care related death	**3 (1%)**	2 (0.6%)	0	0
(e) - no certificate provided by doctor	**139 (40%)**	139 (44%)	130 (41%)	157 (48%)
(f) - no attendance by a doctor in 6 months	**10 (3%)**	8 (3%)	7 (2%)	8 (2%)
(g) - accident	**56 (16%)**	46 (15%)	49 (16%)	66 (20%)
(h) - Attorney-General direction	**0**	0	0	0
(i) - death in custody	**6 (2%)**	2 (0.6%)	7 (2%)	3 (1%)

[1] As provided in section 13(1) of the Coroner's Act. Subsections abbreviated for ease of reference.



Across the jurisdiction of the coroner there was a marked increase in deaths reported as occurring in violent, unnatural or unknown circumstances: section 13(1)(a). As I note every year, these figures need to be considered in context. Firstly, these numbers reflect only the basis on which a matter is referred to the Coroner by Police and do not reflect the ultimate findings made by a Coroner. Secondly, matters may be referred under multiple heads of jurisdiction such as (hypothetically) a suspicious death in custody.

Hearings / Attendances

The Court maintained a busy hearing schedule in 2019/20: see Table 3

Table 3: Attendances								
	2019/2020	2018/19	2017/18	2016/17	2015/16	2014/15	2013/14	2012/13
No. of hearings	**15**	8	6	8	16	9	11	16
No. of attendances	**46**	49	50	57	72	31	93	92
Attendance indicator	**3.1**	6.1	8.3	7.1	4.5	3.4	8.5	5.8
Hearing time (days)	**55**	27	37	28	-	-	-	-

The number of attendances is the number of times that parties, or their representatives are required to be present in court for inquests that were finalised in that year, irrespective of the timing of a hearing. This is a very raw number: a 15 minute directions hearing is recorded in exactly the same way as a full day of court. The 'attendance indicator' is defined as the average number of attendances recorded (no matter when the attendance occurred) for those inquests that were finalised during the year. There are many reasons why an inquest is not finalised in the year in which the hearing was held, including but not limited to inquests which are:

- complex and lengthy
- traverse the end-of-financial-year period
- paused due to criminal or collateral proceedings on foot.

For those reasons, I requested statistics for the actual number of hearing days in the financial year, irrespective of whether the inquest in question was finalised. Internal court records show that in the 2019/20 year, the Court sat for 55 days of hearing time across all Coroners. This is again roughly double the number of sitting days in the previous year. Noting that COVID -19 necessitated a long pause in sitting days over several months, this is a proportionally large increase and reflects the number of

complex and ongoing inquests as well as the focus of the Court to finalise matters in which a hearing must be held.

Cases Finalised

The majority of matters are completed by in-chambers findings without the necessity to proceed to a public hearing: see Table 4.

Table 4: Cases Finalised								
Type	**2019/20**	2018/19	2017/18	2016/17	2015/16	2014/15	2013/14	2012/13
With a Hearing	**15**	8	6	8	16	9	14	16
Deaths	**15**	8	6	8	16	9	12	12
Fires	**0**	0	0	0	0	0	2	4
Disasters	**0**	0	0	0	0	0	0	0
By Chambers decision	**344**	333	294	297	234	1007	1171	1375
Deaths	**340**	330	294	297	234	305	317	376
Fires	**4**	3	0	0	0	702	854	999
Disasters	**0**	0	0	0	0	0	0	0
Total Cases	**359**	341	300	305	250	1016	1185	1391
% Hearing Rate	**4.2**	2.3	2.0	2.6	6.4	3.0 *	4.4 *	4.2 *

Matters which resolved without the need to proceed to hearing constitute 95.8% of all inquests finalised in the 2019/20 year.

The Court achieved a clearance rate of 104.6% over the 2019/2020 reporting period. In other words, the Court finalised a higher number of cases than the number of cases lodged with the Court during the same period. This is a fine effort that reflects the hard work of Coroners and support staff over the past

year both to ensure that routine inquests progress through the coronial system effectively and a commitment to finalise older matters.

Timeliness / Backlog

I am pleased to report that the number of inquests pending as at 30 June 2020 decreased again this year by a further 11% year on year: see Table 5.

Table 5: Pending Cases

Time Pending	**2019/2020**	2018/19	2017/18	2016/17	2015/16	2014/15	2013/14	2012/13
< 12 months	**69**	66	92	95	108	84	97	149
> 12 months < 24 months	**20**	31	38	35	23	20	26	45
> 24 months	**47**	52	46	34	27	33	27	40
Total Pending	**136**	158	176	164	169	137	150	234
% of year deaths lodgements	**39**	50	57	55	58	47	51	72

Long term pending cases decreased year on year, showing the Court's continued focus on outstanding matters. I am pleased to report that in 2019/20, the Court finalised 44 cases which were older than 12 months old.

Overall 'pending cases' represents just 39% of the lodged cases in the year. This is the lowest number of pending cases reported in the Territory in recent times and a notable improvement on previous years. Again, this figure reflects the hard work and dedication of the Coronial team.

Pending cases figures include matters where related criminal charges are on foot or contemplated and either the inquest is formally statutorily paused under sections 58 and 58A of the Act, or a Coroner has otherwise decided that it would be inappropriate to continue with the inquest until after the finalisation of the criminal proceedings or investigation (either in the ACT or elsewhere).

We undertook more hearings this year than last year. Again, the hearings were generally more complex and lengthier than some of the cases in previous years. I again note that as these statistics report only on matters finalised in the reporting year, they do not reflect a number of significant lengthy hearing

matters which are yet to be finalised, such as the Wood inquest and The Canberra Hospital suicides inquests, which each had more than three weeks of hearing in the 2017/2018 year and further sitting days in the 2019/2020 year after statutory pauses. These matters remain our longest outstanding matters.

The national benchmark for Coroners Courts is that 90% of matters take less than 12 months to finalise. The Court came extremely close to this target in 2019/2020, with 88% of matters finalised in that timeframe: see Table 6.

This result compares very favourably with previous results. Although of course it is preferable to hit targets rather than not, this is a commendable achievement in light of the increase in cases lodged in this reporting period, some delays on receiving toxicology results from ACT Government Analytical Laboratory (ACTGAL) from March 2020 and the impact more generally of COVID-19 restrictions on the business of the Court.

Table 6: On-time case processing indicator

	2019/20	2018/19	2017/18	2016/17
%	**88**	88	91	92

Overall, the median number of days taken to finalise a matter from the time it was reported to the Court was 60 days: see Table 7.

Table 7: Median days to finalisation

	2019/20	2018/19	2017/18	2016/17	2015/16	2014/15
Days	**60**	76	92	94	75	83

FORENSIC MEDICINE CENTRE

The Forensic Medicine Centre (FMC) admitted 470 cases during the 2019/2020 reporting period.[2] From this, there were 60 Medical Certificate Cause of Death (MCCD) issued (48 for ACT and 12 for NSW) and the admission was not referred to the Coroner. This usually occurs when there is a delay in obtaining a MCCD and the deceased person is transported to the FMC pending the GP issuing a MCCD. There were also 8 admissions for temporary storage of deceased persons (5 for the Canberra Hospital, 1 for Calvary Hospital, 1 for Clare Holland House and 1 admission for temporary storage of human remains from a NSW incident, pending transport to Sydney for DVI investigation): see Table 8.

Table 8: Total Admissions to FMC

	ACT	**NSW**	**TOTAL**
Coronial Admissions	338	64	**402**
Medical Certificate	48	12	**60**
Temporary Storage	7	1	**8**
TOTAL ADMISSIONS	**393**	**77**	**470**

[2] 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 and where a referral to the Coroner's Court is accepted without the body of the deceased person being admitted to the FMC.

There was an average of 33 coronial admissions per month (28 ACT cases and 5 NSW cases), and an average of 5 MCCDs admitted per month (4 ACT and 1 NSW). See: Chart 2

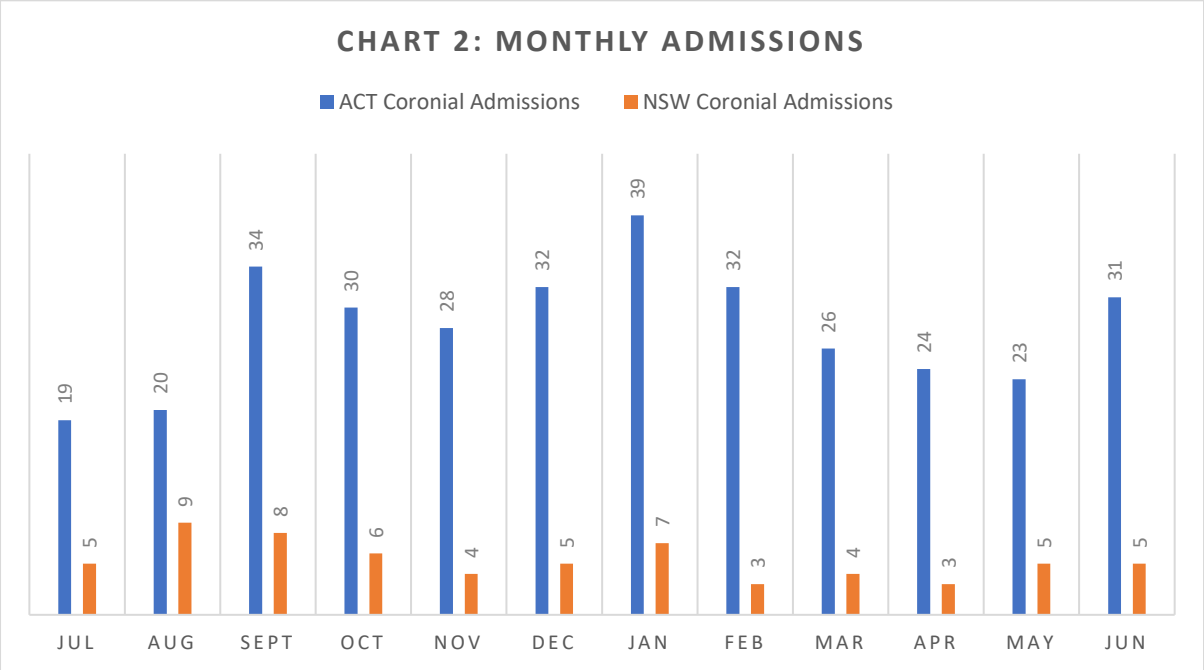
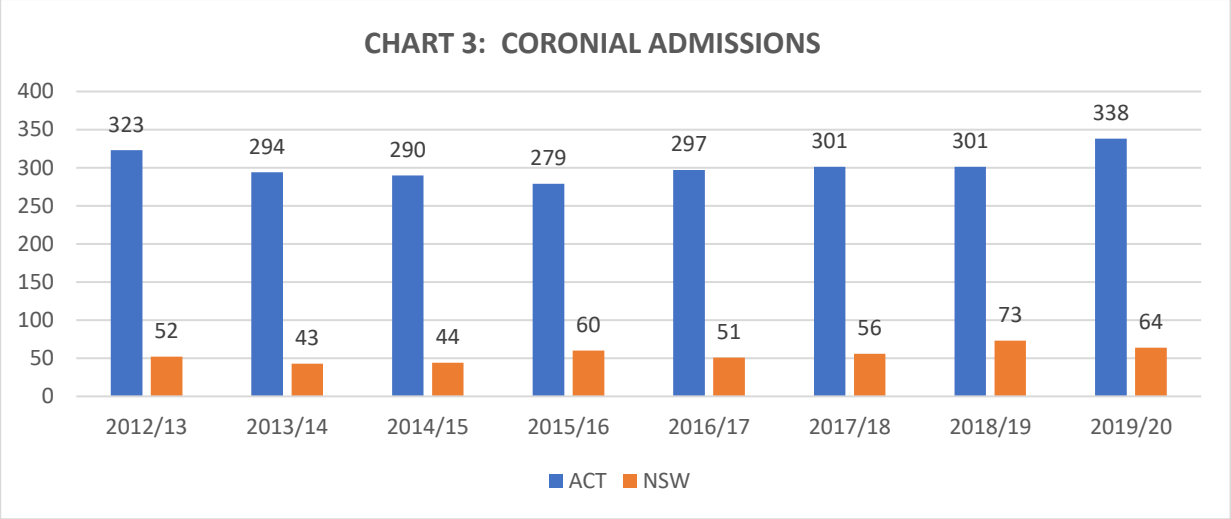


Table 9 and Chart 3 show the annual number of coronial admissions since 2012/2013.

Table 9: Annual Coronial Admissions			
Year	**ACT**	**NSW**	**TOTAL**
2012/13	323	52	375
2013/14	294	43	337
2014/15	290	44	334
2015/16	279	60	339
2016/17	297	51	348
2017/18	301	56	357
2018/19	301	73	374
2019/20	**338**	**64**	**402**



There has been a steady increase in the number of annual coronial admissions in the Territory in recent years, with an increase from 374 in 2018/19 to 402 in 2019/20.

Post mortem examinations

Of the 402 coronial admissions to the FMC, 393 required a post mortem examination, comprising 335 ACT cases and 58 NSW cases (3 ACT cases either medical record review or transferred to NSW facility, and 6 NSW cases where a Coroner's certificate was issued after case assessment by the state duty pathologist). Of these, 237 required an invasive post mortem (198 ACT cases and 39 NSW cases) and 156 cases required only an external post mortem to determine cause of death (137 ACT cases and 19 NSW cases).

Table 10: Post mortem examinations – 2019/2020			
	ACT	**NSW**	**TOTAL**
Internal post mortem	198	39	**237**
External post mortem	137	19	**156**
TOTAL ADMISSIONS	**335**	**58**	**393**

The total number of post mortems conducted at the FMC is higher than the previous reporting periods: see Table 11. This is due to the increase in ACT cases, as the number of NSW cases requiring internal post mortem decreased from the previous year.

Table 11: Post-Mortem Examinations (ACT cases)			
Year	**Total Examinations**	**Invasive Autopsy**	**External Examination (% of total)**
2007	392	388	4 (1.0%)
2008	405	400	5 (1.2%)
2009	427	420	7 (1.6%)
2010	385	374	11 (2.9%)
2011	373	362	11 (2.9%)
2012	394	345	49 (12.5%)
2013/14	295	238	57 (19.5%)
2014/15	290	215	75 (25.9%)
2015/16	279	207	72 (25.8%)
2016/17	297	215	82 (27.6%)
2017/18	301	196	105 (34.9%)
2018/19	301	198	103 (34.2%)
2019/20	**335**	**198**	**137 (40.9%)**

Period of admission

On average, it took 2.6 days from the time of admission to the time of conducting a post mortem examination. The median number was two days. The average number of days from post mortem to release from the FMC was 7.7 days and the median is three days. Overall, the average length of admission at the FMC was 10.2 days, with a median of six days: see Table 12.

There were 13 ACT cases and four NSW cases that were in the FMC for greater than 30 days. The reasons for the extensive times in the FMC included cases waiting to be formally identified and cases waiting for the making of destitute cremation arrangements.

Table 12: Average time in the FMC				
		Admission to PM	**PM to Release**	**Total time in FMC**
ACT	Average	2.4	7.4	9.8
	Median	2	3	6
NSW	Average	3.7	9.2	12.9
	Median	3	4	7
Overall	**Average**	**2.6**	**7.7**	**10.2**
	Median	**2**	**3**	**6**

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 the financial year 2019-2020 this KPI was achieved in 94.7% of cases: see Table 13. On 23 occasions the post mortem examination was performed on the day of admission.

Table 13: Percent of cases receiving PM in 5 days		
Admission to PM	**Number**	**Percent**
5 days or less	373	94.7
More than 5 days	21	5.3

Pathologists

Professor Johan Duflou continues to provide his services as a consultant forensic pathologist on a fee for service basis. In the absence of a resident forensic pathologist in the Territory, the majority of post mortem examinations are undertaken by Professor Duflou. Dr Sanjiv Jain, an anatomical pathologist, has performed a number of post mortem examinations during the reporting period as well. For extra cover during the year when the main pathologists were unavailable, forensic pathologists Dr Beng Ong and Dr Nathan Milne were able to assist with the caseload. Professor Peter Ellis also assisted with a homicide case when Professor Duflou was unavailable. The Court extends its gratitude to these doctors who provided their services throughout the year.

Mortuary Technicians

The FMC was staffed by six Mortuary Technicians. The FMC is in a position where the majority of assistance in theatre is done by permanent FMC staff. The FMC continues to rely on the services of casually employed Mortuary Technicians to assist with theatre work.

Toxicology

Throughout this reporting period, 164 Territory cases underwent toxicology analysis (48.5%). Of these, 146 were performed at ACTGAL and 17 were sent to Victorian Institute for Forensic Medicine (VIFM) for overnight screening. VIFM is used when rapid results are required as they perform an overnight screening which detects more than 300 common drugs and poisons and provide verbal results the following day. This is followed up with a formal report after quantitative analysis is performed. There was one ACT case sent to Forensic Analytical Science Service in NSW for testing due to specific analysis which was required. Of the NSW cases, 39 required toxicology analysis (67.2%).

Table 14 shows the average time taken for toxicology results to be reported on. This includes the number of days it takes to get samples sent to the laboratory (dropped off at ACTGAL or couriered interstate). The number of days between toxicology samples being sent out and receiving the results are also shown in the table.

Table 14: Toxicology Results

		PM to Tox out	**Toxicology out to report in**
ACT (ACTGAL)	Average	2.2	30.5
	Median	2	29
ACT (VIFM)	Average	-1.4	19.5
	Median	-2	15
NSW	Average	0.62	17.9
	Median	1	18

This year ACTGAL has improved its performance in reporting results. In the previous reporting period, ACTGAL averaged 35.3 days to report on results once received. This timeframe has reduced to an average of 30.5 days in 2019/20. This is higher than other reporting periods, as shown in Table 15. These results are usually the last piece of information that the pathologist requires before they submit their final report to the coroner.

Table 15: Average annual reporting days for ACTGAL							
	2019/20	2018/19	2017/18	2016/17	2015/16	2014/15	2013/14
Average days	**30.5**	35.3	21.7	26.9	26.3	26.5	24.5

Observers

In the previous reporting year I issued Coronial Practice Direction (CPD) No. 2 of 2018 to formalise the framework around which observers are permitted to attend the FMC for training and observing post mortem examinations. All observers attend with the approval of the Court and the approval from the deceased's Next of Kin.

As part of that CPD I committed to reporting each year the number and professional identity of the applicants/observers at the FMC. This year restrictions were placed on observers attending the FMC due to COVID-19. As such, the number of observers decreased significantly. Those who did attend after restrictions were in place abided by social distancing and the requirement to wear PPE as appropriate. Table 17 provides a general list of observers who attended the FMC.

Table 16: Observers attending the FMC		
ANU Medical Students	41	Observe PM
DFAT	77	Discussion/Tour/View deceased
AFP Forensics Gradual Exposure	32	Gradual Exposure
AFP Recruits	27	Discussion/Tour/View deceased
JMPF (ADFIS/ADFIC)	70	Tour/Fingerprinting/Photography
CFMS	4	Discussion/Tour
CIT	10	Discussion/Tour/View deceased
Donate Life	7	Discussion/Tour
TOTAL	**268**	

Not all observers viewed a post mortem examination. This was only done if relevant to their field, such as ANU medical students. All observers were given an overview of the coronial process and the role of

the FMC within that process. They were then given a tour of the facility. Most observers viewed a deceased person. The aim of this was to assist observers in their preparation for when their duties required that they work with deceased persons or their families. Members of the Australian Defence Force who attended as part of their investigative training also trained in photography and fingerprinting techniques. Traditionally AFP recruits have viewed a post mortem examination, however currently they only participate in the discussion, tour and viewing of a deceased person.

AFP forensic officers who are likely to be more exposed to deceased persons undertake a phased gradual exposure process. The members are assessed by a psychologist after each phase to ensure they are coping with the process and able to proceed to the next phase. The program consists of the following phases:

- Phase 1 – Tour of FMC including presentation of the coronial process
- Phase 2 – View/examine a deceased person (Intact and non-decomposed)
- Phase 3 – View a post mortem (non-decomposed)
- Phase 4 – View/examine a deceased person (at scene)
- Phase 5 – Exposure to a decomposed body in field/at FMC

Imaging

The FMC continued to utilise imaging services at The Canberra Hospital (TCH). CT scans are conducted out of hours at TCH and X-rays are performed at the FMC by TCH Imaging staff. There were 44 cases that had a CT scan performed at TCH (30 ACT cases and 14 NSW cases). There were 3 cases that had an X-Ray done (2 ACT and 1 NSW), and 3 cases where both CT and XR were done, all ACT cases.

The Court continued to engage Dr Derek Glenn to report on routine cases. Dr Mohamed Nasreddine has now been engaged to report on suspicious and complex cases at the request of Professor Duflou. This decision was made given Dr Nasreddine's formal qualifications in the field of forensic radiology and his current experience at NSW FMCCC.

Funding was received for a trial where all ACT coronial cases would receive a CT scan prior to post mortem examination (PMCT). The scans were completed at I-MED in Tuggeranong and were reported on by Dr Chris O'Donnell from I-MED, who is also an experienced forensic radiologist from VIFM. A total of 27 cases received PMCT. The effectiveness of the trial is under evaluation.

STAFFING AND RESOURCES

Coroners

Between August 2019 and April 2020 Magistrate Glenn Theakston assumed the role of Acting Chief Coroner due to my appointment as an Acting Judge of the ACT Supreme Court. As the COVID-19 health emergency began to impact upon the work of the courts, I resumed my duties as Chief Magistrate and Chief Coroner. I express my gratitude to Magistrate Theakston for his confident and effective leadership during this time.

The ACT Coroner's Court received no allocated resourcing for the performance of judicial coronial functions. Every magistrate retained an active coronial case load in 2019/20, but that case load was discharged as a secondary priority when duties as a magistrate commanded more immediate attention.

I make my call again for proper resourcing of the ACT Coroners Court and the appointment of a dedicated Coroner. My coronial colleagues and the staff of the Court do the best they can within the time available to them, and as this report demonstrates, have achieved truly remarkable results in the circumstances. A dedicated Coroner is the next step to professionalise the jurisdiction and to ensure consistency and efficiency in dealing with matters.

Administrative Staff

The administrative needs of the ACT Coroner's Court are met from within the ACT Courts and Tribunal Administration, a business unit of the Justice and Community Safety Directorate (JACS), by way of a small dedicated support section. Staff report to the Legal Manager and Counsel Assisting, who reports to the Registrar of the Magistrates Court.

In 2019/20, the Coroner's Court welcomed the introduction of a Family Liaison Officer to provide additional support to families and witnesses and to act as their primary point of contact with the Court. The primary function of the Family Liaison Officer is to explain the coronal process to persons impacted by the coronial process and to refer persons to external counselling and support agencies if required.

Counsel Assisting

The Act 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).

The Court has one dedicated legal position, which is the Legal Manager and Counsel Assisting. Part of the rationale for appointing a lawyer to the Coroners Unit is to enable the development of in-house advocacy capacity to provide inexpensive but specialised Counsel Assisting services to the Coroners, within operational capacities. This continues to prove beneficial and cost effective.

A number of cases were briefed to the private bar in 2019/20 due to the complexity of the matter or the capacity of our in-house practitioners. In such matters the Court's in-house practitioners provide legal support to Counsel Assisting as required.

Coroner's Investigators

Section 59 of the Act 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.

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. In matters where police are investigating deaths of other police members, or which involve police, we were able to develop in 2018/19 a suite of documents supporting a protocol to ensure that coronial investigators have sufficient independence from the AFP to properly investigate the matter.

The AFP provides an excellent service to the jurisdiction. It provides a dedicated unit – the ACT Coronial Liaison Unit – whose members who are the first point of contact in relation to possible reportable deaths, provide initial reports of deaths to the Coroner and subsequently perform coordination, liaison and investigative tasks as required. Members of the unit perform a valuable task in filtering out reports of deaths which do not fall within the Court's jurisdiction, which is highly efficient and obviates the need for additional work at the Court or by the Coroner.

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.

Other agencies such as Worksafe ACT have also readily supported the coronial investigative function in relevant matters.

ENGAGEMENT AND EDUCATION

Support services in the community

All Coroners are acutely aware that grieving families find the coronial process difficult. In 2019/20 Relationships Australia Canberra Region continued to receive funding from ACT Health to operate 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 impacted by the coronial process. Clients may receive ongoing counselling services at no cost during the coronial process and for up to three months after the coronial process has been concluded. There is regular engagement between the Service, Court and Police to ensure that persons in need of help and support are directed to the Service, and Counsellors also regularly act as advocates and provide support to family members in dealings with the Court. The feedback to the Court about the Service and individual counsellors is uniformly positive and I thank ACT Health and Relationships Australia for their support to the jurisdiction.

Direct Engagement

During the 2019/20 year, the Court and its staff engaged widely with groups and individuals whose interests intersect with the jurisdiction, including the Department of Foreign Affairs and Trade, the AFP's Disaster Victim Identification Commander, the Legislation, Policy and Programs area of the JACS Directorate, the ACT Coronial Reform Group, the ACT Human Rights Commission and the ACT Child & Young Person Death Review Committee. The Coroners Legal Manager also engaged in regular liaison meetings with key coronial stakeholders, including NCIS, Canberra Health Services, Calvary Hospital, ACTGAL, ACTAS and the AFP, and provided training to ACT F&R.

CORONIAL PRACTICE DIRECTIONS

Section 51A(2) of the Act permits the Chief Coroner to issue Coronial Practice Directions (CPDs) to prescribe practices and procedures for taking of steps in inquests and inquiries. I issued three new CPDs in 2019/20 as follows:

- CPD 1 of 2020 – Possible COVID-19 deaths referred to the Coroner issued 25 March 2020 (unpublished);
- Coroners Court Interim Covid-19 Measures issued 6 April 2020 (unpublished); and

- CDP 3 of 2020 Ancillary examination, post mortem examinations and movement of human remains throughout the PMCT Trial issued 11 May 2020 (unpublished).

COVID-19 PREPAREDNESS AND RESPONSE

The announcement of a public health emergency in the ACT on 16 March 2020 relating to the COVID-19 global pandemic was a matter of concern for all Canberrans. The Court undertook planning and preparation in the event that the ACT experienced a surge in deaths. As part of that preparation, a practice direction was issued on 25 March 2020 (CPD 1 of 2020) which prescribed practices for the management of suspected or confirmed cases of COVID-19 deaths in the ACT.

To ensure that the essential business of the Court continued, an Interim Coronial Practice Direction was issued on 6 April 2020 outlining measures designed to allow the Court to operate, while supporting the Government's response to the crisis and protecting court staff and users.

The FMC introduced a surge plan to prepare for a significant increase in admissions. The FMC was identified as a facility which had the capacity to store non-coronial deceased persons in the event of a delay in burials or cremations due to the number of deaths or unavailability of funeral or crematorium staff. As part of this surge plan, additional temporary racks were placed into the cool room facilities, increasing the capacity from 40 to 52. Four refrigerated shipping containers with the capacity to accommodate up to 30 to 40 deceased persons were placed at the FMC, with two of these fitted out with temporary racks. Thankfully these containers were not required.

Under the CPD, when a deceased person was admitted to the FMC with any recent flu like symptoms, a nasopharyngeal swab was taken and submitted to ACT Pathology. This was performed on 16 occasions and all tests returned a negative result.

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 Act '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 2019/2020 year, there were five inquests into deaths in custody finalised by a Coroner:

- Adrian Pitman (CD 64 of 2016);
- Anthony McKinnon (CD 203 of 2017);
- Lionel Williams (CD 254 of 2017);
- Filippo Onarato (CD 234 of 2018); and
- Ross Graham (CD 64 of 2020).

Summaries of these inquests, and the findings made, can be found later in this Report in the selected case notes section.

Paragraph 102(2)(b) matters – decisions not to conduct a hearing

Section 34 of the Act authorises Coroners to conduct hearings for inquests or inquiries. Section 34A prescribes 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, section 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 2019/20 year, there were 344 notices given by Coroners under subsection 34A(3), in respect of 340 deaths and 4 fires.

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 Act. 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.

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.

In 2019/20, six section 57 reports were made to the Attorney-General:

- Theodora Zaal (CD162 of 2015);
    - Sent to Attorney-General 7 August 2019. Presented by Minister Gentleman to the Legislative Assembly 7 May 2020.
- Joanne Lovelock (CD 261 of 2015);
    - Sent to Attorney-General 5 March 2020. Presented by Minister Gentleman 20 August 2020.
- Jandy Shea (CD 60 of 2018)
    - Sent to Attorney-General 24 September 2019. Presented by Minister Gentleman 23 July 2020.
- Adrian Pitman (CD 61 of 2016);
    - Sent to Attorney-General 15 September 2019. Not yet presented.
- Name suppressed (CD 139 of 2019);
    - Sent to Attorney-General 21 February 2020. Not yet presented.
- Name suppressed (CD 188 of 2019);
    - Sent to Attorney-General 2 January 2020. Not yet presented.

Paragraph 102(2)(d) matters – agency responses to 'deaths in custody'

Under section 74 of Act, Coroners are 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.

There were five inquests into deaths in custody finalised by a Coroner in the 2019/20 year:

- Adrian Pitman (CD 64 of 2016);
- Anthony McKinnon (CD 203 of 2017);
- Lionel Williams (CD 254 of 2017);
- Filippo Onarato (CD 234 of 2018); and
- Ross Graham (CD 64 of 2020).

The Government responses to these Coroners' reports have not yet been tabled.

SELECTED CASE NOTES

The following cases are reported as cases which require a mandatory report.

The name of a deceased person is included in the case note where a hearing has been held in which the name of the person has been made public, or where other action is taken which results in the publication of the deceased's name (such as presentation of coronial reports to the Legislative Assembly or publication of reasons on website). In other cases, or where the deceased person is of indigenous origin and their name has not been publicised, the name of the deceased person is withheld.

Full copies of coronial findings and recommendations are available by searching for cases via http://courts.act.gov.au/magistrates/judgment .

Reports under Paragraph 102(2)(a) matters – reports into 'deaths in custody'

Court Reference:	CD 64/16
Age:	55 years
Gender:	Male
Date of Death:	15 March 2016
Place of Death:	Fairburn Avenue, Campbell ACT
Coroner:	Stewart
Date of Findings:	14 October 2019
Reported as:	[2019] ACTCD 13

1. Adrian Pitman was born in 1961. There is no dispute that he died from multiple injuries after his car hit a stone retaining wall and caught on fire on Fairburn Avenue, Campbell, ACT. This happened at about 12.01 am on Tuesday 15 March 2016. The Court is aware of the sadness caused by my determination that the manner of Mr Pitman's death was suicide by intentional motor vehicle collision. Those interim findings were made on 13 June 2019.

…

2. At his time of death Mr Pitman was deemed to be in custody. This is because Mr Pitman was subject to a community-based Psychiatric Treatment Order ("PTO") through ACAT and under the *Mental Health (Care and Treatment) Act 1994* ("the MHCT Act"). Section 3C of the *Coroners Act 1997* ("the CA") dictates that when someone dies whilst subject to an order under the MHCT Act that death

is deemed to be a death in custody. [The MHCT Act has now been repealed and replaced by the *Mental Health Act 2015* with consequential amendments to the CA.]

3. Section 13(1)(k) of the CA mandates that an inquest must be held when there is a death in custody – thus my jurisdiction as a Coroner is enlivened. Further, under section 34A(2), I must hold a hearing for the purposes of my inquest.

…

49. Potapowicz is an Assistant Director of Traffic Safety at Transport Canberra and City Services. He conducted checks of Roads ACT records in relation to vehicle suicide risk at the intersection of Mount Ainslie Drive and Fairbairn Avenue in Campbell. Prior to Mr Pitman's death at that site, the rea was not known to be an intersection where there was a high risk of vehicle or crash-related suicides.

50. No action was taken in relation to this site following Mr Pitman's death on 15 March 2016. On 1 August 2017, another death occurred which was found subsequently by a Coroner to be a suicide attempt. There was also another attempted suicide at the site on 6 August 2017.

51. Following these events, temporary traffic measures were implemented on 11 August 2017. Consequently, a report was commissioned by Roads ACT for the recommendation of permanent measures. Work on the project, acting on the recommendations of the report, commenced on 12 May 2019.

52. At the time Mr Potapowicz gave his testimony, the substantive works on this intersection were mostly complete. A number of measures had been put in place for the purposes of traffic management in this area. Of note are the introduction of a permanent chicane, a deflection on the road on the approach to the intersection Fairbairn Avenue, greater street lighting, extensive line marking and a speed limit reduction.

53. In my view these measures have satisfied public safety concerns arising out of this incident.

…

70. 70.There was overwhelming evidence at the inquest of Mr Pitman's expressed desire to maintain confidentiality over his medical issues and treatment.

71. In these circumstances I can make no criticism of any failure to disclose to Mr Pitman's family.

72. Matters of public safety

73. Because of the changes that Roads ACT have made to the intersection of Mt Ainslie Drive and Fairburn Avenue Campbell since March 2016 I find that there is no longer a public safety issue at that intersection. There are no further public safety issues or recommendations arising from this inquest.

Court Reference:	CD203/17
Age:	48 years
Gender:	Male
Date of Death:	11/09/2017
Place of Death:	Belconnen, ACT
Coroner:	L.A. Walker
Date of Findings:	22/6/2020
Reported as:	N/A

1. Anthony James McKinnon died on 11 September 2017 at Totterdell Street, Belconnen in the Australian Capital Territory.

2. Mr McKinnon's death resulted from ischaemic heart disease. Influenza A infection was a contributory factor.

3. No matter of public safety arises.

4. Pursuant to section 74 of the Act there is no evidence that the quality of care, treatment or supervision of Mr McKinnon contributed to his death.

Court Reference:	CD 254/17
Age:	46 years
Gender:	Male
Date of Death:	7/11/2017
Place of Death:	Garran, ACT
Coroner:	B.C. Boss
Date of Findings:	13/03/2020
Reported as:	N/A

1. Mr Lionel Williams died on 7 November 2017 at The Canberra Hospital, Yamba Drive Garran in the Australian Capital Territory.

2. The cause of Mr Williams' death was liver failure due to hepatitis C virus cirrhosis.

3. The manner of Mr Williams' death was natural causes.

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

5. Pursuant to section 74 of the Act there is no evidence that the quality of care, treatment or supervision of Mr McKinnon contributed to his death.

Court Reference:	CD 234/18
Age:	56 years
Gender:	Male
Date of Death:	20/09/2018
Place of Death:	Ainslie, ACT
Coroner:	P.J. Morrison
Date of Findings:	10/01/2019
Reported as:	N/A

1 Filippo Onorato died on 20 September at Quick Street, Campbell in the Australian Capital Territory.

2. The cause of Mr Onorato's death was choking on food while under the influence of heroin.

3. Mr Onorato's death was as a result of an accident.

4. The cause of death was established by a post-mortem examination.

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

Court Reference:	CD 64/2020
Age:	44 years
Gender:	Male
Date of Death:	Between 18/02/2020 and 20/02/2020
Place of Death:	Gungahlin, ACT
Coroner:	L.E. Campbell
Date of Findings:	24/06/2020
Reported as:	N/A

1. Ross James Graham died at The Valley Avenue, Gungahlin in the Australian Capital Territory on a date within the date range of 18 February 2020 and 20 February 2020.

2. The manner and cause of death was aspiration pneumonia due to methadone toxicity.

3. The cause of death was established by a post-mortem examination.

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

Reports under Section 57 Reports made to the Attorney-General and tabled in the Legislative Assembly

Court Reference:	CD 162/15
Age:	75 years
Gender:	Female
Date of Death:	07/08/2015
Place of Death:	Bruce, ACT
Coroner:	B.C. Boss
Date of Findings:	6/11/2019
Reported as:	[2019] ACTCD 17

1. Theadora Zaal was a 75 year old woman when she was admitted to the Calvary John James Hospital on 7 August 2015 for debridement surgery on an ulcer on her left ankle and leg... Mrs Zaal agreed to undergo this surgery and it was booked for 7 August 2015.

…

14. The ACT Coroner has jurisdiction over Ms Zaal's death because at the time she died, the *Coroners Act 1997* required that all deaths of patients within 24 hours of having undergone surgery were reportable to the Coroner. (This time-based criterion has now been replaced with a causation-based criterion.)

15. I am required by section 52(1) of the *Coroners Act 1997* to make findings as to the identity of the deceased person, when and where they died, and the manner and cause of their death. I am also required by section 52(4)(a) of the *Coroners Act 1997* to state whether a matter of public safety is found to arise in connection with the inquest, and if I find such a matter, to comment upon it.

16. The then Chief Coroner Walker gave directions for the conduct of a post-mortem examination of Ms Zaal. A post mortem report was subsequently prepared by Associate Professor Sanjiv Jain dated 13 September 2015. In that report, A/Professor Jain recommended that former Chief Coroner Walker direct an expert review of Mrs Zaal's post-operative management at Calvary John James Hospital. He

declined to suggest a medical cause of death at that time, but noted that Mrs Zaal suffered from aortic stenosis (of moderate to severe severity), coronary artery disease and left ventricular hypertrophy, and there were no suspicious circumstances surrounding Mrs Zaal's death.

17.Additionally, the Court had been contacted by Mrs Zaal's family shortly after the death to express concerns that there may have been a delay in defibrillating Mrs Zaal due to the unfamiliarity of staff with a new defibrillator.

…

19. At the direction of former Chief Coroner Walker a brief of evidence was prepared by Constable Stevenson of the AFP, including statements from all the key treating professionals involved with Mrs Zaal's surgery and resuscitation. The statements were taken at a point in time before Dr Stachowski's report was available.

20.I also provided a copy of the brief of evidence and Dr Stachowski's report to Calvary John James Hospital for their review and comment.

…

46. In all the circumstances, in my view there is no necessity to hold a public hearing in relation to Mrs Zaal's death, and her manner and cause of death are sufficiently disclosed. I believe I have all the evidence which exists or is likely to exist which could possibly bear on the decisions I must make. There is no issue about which I would be empowered to hold a public hearing and which in and of itself warrants that course being taken.

47. On the basis of the facts above, I make the findings of fact required under the *Coroners Act 1997* as follows:

> Theadora Zaal died on 7 August 2015 at Calvary John James Hospital, 173 Strickland Crescent, Deakin in the Australian Capital Territory; and
>
> The manner and cause of Ms Zaal's death is cardiac arrest, in the context of aortic stenosis (of moderate to severe severity), coronary artery disease and left ventricular hypertrophy.

48. I have found two matters of public safety arise in connection with this inquest:

a. insufficient medical coverage of the wards; and

b. a lack of appropriately trained staff in life saving technique.

49.Calvary John James Hospital disputes that there were any matters of public safety arising from the manner in which Mrs Zaal's resuscitation was carried out; however it also informs me that it has implemented a plan to have all of its ICU staff trained in ALS by the end of 2019, and after Mrs Zaal's death it provided a supplementary training session for ICU staff in using the defibrillator. On that basis I am satisfied that the risk to public safety in respect of the defibrillation process employed in the attempted resuscitation of Mrs Zaal is sufficiently ameliorated.

50. I make the following recommendations:

a. I recommend that Calvary John James Hospital implement training and changes to procedures such that where a discretion is exercised to not make a MET call that is otherwise warranted, the exercise of that discretion and the reasons behind it should be formally recorded in the patient progress notes to put beyond doubt that patient warning signs have not been overlooked or disregarded accordingly.

b. I recommend that Calvary John James Hospital undertake as a matter of priority an audit of its central cardiac monitoring systems and defibrillators to ensure that they are all operating correctly and that there is no discrepancy between the rhythms being detected on each machine when used on patients.

c. I recommend that Calvary John James Hospital undertake refresher training of its staff as to the importance of keeping accurate records, and specifically, the need to properly scribe resuscitation efforts.

d. I recommend that Calvary John James Hospital consider rostering two RMOs on duty to deal with emergencies during peak surgery times when many VMOs and other doctors will be in surgery on other cases:

51. I direct that a copy of my findings and recommendations be forwarded to the Attorney-General, the Minister for Health, and the Little Company of Mary (who operate Calvary John James Hospital), for their information. I also direct that these findings be published in due course on the Coroner's Court website, together with any response I receive in relation to my findings and recommendations.

52. I extend my condolences to Mrs Zaal's family, friends and work colleagues. I acknowledge in particular the efforts of Dominic Zaal in advocating for his mother.

Court Reference:	CD 60/18
Age:	27 years
Gender:	Female
Date of Death:	04/03/2018
Place of Death:	Gordon, ACT
Coroner:	B.C. Boss
Date of Findings:	20/09/2019
Reported as:	[2019] ACTCD 12

1. The death of Jandy Renia Shea, a 27 year old woman at the date of her death, was reported to then ACT Chief Coroner Walker as she was thought to have died unnaturally in unknown circumstances.

2. Shortly after Jandy's death was reported, her parents, Renia and David Ferguson, contacted Police to suggest that Jandy might have died as the result of the actions of another person. Accordingly Chief Coroner Walker directed a police investigation into the events of Ms Shea's death occur.

…

4. The then Chief Coroner had prepared draft findings in this matter, and caused a section 55 notice to be forwarded before her appointment as an acting Judge. I have had an opportunity to review all of the evidence that was before the then Chief Coroner. I have had an opportunity to consider that evidence, the submissions made, and the findings drafted for publication by the then Chief Coroner. I find no reason to alter the conclusions drawn from the evidence and the proposed findings and recommendation articulated by the then Chief Coroner.

5. I am satisfied on review of the available evidence that there is no utility in a public hearing. I make the following factual findings.

….

<u>Adverse Comments and Findings</u>

47. Subsection 55(1) of the Act provides as follows:

A coroner must not include in a finding or report under this Act (including an annual report) a comment adverse to a person identifiable from the finding or report unless the coroner has, making the finding or report, taken all reasonable steps to give to the person a copy of the proposed comment

and a written notice advising the person that, within a specified period (being not more than 28 days and not less than 14 days after the date of the notice), the person may

(a) make a submission to the coroner in relation to the proposed comment; or

(b) give to the coroner a written statement in relation to it.

48. In making findings and comments of this type, I have regard to the principle laid down in in *Briginshaw v Briginshaw* (1938) 60 CLR 336 as stated by Dixon J at 361-3:

"The truth is that, when the law requires the proof of any fact, the tribunal must feel an actual persuasion of its occurrence or existence before it can be found. ... Except upon criminal issues to be proven by the prosecution, it is enough that the affirmative of an allegation is made out to the reasonable satisfaction of the tribunal. But reasonable satisfaction is not a state of mind that is attained or established independently of the nature and consequence of the fact or facts to be proved. The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding are considerations which must affect the answer to the question whether the issue has been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences. It is often said that such an issue as fraud must be proved "clearly", "unequivocally", "strictly" or "with certainty" (case references omitted). *This does not mean that some standard of persuasion is fixed intermediate between the satisfaction beyond reasonable doubt required upon a criminal inquest and the reasonable satisfaction which in a civil issue may, not must, be based on a preponderance of probability. It means that the nature of the issue necessarily affects the process by which reasonable satisfaction is attained. When, in a civil proceeding, a question arises whether a crime has been committed, the standard of persuasion is, according to the better opinion, the same as upon other civil issues* (case references omitted). *But, consistently with this opinion, weight is given to the presumption of innocence and exactness of proof is expected."*

49. As I noted above, while she still had carriage of the matter, the then Chief Coroner had prepared draft findings in this matter, and caused a section 55 notice to be forwarded to Christopher Shea in relation to a proposed adverse comment and finding. Mr Shea, through his legal representatives, made submissions that the adverse comment and finding should not be made. It was suggested that much of the evidence relied upon by the then Chief Coroner was opinion information provided to Police after Jandy's death, and possibly influenced by her passing. It was also submitted that there was no psychological evidence before the then Chief Coroner about Jandy's mental state immediately prior to her death and that in circumstances where there were multiple stressors in Jandy's life, it would not be

appropriate to single out Chris. References were made to *Briginshaw* and particularly the quote in relation to *"inexact proofs, indefinite testimony, or indirect inferences".*

50. I have carefully considered the submissions put forward on behalf of Chris and revisited the evidence in light of those submissions. I accept that the childhood sexual assault was a significant stressor and contributor to Jandy's mental health. But the proposed adverse comment was put in terms of a contribution towards Jandy's decision to end her own life, not as the sole or primary contribution. I have had regard to the passage in *Briginishaw* I was taken to and its context. I am satisfied that the evidence relied on to support the adverse comment and finding are not *"inexact proofs, indefinite testimony, or indirect inferences".* I note that the evidence before me includes contemporaneous videos, text messages and Facebook messages involving Jandy or including Jandy. I am satisfied in my own right, and to a level of reasonable satisfaction, that it is appropriate to make the proposed adverse comment and finding contemplated by the then Chief Coroner.

51. I therefore find that there is no evidence that Chris directly caused Jandy's death or was otherwise involved in her hanging. However, I am satisfied that Chris's conduct towards her contributed to Jandy's decision to end her own life, and I so find.

…

52. In all the circumstances, in my view, there is no utility in holding a public hearing in relation to Jandy's death.

53. I recommend that the ACT Government create a register of family violence perpetrators on which those convicted of a serious criminal offence against a family member shall be recorded. I direct that copies of my findings and recommendation be forwarded to the Attorney-General, the Minister for the Prevention of Domestic and Family Violence, and the Office of the Coordinator-General for Family Safety for their consideration.

54. I direct that these findings be published in due course on the Coroner's Court website.

55. I thank First Constable Joel Williams for the thorough investigation he undertook of Jandy's death.

56. I extend my condolences to Jandy's family and friends.

Court Reference:	CD 261/15
Age:	53 years
Gender:	Female

Date of Death: 04/03/2018

Place of Death: Gordon, ACT

Coroner: G.S Theakston

Date of Findings: 24 /02/2020

Reported as: [2020] ACTCD 1

1.The death of Joanne Lea Lovelock, a 53 year old woman at the date of her death, was reported to the ACT Coroner on 25 December 2015 in accordance with section 13(1)(a) of the *Coroners Act 1997*, as she was thought to have died unnaturally in unknown circumstances.

…

3.Ms Lovelock had a complicated medical history. She had suffered a leg injury about 12 years prior to her death, and suffered from chronic pain in her leg, back and hips as a result. Ms Lovelock also suffered from atrial fibrillation and a hernia. She was described by her family as being a heavy smoker and social drinker, with no apparent suicidal thoughts. Ms Lovelock had previously used heroin for a short period 20 years prior but was able to stop by way of engagement with the Methadone program.

…

5. Then Chief Coroner Walker initially had carriage of this matter. Her Honour directed that a post-mortem examination of Ms Lovelock take place. Associate Professor Jain undertook that examination and opined that Ms Lovelock died from the combined effects of alcohol, Amitryptyline and Methadone. There was no evidence of injury located, but toxicological testing of Ms Lovelock's blood identified the following:

c. Alcohol was present at 0.289 g/100 ml of blood (by way of reference, the driving limit is 0.05 g/100 ml), and this level of alcohol has been reported to produce both toxic and lethal effects;

d. Amitryptyline at 0.30 mg/L of blood, and this level has been reported to produce both toxic and lethal effects; and

e. Methadone at 0.24 mg/L of blood, and this level has also been reported to produce both toxic and lethal effects.

Other substances located in Ms Lovelock's blood at lower or trace levels were Diazepam (Valium) and its metabolite Nordiazepam), Oxycodone, Promethazine, Codeine, and Morphine (but this is also a metabolite of Methadone).

…

9. I am also required by section 52(4)(a) of the *Coroners Act 1997* to state whether a matter of public safety is found to arise in connection with the inquest, and if I find such a matter, to comment upon it.

10. The matter of public safety evident in this case is the prescription medications that Ms Lovelock was able to access, and which ultimately contributed to her death. This is both an issue of general public importance, but I also examine the issue from the perspective of whether the individual doctors who prescribed medications to Ms Lovelock acted appropriately in all the circumstances.

…

22. It is of some concern that when Dr Sutherland caused the Doctor Shopping Phoneline to be contacted and was advised that Ms Lovelock was not identified as a doctor shopper. This Phoneline is now known as the Prescription Shopping Information Service (PSIS), which is part of the Prescription Shopping Programme (PSP) run by the Federal Department of Human Services. It is not clear to me exactly how this system or its equivalent operated in the past, but I presume it was along similar lines to how it is presently run, by which I understand:

    a. It has access to Pharmaceutical Benefits System (PBS) data via pharmacies;

    b. The data is updated every 24 hours;

    c. Patients meet the PSP criteria if in any three month period, they received:

        i. PBS items from six or more prescribers; or

        ii. 25 or more PBS target items (there is a list available at https://www.humanservices.gov.au/organisations/health-professionals/services/medicare/prescription-shopping-programme but for current purposes it is sufficient to note that the list includes Methadone, Codeine, Amitriptyline, Oxycodone and many other prescription drugs of dependence); or

        iii. 50 or more PBS items irrespective of whether they are targeted items; and

d. It is not a proactive identification system but relies upon doctors holding sufficient concerns to call the PSIS to obtain information, whereby they are given point-in-time advice as to whether the patient meets the PSP criteria in respect of the last three months.

23. Certainly, by the year immediately before her death, Ms Lovelock met the PSP criteria on multiple bases in order to have been identified as a doctor shopper. However, given its point-in-time nature, and the lengthy period over which Dr Sutherland treated Ms Lovelock, it is entirely conceivable that when the practice contacted the Doctor Shopping Phoneline the advice that Ms Lovelock did not meet the doctor shopping criteria was correct at that point in time. If the PSIS had been contacted by a doctor in 2015, I consider it possible that the advice provided would have been that Ms Lovelock was a doctor shopper. However, it is clear from the statements received from her treating doctors that at no time did her conduct or presentation raise any concerns for them about addictive or drug seeking behaviours, and certainly not to a level at which I could find they should have contacted the PSIS in 2015.

24. On that basis I do not think any referral to AHPRA is warranted in respect of individual doctors who treated Ms Lovelock in the last year of her life. I find that no matter of public safety arises in respect of the treatment of Ms Lovelock by individual doctors.

25. Easy access to opioid painkillers and other medications by drug dependent persons has been recognised as a matter of public safety by a number of Coroners around Australia, and specifically recently in the ACT in the *Inquest into the death of Suellen Edith Davis* [2018] ACTCD 10, the *Inquest into the death of Lauren Maree Johnstone* [2019] ACTCD 5, and the *Inquest into the death of Jay Alan Paterson* [2019] ACTCD 6. In these cases, ACT Coroners have made recommendations in support of expanding the ambit of the Drugs and Poisons Information System Online Remote Access system ('DORA') in operation in the ACT, as well as the need for a real time prescription monitoring system in NSW, ideally as part of a national system.

26. I find, pursuant to s 52(4)(a)(i) of the *Coroners Act 1997*, that a matter of public safety – being the easy access to prescription medications by drug dependent persons – is found to arise in connection with this inquest.

27. This case demonstrates why a proactive system of identifying drug dependent persons is required, rather than point-in-time information provided under the PSIS. Had a system existed in the PSP to audit PBS data on such a basis, Ms Lovelock could have been identified as a doctor shopper early

on, her doctors informed, and prescriptions then issued by her doctors with a much better understanding of the medications she was already receiving.

28. In all the circumstances, in my view there is no need to hold a public hearing in relation to Ms Lovelock's death. I believe I have all the evidence which exists or is likely to exist which could possibly bear on the decisions I must make. There is no issue about which I would be empowered to hold a public hearing and which in and of itself warrants that course being taken. I note specifically in this regard the ACT Coroners Court has in the last few years held hearings in a number of doctor shopping and/or prescription drug misuse deaths, including the cases I have listed above. Furthermore, my ability to make recommendations is not predicated on the holding of a hearing.

29. I add my voice to that of other ACT Coroners, and NSW Deputy State Coroner Grahame in the matter of *Inquest into the deaths of DB, RG, AH, JD, DC & AB* (delivered on 1 March 2019), in that I also recommend a national, real time prescription monitoring system be instituted, with such system to include a proactive auditing and identification function to identify drug dependent persons. I note that while the ACT DORA system does potentially include proactive auditing functionality, it does not do so for as wide a target list as does the PSP.

30. I direct that these findings be published in due course on the Coroner's Court website. I also direct that any response to my recommendations also be published on the Court website.

31. I extend my condolences to Ms Lovelock's family and friends. I hope my recommendations act as a significant legacy from her untimely death.