Office of Chief Coroner
Law Courts of the ACT
GPO Box 370
Canberra City ACT 2601
Telephone: (02) 620 59562

Mr Gordon Ramsay MLA
Attorney-General
ACT Legislative Assembly
GPO Box 1020
CANBERRA ACT 2601

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 2019.

Yours sincerely

Lorraine Walker
Chief Coroner

Date: 30 July 2019

ACT CORONER'S COURT

ANNUAL REPORT 2018/19

[Coroners Act, section 102]

The Irish Strawberry Tree I planted at the ACT Forensic Medicine Centre, Phillip, on 4 June 2019 to commemorate those we in the Coroners Court have cared for and whose lives we have touched

Issued at the direction of
Chief Coroner Lorraine Walker

30 July 2019

TABLE OF CONTENTS

Coroners Act 1997 (excerpt)

s102 Annual report of court

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

(2) The report must include particulars of—

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

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

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

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

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

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

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

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

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

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

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

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

(9) If the Chief 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	**2018/19**	2017/18	2016/17	2015/16	2014/15	2013/14	2012/13
Deaths	**313**	305	299	291	290	295	324
Fires	**2**	3	0	1	683	846	1014
Disasters	**0**	0	0	0	0	0	0
Total Cases	***315***	*308*	*299*	*292*	*973*	*1141*	*1338*

Of note the Court received reports of:

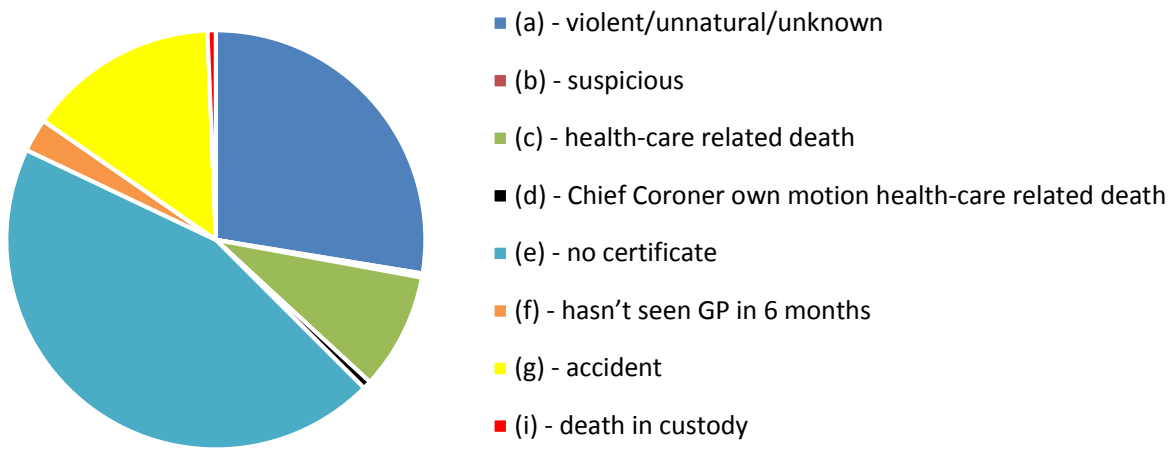
- 31 deaths of NSW residents which occurred within the ACT (9.8% of the total), as well as 1 death of a WA resident, and 1 death of a Queensland resident;
- 1 death that occurred within the Jervis Bay Territory; and
- 2 deaths which were referred to the Court directly by the families of the deceased.

Type of Referral

This is the third year the Court has been collecting statistics on the head of jurisdiction under which matters have been referred, which is to say, the specific 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: Heads of Jurisdiction	**2018/19**	2017/18	2016/17
(a) - violent/unnatural/unknown	**86 (27%)**	101 (32%)	61 (19%)
(b) - suspicious	**1 (0.3%)**	5 (2%)	10 (3%)
(c) - health-care related death	**28 (9%)**	17 (5%)	21 (6%)
(d) - Chief Coroner own motion health-care related death	**2 (0.6%)**	0	0
(e) - no certificate	**139 (44%)**	130 (41%)	157 (48%)
(f) - hasn't seen GP in 6 months	**8 (3%)**	7 (2%)	8 (2%)
(g) - accident	**46 (15%)**	49 (16%)	66 (20%)
(h) - Attorney-General direction	**0**	0	0
(i) - death in custody	**2 (0.6%)**	7 (2%)	3 (1%)

Chart 1: Heads of Jurisdiction



These numbers reflect the basis on which a matter is referred to the Coroner by Police, not necessarily the ultimate findings made by a Coroner. Matters may be referred under multiple heads of jurisdiction such as (hypothetically) a suspicious death in custody.

Hearings / Attendances

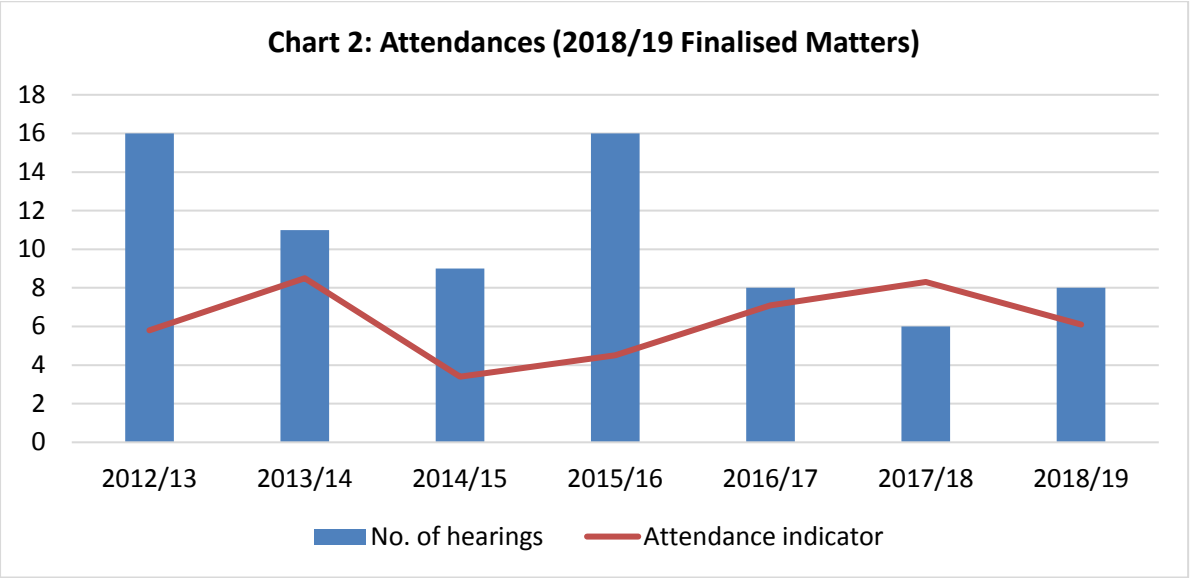
The Court kept up a busy hearing schedule in 2018/19: see Table 3 and Chart 2.

Table 3: Attendances

	2018/19	2017/18	2016/17	2015/16	2014/15	2013/14	2012/13
No. of hearings	**8**	6	8	16	9	11	16
No. of attendances	**49**	50	57	72	31	93	92
Attendance indicator	**6.1**	8.3	7.1	4.5	3.4	8.5	5.8
Hearing time (days)	**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 when the hearing was held. It 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 various 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, inquests which straddle the end-of-financial-year period, as well as inquests which are paused due to criminal or collateral proceedings. The Wood inquest is an example of a paused inquest, as I am presently injuncted from continuing the inquest pending the finalisation of related criminal proceedings, as well as an appeal against my decision to continue the inquest and



subpoena a particular witness; special leave was also granted by the High Court of Australia in relation to a point of law about the extension of the privilege against self-incrimination in coercive proceedings for corporate agents, possibly to be heard in November 2019. For these reason, I requested that statistics be obtained as to the actual number of hearing days for which the Court sat in the financial year irrespective of whether the inquest in question was finalised. Court records show that in the 2018/19 year, the Court sat for 27 days of hearing time across all Coroners.

Cases Finalised

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

Table 4: Cases Finalised

Type	**2018/19**	2017/18	2016/17	2015/16	2014/15	2013/14	2012/13
With a Hearing	***8***	*6*	*8*	*16*	*9*	*14*	*16*
Deaths	**8**	6	8	16	9	12	12
Fires	**0**	0	0	0	0	2	4
Disasters	**0**	0	0	0	0	0	0
By Chambers decision	***333***	*294*	*297*	*234*	*1007*	*1171*	*1375*
Deaths	**330**	294	297	234	305	317	376
Fires	**3**	0	0	0	702	854	999
Disasters	**0**	0	0	0	0	0	0
Total Cases	***341***	*300*	*305*	*250*	*1016*	*1185*	*1391*

Matters resolved without hearing constitute 97% of all inquests into deaths finalised in the 2018/19 year. The Court achieved a clearance rate of 108% over 2018/19, which 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, but also to address older matters.

Timeliness / Backlog

I am pleased to note that the number of inquests pending as at 30 June 2019 decreased by approximately 10% year on year: see Table 5 and Chart 3.

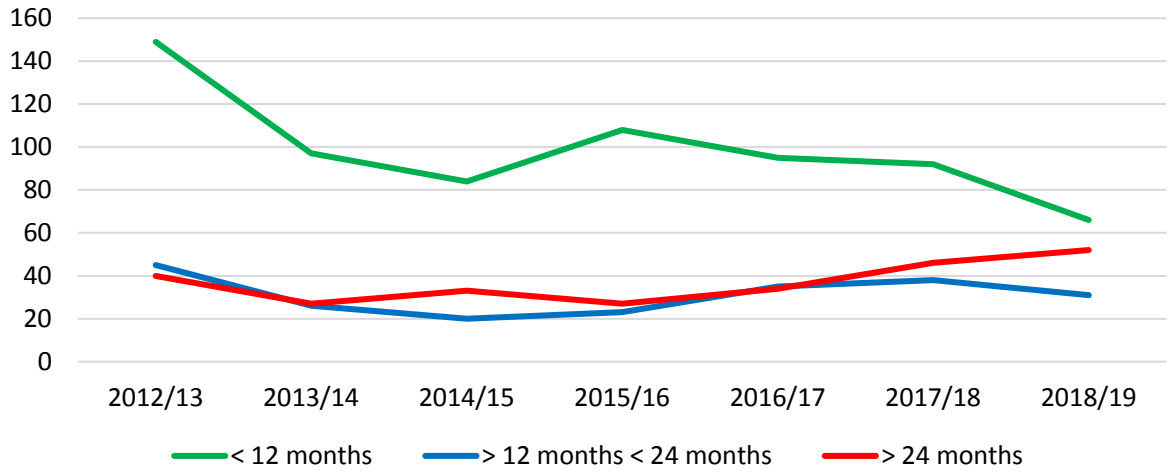
Table 5: Pending Cases

Time Pending	**2018/19**	2017/18	2016/17	2015/16	2014/15	2013/14	2012/13
< 12 months	**66**	92	95	108	84	97	149
> 12 months < 24 months	**31**	38	35	23	20	26	45
> 24 months	**52**	46	34	27	33	27	40
Total Pending	***158***	*176*	*164*	*169*	*137*	*150*	*234*

As I have mentioned in previous reports, I have directed that the oldest inquests still open should receive priority in the workload of the Court. The flow on effect from this directive however is that 'mid-range' inquests – matters which cannot be closed upon receipt of a post-mortem report and require some more investigation and/or work – get older in the meantime while the older cases are being addressed. This explains the proportional increase of longer term pending cases in the statistics.

However, we continue to focus on closure of longer term cases and I am pleased to report that in 2018/19, 41 cases were finalised which were older than 12 months old, as compared to the last two years, where 28 and 24 cases were similarly finalised respectively.

Chart 3: Pending Cases



The new strategic indicator (and national benchmark for Coroners Courts) is that of the matters finalised in 2018/19, 90% took less than 12 months to finalise. The Court came extremely close to this target in 2018/19: see Table 6.

Table 6: On-time case processing indicator			
	2018/19	2017/18	2016/17
%	**88**	91	92

This result compares very favourably with previous results, and is due to the finalisation of a significant number of older matters. The number of short term pending cases (see Table 5 and Chart 3) is the lowest it has been in seven years.

Interpretation

How does the ACT compare to other jurisdictions in terms of backlog? The Productivity Commission prepares an annual *Report on Government Services* (ROGS) which collect statistics on, among other things, the efficiency of coroner's courts throughout Australia. The 2019 report[1] for the 2017/18 year indicates that the ACT and the NT receive roughly the same number of notifications of reportable deaths each year, and are the smallest jurisdictions in Australia, with Tasmania receiving about 600 notifications and all other jurisdictions having a number exceeding 2000. Proportionately speaking, the ACT is the worst in Australia in terms of cases older than 24 months, which reflects the historic backlog of cases evident from 2012/13 which continue to work their way through the system. I suspect a factor also is that we have the lowest rate of judicial officers per 1000 finalisations (0.6) in Australia, when compared to an average across Australia of 1.4. However, that result should also be seen in terms of the ACT having the smallest pending case load (177) in Australia by some distance, with the NT having double our pending case load, Tasmania having triple our pending case load, and all other jurisdictions having a number exceeding 2000 pending cases. Every jurisdiction's pending case load is roughly equivalent to a year of referrals for that jurisdiction, except for the ACT, where our pending case load is less than 60% of a year of referrals for us. No jurisdiction met the national benchmark of having no pending cases older than 24 months old. Our clearance rate of 97% placed us squarely in the middle of the pack of jurisdictions.

The "no certificate" numbers remain, in my view, too high. Given we now have three years of data where this number remains over 40%, we are now probably in a position to be able to draw conclusions from this number. Anecdotally the ACT Coroners Court has the highest proportion of referrals of natural cause deaths in Australia. Many times, natural cause deaths are properly referred to the Coroner where the cause of death is not clear. However, my colleagues and I see far too many referrals of deaths, predominantly but not always elderly people, relating to persons with chronic comorbidities (and often multiple ones) which can reasonably be expected to cause death. Many ACT general practitioners

[1] See Chapter 7.

seem reluctant to write death certificates in cases which probably do not warrant coronial investigation, because of either a lack of understanding of the process to properly certify death, or because they consider death to be 'unexpected'. We have also had cases where the general practitioner says they feel unable to determine with specificity which of the multiple comorbidities caused death and on that basis refuse to write a death certificate! In this way, general practitioners can 'force' a coronial investigation irrespective of the merits of the individual case. Of course, the requirement of section 35 of the *Births, Deaths and Marriages Registration Act 1997* is that the doctor certifies their opinion "as to the probable cause of death" and a 'beyond reasonable doubt' belief is not necessary. If this is to be addressed, the onus is on the appropriate medical professional bodies to provide guidance and education to their members.

I continue to consider a number of fire referrals. The Coronial Practice Direction I issued in September 2018 appears to be having the desired effect in that fires where a coronial inquiry is necessary or may add value are being appropriately drawn to the attention of the Court. The Court was also able to close two long standing fire inquiries this year, those into the Sydney Building fire and the ESI Mitchell fire; excerpts of those findings are at the back of this Report.

The Court held slightly more hearings this year than last year, although comparatively speaking those hearings were shorter than last year. I note that as the statistics provided in this report are for matters finalised in the reporting year. As such they do not reflect a number of significant lengthy hearing matters which are yet to be finalised, such as the Wood inquest and the TCH suicides inquests, which have each had more than three weeks of hearing in the 2017/18 year.

FMC STATISTICS

The total number of admissions[2] to the ACT Forensic Medicine Centre (FMC) in 2018/19 was 446 cases, made up of 362 ACT cases and 84 NSW cases. Medical Certificates on Cause of Death (MCCD) were ultimately issued in 61 ACT cases and 11 NSW cases, which usually occurred when there was a delay in obtaining a MCCD and the body was transported to the FMC pending the GP issuing a MCCD. There were ten occasions where jurisdiction was accepted in relation to a death and a court reference number was allocated, however the body of the deceased was not admitted to the FMC as a post mortem was dispensed with following a medical record review by the Coroner and/or Pathologist. There was one admission from a person who died in the Jervis Bay Territory. There were an average of 31 coronial admissions per month (25 ACT cases and 6 NSW cases), and an average of 6 MCCD cases admitted per month (5 ACT and 1 NSW).

There were four cases that were admitted to the FMC as ACT cases, however primary jurisdiction to investigate the death was transferred to the NSW Coroner prior to post mortem. This might occur, for example, where the incident resulting in death occurred in NSW but the person was transported for treatment to the ACT but ultimately died here. Subsequently, two of these cases had post mortems performed at the FMC for the Queanbeyan Coroner, however the other two cases (involving the Goulburn and Albury Coroners) were transferred to a NSW facility for post mortems.

The FMC has set a Key Performance Index (KPI) of 80% of cases having either an autopsy or medical review within five days or less from admission to the facility. In 2018/19 the facility achieved a KPI of 92.8%, meeting our goal of retaining deceased persons for the minimum time necessary to conduct our enquiries and ensure their return to families and loved ones as soon as possible.

Length of Stay

The median period of stay at the FMC in 2018/19 for all cases was seven days: see Table 7.

Table 7: Length of Stay at FMC

Days	**2018/19**	2017/18	2016/17	2015/16	2014/15	2013/14
Median stay (all cases)	**6**	7	6	5	5	5
Arrival » PM exam	**2**	3	3	3	2	2
PM exam » Discharge	**3**	3	3	2	4	2

We appear to be holding steady at this figure for the time being. Of particular note, 92.8% of cases have a post-mortem examination within five days of admission to the FMC, and on 23 occasions the post-mortem examination was completed on the same day as admission.

[2] 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; also where a referral is accepted without the body of the deceased person being admitted to the FMC.

The data shows that ACT cases receive a post-mortem examination slightly quicker than NSW cases, but NSW cases are generally released quicker. This is most likely due to delays in receiving post mortem directions from NSW Coroners, and delays in receiving release certificates from ACT Coroners due to the need to find the relevant Coroner out of court.

It remains the case that deceased persons 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. There were a small number of deceased persons (10 ACT cases; 3 NSW cases) held for those reasons in excess of 30 days. The FMC complies with its statutory obligations to notify the ACT Registrar of Births, Deaths and Marriages when a deceased person formerly resident in the ACT remains in the care of the FMC for more than 30 days.

Rate of Invasive Autopsy

I am pleased to note our proportion of (ACT) cases subject to external examination remains steady at around one-third of cases: see Table 8.

Table 8: Post-Mortem Examinations[3]

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%)**

As I discussed in detail in last year's Report, in many cases referred for coronial autopsy, an invasive autopsy is the default position in the absence of other information which can identify the person's manner and cause of death, and whether there are any issues or matters of public safety arising in connection with the death which warrant further review. However, a more considered approach to invasive post-mortem examination now prevails

[3] 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.

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 limited use of technology such as CT scanning.

I noted last year that the increase in this percentage may be attributed to greater use of pathologist-led medical reviews. I also stated my belief that we are reaching the limits of how many cases may be diverted out of the autopsy stream without the wider use of investigative tools pre-autopsy, such as default rapid toxicology and CT scanning, and the data tends to show this.

Professor Duflou, our regular visiting forensic pathologist, has indicated that with greater pathologist involvement and triage of cases prior to post-mortem examination, and expanding the use of diagnostic tools in the examination process, a target of 50% of cases receiving invasive autopsies is feasible. I commented last year that I had written to the Attorney-General to ask that Government explore funding the capital and ongoing costs for a CT scanner to be based at the FMC, as blanket CT scanning on admission to coronial mortuaries represents best practice in autopsy service. While I understood that work had commenced to explore costs and prepare a business case for the consideration of Cabinet, this project does not appear to have advanced any further at this time.

Toxicology Services

In 2018/19 122 ACT cases underwent toxicology analysis (40.5% of total cases). Of the NSW cases done at the FMC, 44 required toxicology analysis (60.8%).

Toxicology testing is not required when the manner and cause of death is evident from medical records or other autopsy findings and the pathologist deems that there is no benefit in toxicology testing. The majority of testing is performed at the ACT Government Analytical Laboratory (ACTGAL).

Of the ACT cases, 112 cases were done at ACTGAL and 10 were sent to the Victorian Institute of Forensic Medicine (VIFM) for overnight screening. VIFM are used when rapid results are required as they perform an overnight screening which detects more than 300 common drugs and poisons. They can provide verbal results the following day, with a formal report forthcoming after quantitative analysis is performed.

This year there has been a significant increase in the number of days that it takes for ACTGAL to provide the final toxicology report: see Table 9. This increase is very concerning as toxicological results are usually the last piece of information that the Pathologist waits on before they can submit their final report to the Coroner.

Table 9: Toxicology Timeframes

Type	**2018/19**	2017/18	2016/17	2015/16	2014/15	2013/14
Average days	**35.3**	21.7	26.9	26.3	26.5	24.5

There is benefit in getting rapid toxicology results, specifically in certain types of drug overdoses, as a confirmation result will obviate the need for an invasive autopsy; however, ACTGAL are unable to provide this service. Should this trend continue then the Court may need to reconsider outsourcing all of its toxicological testing to an interstate provider.

I am however pleased to report that a project of some long standing to improve the format and detail of ACTGAL coronial toxicology reports was successfully completed this year. For the last 18 months our Coroners Legal Manager has been working with ACTGAL to professionalise and provide greater specificity in the work that it does for the Court. This has included ACTGAL developing a list of substances which are included in the general screen and limits of detection, which I understand to have been a significant undertaking in its own right. The new version of the report 'went live' from 1 June 2019 and gives Coroners more clarity about the limits of the testing and sufficient assurance to know what was done, and to be able to rely on negative results. This is a significant improvement and I thank ACTGAL for its willingness to engage on the project. Next year's Report should be in a position to comment on the benefits from the implementation of the new format.

STAFFING AND RESOURCES

Coroners

The ACT Coroner's Court receives no allocated resourcing for the performance of judicial coronial functions. Again the arrangements of some long standing whereby every Magistrate retains an active coronial case load continued in 2018/19, but that case load is discharged as a secondary priority with duties as a Magistrate commanding 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 ordinarily available to them, and as this Report demonstrates, have achieved truly remarkable results in the circumstances. A dedicated Coroner however is probably the next step which needs to be taken to professionalise the jurisdiction and ensure consistency and efficiency in dealing with matters.

I wish to acknowledge here the retirement earlier this year of my colleague, Magistrate Karen Fryar. During her many years of service to the Court, Magistrate Fryar also undertook regular coronial duty and dealt with many inquests and inquiries. Two days before her retirement, Magistrate Fryar delivered her findings in the long-running inquest into the death of Ben Catanzariti, a matter which attained significant local publicity and attention. I am told that Magistrate Fryar paid particular attention and care to the wellbeing of Ben's family throughout the long coronial (and criminal) process, and was thanked for her efforts by Mrs Catanzariti at the conclusion of the inquest.

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. Costs in relation to these inquests are borne by the Commonwealth Government on a cost-recovery basis. In 2018/19 the ACT Coroner was notified of one death occurring within the Jervis Bay Territory. The inquest into the death of Captain David Wood, notified to the ACT Coroner in 2016/17 as having occurred in the Australian Antarctic Territory, was the subject of a lengthy hearing in the 2017/18 year and continues into 2019/20.

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 dedicated support section sitting under the Legal Team reporting directly to the Registrar.

The Coroners Section is headed by our Counsel Assisting/Legal Manager and includes legal, court support and forensic medicine staff. The Legal Manager directly manages two administrative support staff co-located with the Magistrates Court Registry, and the mortuary manager (and through them technical staff) located at the FMC in Phillip.

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 and Legal staff 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 operational capacities. This continues to prove beneficial and cost effective.

A number of cases were briefed to the private bar in 2018/19 due to the complexity of the matter or the capacity of our in-house practitioners. In such matters our in house practitioners perform the role of instructing solicitor.

FMC

In 2018/19 we continued to have turnover of mortuary technicians at the FMC due to difficulty in recruiting and retaining these staff. I have directed the creation of a wider pool of appropriately trained staff within the ACT to ensure business continuity.

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 accommodated to the extent operationally possible.

The FMC continued to be an important component of the training offered to medical and forensic students, consular staff, police recruits and members, and defence force personnel in 2017/18 (reported later in this Report under 'Direct Engagement').

Ongoing priorities for the FMC in the forthcoming year include:

- formalising a system of health-based mentoring and professional supervision for technical staff via interstate counterparts;
- a review of FMC Standard Operating Procedures (SOPs) and policy documents, particularly with an eye to the National Code of Ethical Autopsy Practice and Guidelines of the National Pathology Accreditation Advisory Council (NPAAC) to and benchmarking those against best practice in other jurisdictions;
- a triage process for cases at the post mortem examination admission stage, to assist in coronial decision making.

These were also our priorities for the FMC last year, but were unable to be fully completed within the one year.

In 2018/19 we were able to finalise a long-running project in relation to the review and auditing of the way in which the FMC deals with tissue samples and processing materials. Firstly FMC staff conducted an audit to identify all tissue samples still in existence

and which had not been destroyed despite the cases being closed. Fortunately most of the items identified were very small samples or left over tubes and containers. I authorised destruction of those materials. A few more sizable samples were located. As to these, I wrote to the families of those deceased persons to apologise for the delay and to advise that I intended to have the samples destroyed unless they advised the Court that they wished some other course be taken. The responses received back indicated no opposition to the planned destruction and all the samples were respectfully destroyed by cremation. The ashes from the destroyed samples were then buried at the FMC in a ceremony on 4 June 2019 where I planted an Irish Strawberry tree and dedicated a plaque. The photograph on the front page of this Report shows the tree and plaque. At this time I also approved changes to policies and procedures at the FMC to ensure that retained samples are destroyed in a timely fashion when they are no longer required for coronial or other processes.

The FMC remains an identified ACT disaster response venue and maintains surge capacity in the event of a large scale incident with mass fatalities. In December 2018, FMC staff and AFP Disaster Victim Identification (DVI) members participated in a DVI exercise at the FMC. The day commenced with a table-top exercise, and concluded with participants processing several "human remains", in accordance with the Interpol DVI Guidelines, which Australia adopts.

Participants engaging in a Disaster Victim Identification exercise.

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.

Pathologist Services

Professor Johan Duflou continues to provide the majority of the pathology services for the ACT FMC on a fee for service basis. A/Professor Sanjiv Jain also provides continuing services on the same basis. For extra cover during the year when our main pathologists were unavailable Dr Beng Beng Ong and Dr Nathan Milne from Queensland were able to assist. I wish to record the appreciation of the Coroners of the Court to all our pathologists for their support of the coronial system in this Territory.

In July 2018 the ACT Government approved funding to recruit and appoint an ongoing resident forensic pathologist for the ACT. Seeking this funding has been a project of many years for the Court and I am very grateful to the Attorney-General and others within

Government that the call has finally been heeded. However, at the time of writing multiple recruitment attempts have been unsuccessful. There is presently a worldwide shortage of fully qualified forensic pathologists. Due to a lack of appropriate local applicants, I have directed that international recruitment efforts commence. This may result in delay and possibly additional cost during any process to recognise overseas qualifications.

Coroner's 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. 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.

The AFP also 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 that Unit perform a useful 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 by the Coroner.

Primary investigation of 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.

ENGAGEMENT AND EDUCATION

Support Services in the Community

All Coroners are acutely aware that grieving families can find the coronial process difficult. Relationships Australia Canberra Region continued to be funded in 2018/19 by 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. I am pleased to note that the Service was recently extended for another three years.

Direct Engagement

During the 2018/19 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 engages in regular liaison meetings with key coronial stakeholders, including NCIS, Canberra Health Services, Calvary Hospital, ACTGAL, ACTAS and the AFP, and provides training to ACT F&R station officers.

As foreshadowed in last year's Report, the Coroner's Court (together with other areas of the Magistrate's Court Registrar's branch) has formally partnered with ANU to offer internship placements during 2018/19. This is a project which has been largely driven and overseen by the Coroners Legal Manager and Counsel Assisting. While the university students obtain exposure to professional legal practice and gain a greater understanding of the coronial jurisdiction, the Court obtains an additional hands-on legal resource which can be used for research tasks or case preparation. The trial has been successful and a number of students have spent more time at the Court than the minimum period of time required for the internship.

This 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 of post mortems if required. All observers attend with the approval of the Court as well as explicit approval from the deceased's Next of Kin.

As part of that CPD I committed to reporting each year in this Report the number and identity of the applicants/observers at the FMC in each year. I am therefore pleased to be

able to report, for the first time that during 2018/19 there were a total of 533 observers who attended the FMC for various purposes: see Table 10.

Table 10: Approved Observers at FMC in 2018/19		
Category	*Number*	*Purpose of Visit*
ANU Medical Students	102	Observe PM
DFAT consular trainees	153	Discussion/Tour/View deceased
AFP Forensic Biologist	1	Observe PM
AFP Crime Scene Students	49	Gradual exposure to deceased
AFP Recruits	69	Discussion/Tour/View deceased
ADF Investigation Service trainees	47	Tour/Fingerprinting/Photography
ADF Investigative Course students	21	Tour/Fingerprinting/Photography
AFP Protective Services Officer trainees	83	Discussion/Tour/View deceased
Clinical Forensic Medicine Service clinicians	8	Discussion/Tour
TOTAL	**533**	

I see the engagement of the FMC in this regard as being a way in which the Court can assist in training the next generation of police, doctors and investigators.

Asia-Pacific Coroners Society Annual Conference

As foreshadowed in last year's Annual Report, as I assumed the role of Chair of the State and Chief Coroners Council for the 2018 year, it was the ACT's honour to host the annual conference of the Asia Pacific Coroners Society. Although hosted by the ACT, the organisation and running of the conference was undertaken by an enthusiastic group of volunteers rather than as an official court event.

Over two and a half days delegates from around Australia, the Pacific and the United Kingdom heard from a variety of speakers on topics of interest to the coronial jurisdiction. The welcome function was held as the first event in the new ACT Courts building, and the conference formally opened by Justice Virginia Bell AC of the High Court of Australia. Our keynote speaker was Professor Pat McGorry AO, who spoke on the dire need for more funding and attention to primary mental health care. Local speakers included Associate Professor Vanita Parekh AM, who spoke about non-fatal strangulation as a warning sign for violent death; Dr David Caldicott, who spoke about harm minimisation approaches to illicit drugs; and representatives of DFAT and the AFP Offshore & Sensitive Investigations Team about investigation of deaths of Australians that occur offshore. Particular highlights were the presentation by Chief Air Marshall Sir Angus Houston AK AFC (Rtd) on his role on returning home the Australians who died in the MH17 incident; the screening at Palace Electric of 'Joe Cinque's Consolation' with panel discussion facilitated by Coroner Margaret Hunter OAM with Justice Richard Refshauge (Rtd), Jack Pappas, D/S/Sgt Harry Hains and screenwriter Matt Rubenstein; and the Gala Dinner at the National Arboretum featuring The

Baker Boys, Jumptown Swing dance lessons and (then barrister, now Coroner) James Stewart singing the blues!

I thank Principal Registrar of the ACT Courts and Tribunal, Philip Kellow, for seed funding and sponsorship of the Conference. I thank also my organising committee: Coroner Margaret Hunter, Ms Sarah Baker-Goldsmith, Ms Roisin Carmody, Ms Elizabeth Hard, Sergeant Rachel Hutka, Sergeant Rod Anderson, Dr Vanita Parekh and Dr Cath Sansum; as well as our organisers Mandy and Greg at Conference Solutions.

ENVIRONMENT CHANGES

Amendments to Coroners Act 1997

The *Coroners Act 1997* was amended only once in the 2018/19 year. The *Justice and Community Safety Legislation Amendment Act 2019*, which came into effect on 21 June 2019, made amendments to repeal 57(4) and replace subsection 57(5) in its entirety, repeal subsection 57(7), and make a consequential amendment to subsection 57(6). The effect of those amendments was to 'delete' the 'responsible Minister', who was the Minister responsible for the matter that was the subject of the inquest or inquiry, and who had the responsibility to table a coronial report and any response in the Legislative Assembly. Now, the Government will decide who will have responsibility for actioning any response to a coronial report. This was an amendment sought and progressed by the Directorate.

Previous Amendments to Coroners Act 1997

The following amendments were made to the *Coroners Act 1997* in the 2017/18 year:

- The *Justice and Community Safety Legislation Amendment Act 2017 (No 3)* came into effect on 16 November 2017 and made amendments to:
    - remove the unintended exclusion from reportability of deaths that occur in any of the circumstances prescribed by regulation, such as after an intravenous or intramuscular injection, artificial ventilation, resuscitation, or catheter or cannula insertion, by deleting the note at section 13(1)(c); and
    - remove the mandatory hearing requirement in section 34A for deaths which occur while under or as a result of anaesthetic (such deaths remaining reportable to the Coroner);
- The *Courts and Other Justice Legislation Amendment Act 2018)* came into effect on 26 April 2018 and made amendments as follows:
    - the prohibition on Deputy Coroners signing release certificates (s 15(4)) was repealed;
    - section 28, which required Coroners to have regard to cultural and spiritual concerns, was repealed and delinked from the post mortem examination process and now applies generally in relation to inquests [as a reframed s 17A];
    - a new form of examination process – ancillary examinations, intended to be those things less invasive than autopsy – was inserted into the Act [new s 19A, 19C];
    - directions to obtain medical records were delinked from the post mortem examination process, and can now be sought to decide whether to have an autopsy (to obviate the need for short service subpoenas); also a direction can now be made for any (all) medical records, not just the records of last admission [new s 19B];

- the "assistance at PMs" authorisation in section 33 was delinked from the order for an examination and the language reframed to open the scope for standing directions for assistance; also the doctor conducting a post-mortem examination may also authorise assistants to help him or her [new s 33];
- the provisions in relation to CISOs were corrected so that "other persons" can now use CISOs powers, not just Police [ss 68C-H etc.]; and
- other contingent amendments.

These amendments have increased the efficiency of coronial processes.

Coronial Practice Directions

Section 51A(2) of the Act permits me to issue Coronial Practice Directions (CPDs) to prescribe practices and procedures for taking of steps in inquests and inquiries. I issued my first CPDs in 2018/19 as follows:

CPD 1 of 2018 – *Release of Bodies* issued 20 September 2018

CPD 2 of 2018 – *Observers at PM* issued 20 September 2018

CPD 3 of 2018 – *Issue of Subpoenas* issued 20 September 2018

CPD 4 of 2018 – *Donation of Eye Tissue* issued 20 September 2018

CPD 5 of 2018 – *Fire Jurisdiction* issued 20 September 2018

CPD 1 of 2019 – *Suspected Deaths* issued 28 February 2019

CPD 2 of 2019 – *Release of Information* issued 26 June 2019

These CPDs are available on our public website at https://www.courts.act.gov.au/magistrates/courts/coroners_court/coronial-practice-directions .

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. Section 34A(2)(a) mandates a hearing for all deaths in custody.

In the 2018/19 year, there were two inquests into deaths in custody finalised by a Coroner:

- Mark O'Brien (CD 118 of 2016); and
- Mark O'Connor (CD 110 of 2017).

Details are provided later in this report.

[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 prescribes the circumstances in which a hearing must 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 2018/19 year, there were 333 notices given by Coroners under subsection 34A(3), in respect of 330 deaths and 3 fires. (There were no inquiries into disasters finalised in the 2018/19 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 in respect of matters finalised in this year.

A section 90 application to the Supreme Court was made on 20 September 2016 in respect of the inquest into the death of Corinna Medway (CD 127 of 2011). That matter – *Foote v Coroner's Court of the ACT* – remains outstanding at the present time. A preliminary decision was delivered by Associate Justice McWilliam on 4 May 2018 in relation to certain questions of law about proceedings brought under section 93 of the Act: *Foote v Coroner's Court of the ACT* [2018] ACTSC 119, available at https://courts.act.gov.au/supreme/judgments/foote-v-coroners-court-of-the-act .

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.

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 the 2018/19 year, the following section 57 reports were made to the Attorney-General and tabled in the Legislative Assembly:

- Fire at Energy Services Invironmental (CF 319 of 2012);
- Fire at the Sydney Building (CF 178 of 2014);
- Siauto Eliuta Tunumafono (CD 306 of 2013);
- Timothy Allen Smith-Brown (CD 179 of 2015);
    - All of these reports were presented to the Legislative Assembly by Minister Gentleman on 21 March 2019.
- Tania Klemke (CD 240 of 2017)
    - This report was presented by Minister Gentleman on 2 April 2019.
- Constance Harrison (CD 200 of 2014)
    - This report was presented by Minister Gentleman on 16 May 2019.

Additionally, in the 2018/19 year, the Government decided of its own accord to formally respond in the Legislative Assembly to the Coroner Cook's report in the Steven Freeman matter (CD 125 of 2016) and this occurred on 23 August 2018.

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.

For the two inquests into deaths in custody finalised by a Coroner in the 2018/19 year:

- Mark O'Brien (CD 118 of 2016); and
- Mark O'Connor (CD 110 of 2017);

both Coroner Cook (O'Brien) or Coroner Theakston (O'Connor) found that the treatment given to the deceased did not affect the quality of custodial care, treatment and supervision of him to the extent that it could be said to have contributed to his cause of death. The Government responses to these Coroners' reports have not yet been tabled.

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, 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 .

Court Reference:	CD 179/15
Age:	35 years
Gender:	Male
Date of Death:	04/09/2015
Place of Death:	Kambah, ACT
Coroner:	P.J. Morrison
Date of Findings:	14/08/2018
Reported as:	[2018] ACTCD 13

1. Timothy Allen Smith Brown died at approximately 17:45 hours on 4 September 2015 as a result of multiple injuries (including subarachnoid haemorrhage, and left pleural effusion suggesting rupture of the pulmonary vessels with exsanguination into the left haemothorax) sustained in a motor vehicle collision that occurred at the intersection of Drakeford Drive and Boddington Circuit, Kambah, in the ACT, immediately after a police pursuit; and

2. Pursuant to the requirements of s 52(4)(a)(i) of the *Coroners Act 1997* I state that a matter of public safety arises in connection with this inquest.

…

156. Proper consideration of the danger to others demonstrated by that conduct, when weighed against the minor nature and comparative seriousness of the offence/matter as known to Senior Constable Stone, ought to have resulted in him terminating the pursuit immediately after the Athllon Drive intersection. Proper application of the Old Pursuit Policy required him to do so.

157. In the end result I find that the pursuit ought to have been terminated by Senior Constable Stone after the deceased travelled through the Athllon Drive intersection. If the pursuit had been terminated at that time the high speed driving of the pursuit vehicle from that point would have ceased. Again, any assessment of what the deceased would have done beyond that point is speculative.

158. Having regard to what is apparent from the video record, I find that a matter of public safety arises because the continuation of the pursuit beyond that point by

Senior Constable Stone unjustifiably placed other users of Drakeford Drive and the intersecting carriageways in danger.

159. Insofar as the finding just made is an adverse comment against the conduct of Senior Constable Stone, it is a comment which must be viewed against the background of the evidence of Sergeant McPherson suggesting that traffic offences were, before the change of policy, a common justification for pursuits both in the ACT and in other jurisdictions.

160. I am required by section 52(4)(a)(ii) of the Act to comment on the matters of public safety which I have found to arise.

161. By way of comment, I record that the Old Pursuit Policy has now been replaced. The new version of the AFP Policy on pursuits and urgent duty driving will not authorise the pursuit of a fleeing driver "in ordinary circumstances for traffic and property offences", and pursuit "will be limited to circumstances where there has been or is, an immediate or ongoing risk to life or serious injury posed by occupant/s of the fleeing vehicle, and may only be conducted where the risk posed by pursuing the fleeing driver is less than the risk posed to the community by not attempting to immediately apprehend the driver and/or occupant/s". (see https://police.act.gov.au/road-safety/urgent-duty-driving-and-pursuits)

162. Self-evidently the new policy is designed to reduce the number of police pursuits. Counsel for the family submits that the institution of the new policy is to be commended and that is a submission with which I agree.

163. In the circumstances no further comment is called for.

Court Reference:	CF 178/14
Date of Fire:	17/02/2014
Place of Fire:	Canberra City, ACT
Coroner:	P.J. Morrison
Date of Findings:	01/11/2018
Reported as:	[2018] ACTCD 15

1. A fire occurred at Sydney Building, London Circuit, Canberra City on 17 February 2014.
2. The point of origin of the fire was that part of the building occupied by the business known as Izakaya Coo 2 G 4 U and was caused by an unattended cooking wok on a gas stove which in turn ignited the cooking oil within the wok.
3. The cause and origin of this fire are sufficiently disclosed and a hearing is unnecessary.
4. Pursuant to s 52(4)(a)(i) of the *Coroners Act 1997*, two matters of public safety are found to arise in connection with this inquest.

…

17. This evidence gives rise to two areas of concern as matters of public safety, as follows:
    a. The content and efficacy of procedures for isolating or otherwise making safe gas supplies after a fire; and
    b. The content and efficacy of procedures for post-fire release of multi-tenanted buildings or complex tenancies.

…

19. In the present case there is no dispute that there was a need to isolate gas at the point of entry to the building at least to Coo and surrounding sites while firefighting activity proceeded and while the site remained unsafe. I consider on the facts of this case that the point of entry gas meter should have been disconnected or capped off as soon as practicable.
20. I sought comment and advice from ActewAGL and ACTF&R about their standard fire response processes. Both agencies accept that:
    a. ActewAGL does not act unilaterally to disconnect utilities.
    b. The onus is on emergency services to make a request to that effect to ActewAGL, to which ActewAGL (or its contractors) will respond.
21. I am satisfied that the practice just described is, in principle, an appropriate one.
22. ActewAGL internal processes require that separate requests be placed in respect of each of electricity and gas, and that the requests be directed to different contractors – the electricity distributor and the gas distributor being different entities. It is agreed by ActewAGL and ACTF&R that there was no request made by ACTF&R on the day of the fire to disconnect the gas supply.
23. ACTF&R acknowledges that a critical part of its risk mitigations activities at emergency incidents is ensuring the isolation of utilities, including gas and electricity, to buildings. I have been advised by ACTF&R that it has, since this fire, updated its Operational Guideline that details command and control procedures at incidents. Additionally, ACTF&R Commanders have been specifically briefed on the need to ensure appropriate isolation is undertaken at multi-tenancy buildings.
24. Although the potential risk to public health and safety resulting from the failure to correctly isolate gas to the Sydney Building was significant, no ongoing matter of public safety arises in light of the advice I have received from ACTF&R about the steps already taken in this regard. In the circumstances I make no further recommendation.
25. Noting that in critical incidents there is often a level of confusion and a number of actors not necessarily working in coordination, a single agency should take responsibility for ensuring site safety (or responsibility for advising that the site is unsafe) before the site is released to the occupant and/or other public access is permitted. In my view, ACTF&R is best placed to fulfil that role. I am advised by ACTF&R that it has documented processes for release of single tenanted premises such as residences. In those cases there is a template "Release of Premises" (ROP) form which is filled out and signed off both by a fire officer and the person to whom the residence is released. There are however obvious difficulties for post-fire release of multi-tenanted buildings or complex tenancies. The standard "Release of Premises" form does not expressly address the issue of utility connection, but ACTF&R advise that hazards such as compromised gas or electrical installations are routinely included on this form to advise occupiers of potential risk. In any case, the standard form was not completed for this fire because the building was not to be released to a single identifiable person.

…

28. It is crucial that responders direct their attention to potential risks when premises are released after an incident, and that occupants are fully informed of such risks at the time of release. The ROP form is a useful mechanism for this. In my view it should expressly:
    a. Include reference to the status of utilities such as electricity and gas etc.; and

b. Prompt consideration of identifying the appropriate persons to be made aware of risks in the case of multi-tenancy buildings.

I recommend accordingly.

Court Reference: CF 128/12 & CF 319/12
Date of Fire: 15/09/2011
Place of Fire: Mitchell, ACT
Coroner: L.A. Walker
Date of Findings: 01/11/2018
Reported as: [2018] ACTCD 16

29. The key findings I make in this matter are:
    (a) prior to the explosion and fire on 15 September 2011, the ESI facility was appropriately managed and the operational risks were identified and managed;
    (b) the response of ACT public authorities to the explosion and fire was appropriate;
    (c) despite significant investigation by multiple agencies, no cause or origin of the fire is able to be established, due to the ferocity of the explosion and subsequent fire;
    (d) the cause and origin of this fire is unascertained.

…

36. The EPA was unable to identify who had responsibility for pollution of the stormwater system and environment. The evidence available to me does not enable me to conclude whether the discharge of liquid waste from the ESI site was due to a structural failure of the premises' bunding or whether the additional volume of firefighting foam in combination with the liquids stored on site exceeded the capacity of the bund. Both are clearly possible.

37. Nevertheless, I am satisfied that the actions of the ACT EPA were appropriate and timely and in particular, the construction of the additional bunds on 16 November 2011 prevented a potential mass environmental disaster in the ACT.

…

42. Recent advice from the EPA confirms that the former ESN site (Block 15 Section 22 Mitchell) is on the Contaminated Sites Register; and the site is regularly inspected and there has been no redevelopment since initial demolition was completed.

43. Ultimately the EPA found that ESI did not breach the conditions of its environmental authorisation and no breach of the Environment Protection Act 1997 was identified.

…

47. I have no evidence to suggest that there were any issues with management of the ESI facility, or that operational risks were not properly identified and managed, prior to the explosion and fire on 15 September 2011.

48. I have already noted the vast discrepancies in the understanding of key agencies as to the total amount of sodium metal stored on the ESI premises and my acceptance that the amount was likely in the vicinity of 3 tons. Although the amount of sodium on-site is unlikely to have impacted on the cause of the fire, undoubtedly it would have had an impact on its severity and duration and accordingly on the effort required of firefighters and others to control it. It is concerning that the key agencies

were ill-informed whilst the fire was ongoing as to this important information however I am unable to conclude that there was any risk to public safety as a result.

49. Despite investigation and interview of relevant witnesses, no breaches of the *Work Safety Act 2008* were identified.

…

51. Media reports in the days after the ESI explosion and fire criticised the Emergency Alert system used to advise nearby residents with some residents complaining they did not receive the warning and others saying they had received a warning despite being interstate or overseas.

52. On 23 November 2011 the Australian Parliament's Senate Environment and Communications References Committee delivered its report into "The capacity of communication networks and emergency warning systems to deal with emergencies and natural disasters". The report examined the Emergency Alert system's operation on 16 September 2011 in respect of the ESI explosion and fire. The Committee concluded that some of the issues complained of arose from the lack of a location-based mobile telephone emergency warning capability but were also due to a failure by the ACT ESA to use the Emergency Alert system in accordance with the 'Recommended Use Guidelines'. See http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Environment_and_Communications/Completed_inquiries/2010-13/emergencycommunications/report/c03 .

53. Given both the ACT Government and the Senate Committee reviews of the issue, I see no benefit in further inquiry.

Court Reference:	CD 81/15
Age:	50 years
Gender:	Male
Date of Death:	18/04/2015
Place of Death:	Garran, ACT
Coroner:	L.E. Campbell
Date of Findings:	26/11/2018
Reported as:	[2018] ACTCD 17

1. Adrian Charles Wilfred Van Die died on 18 April 2015 at The Canberra Hospital, 1 Dann Close, Garran;
2. The manner and cause of death of Mr Van Die are sufficiently disclosed and a hearing is unnecessary;
3. The manner and cause of Mr Van Die's death was multi-organ failure, caused by low flow ischaemia of coeliac artery and superior mesenteric artery territory viscera, due to obstruction of the coeliac, renal and superior mesenteric arteries by an Intra-Aortic Balloon Pump; and
4. Pursuant to s 52(4)(a)(i) of the *Coroners Act 1997*, no matter of public safety is found to arise in connection with this inquest.

…

25. In the light of Dr Collins's report, there is no cogent evidence supporting any adverse finding or comment against TCH or any individual medical practitioner. In circumstances where the procedure was conducted in accordance with accepted

Australian medical procedure, and with reference to published medical literature, no matter of public safety arises.

26. It is very unfortunate that the operation record does not appear to have been placed on Mr Van Die's hospital record, or at least, on the version of the records which was provided to me in response to a subpoena I issued. However, Dr Collins appears to have had sufficient information before him to review and form his opinions, and clearly this is not a matter going to either the manner and cause of Mr Van Die's death or a wider matter of public safety.
27. Given the top end of the balloon was confirmed to be correctly placed on a number of occasions by imaging, and given the ultimate fact that the distal end of the balloon obstructed the lower trunk arteries, I conclude that the balloon used was too long in Mr Van Die's specific case. Ms De Chellis, Mr Van Die's sister, reported to Police after his death that she recalled staff saying in her presence that "they looked at Mr Van Die's height and weight" to calculate the right size of balloon; the treating team appears to have ultimately come to the same conclusion as I have. However, the choice of balloon was within recognised parameters within the applicable literature, and therefore the choice of balloon cannot be criticised.
28. Mr Van Die's death appears to have been as the result of a rare but recognised complication of the procedure. Mr Van Die was appropriately informed of the risks pre-operatively and accepted them. As Dr Collins has explained, while Mr Van Die's worsening symptoms and possible reasons for them were not recognised as quickly as might have been the case, this was likely due to other confounding conditions, and accordingly I consider no adverse comment is warranted.
29. I note for completeness that an ICU review of the circumstances of Mr Van Die's death identified that the pulmonary artery catheter inserted in Mr Van Die as part of the first balloon procedure was a little lower than was ideal and it was ultimately repositioned. However two chest x-rays of Mr Van Die failed to pick up this issue. Discussions with staff identified that Mr Van Die's co-morbid cardiomegaly made interpretations of x-rays direct from the machine before processing challenging, and all medical staff were reminded to recheck formal x-rays once processed. Additionally, subsequent consideration of events around the first ruptured balloon suggested that the balloon should have been changed in the Cardiac Catheter laboratory before Mr Van Die went into theatre. As these do not appear to be matters going directly to Mr Van Die's death, I do not consider they are matters for me to enquire into, but I acknowledge the work done by TCH on this issue.
30. Notwithstanding that I have found no matter of public safety arises in relation to Mr Van Die's death, the Coroners Act 1997 (ACT) clearly contemplates that I can make recommendations in relation to the prevention of deaths, the administration of justice and the need for a matter to be investigated or reviewed by another entity. Coroners also have a well-recognised power at common law to make recommendations in the public interest. Accordingly, I make the following recommendations on that basis.
31. I recommend:
    (a) If it has not already done so TCH should implement all of the "Suggestions for Improvement" from its Clinical Review Committee reviews of Mr Van Die's death.
    (b) TCH should put in place procedures to ensure that operation reports are appropriately recorded and accessible on a patient's file.

(c) The Cardiac Society of Australia and New Zealand, as the professional body for cardiologists and those working in the area of cardiology, should consider the development and promulgation of:
   (i) An alert to its members of the facts of Mr Van Die's case, noting that although the balloon used was in accordance with published algorithms, nevertheless it was too large in his case.
   (ii) Guidelines or procedures, formalising the broadly accepted practices, as to the practice of insertion or operation of intra-aortic balloon pumps, and particularly the selection of appropriately sized balloons.

Court Reference:	CD 240/17
Age:	46 years
Gender:	Female
Date of Death:	25/10/2017
Place of Death:	Watson, ACT
Coroner:	K.M. Fryar
Date of Findings:	29/11/2018
Reported as:	[2018] ACTCD 18

1. Tania Louise Klemke died on 25 October 2017 at 41 Molesworth Street, Watson, in the Australian Capital Territory;
2. The manner and cause of death of Ms Klemke are sufficiently disclosed and a hearing is unnecessary;
3. The manner of Ms Klemke's death was from multiple significant injuries with associated exsanguination caused by a determined attack by her own large dog;
4. I find that a matter of public safety is found to arise in connection with this inquest and my relevant comments are contained in my findings below.

…

21. In the context of the facts of this inquest I am satisfied on the balance of probabilities that a matter of public safety is found to arise in relation to the operation of the legislative framework for regulating dangerous dogs. However my consideration has been largely overtaken by events.
22. The week after Ms Klemke's death, the ACT Legislative Assembly passed changes to the *Domestic Animals Act 2000* (ACT) and *the Domestic Animals Regulation 2001* (ACT). The *Domestic Animals (Dangerous Dogs) Legislation Amendment Act 2017* (ACT) was said by the ACT Government to "provide even stronger protections for public safety and animal welfare", ensuring "that the ACT comes in to line with best practice in other jurisdictions in Australia and around the world and that there is a holistic approach to addressing dangerous dogs and potentially dangerous dogs" (taken from the Government's Supplementary Explanatory Statement to the Bill, dated 29 November 2017, p2). The legislation was, as I understand, crafted in response to a number of concerns in relation to dangerous dogs, and other dog attacks, not just the circumstances surrounding Ms Klemke's death. Relevant to the events of Ms Klemke's death, the amendments to the *Domestic Animals Act 2000* (ACT) effective from 14 December 2017 (according to the Supplementary Explanatory Statement):

(a) introduce three new 'classes' of responding to a dog attack with proportionate powers to act by the Registrar;
(b) permit the Registrar to destroy a dog in extreme and serious circumstances with reduced appeal timeframes so that action can be taken promptly and without delay;
(c) result in a three-tiered system for managing dogs with the introduction of a 'Dog Control Order', along with existing nuisance notices and dangerous dog licences, depending on the type of behaviour exhibited by the dog and the owner and the risk to the community;
(d) introduce a general public safety consideration in (a) how the Registrar exercises discretion in dealing with dogs that could be dangerous, and (b) in making important decisions about dogs and community safety;
(e) impose greater restrictions on keepers of dangerous dogs with public safety being the paramount consideration; and
(f) increase enforcement powers and give authorised officers an ability to seize and act on nuisance, harassing or dangerous dogs in a greater range of circumstances, particularly where they pose a potential or actual threat to public safety.

23. Additional changes to the dangerous dogs regulatory framework were also made by the *Domestic Animals Legislation Amendment Act 2018* (ACT), effective 24 May 2018. According to the Government's Revised Explanatory Statement to the Bill, dated 10 April 2018, p2-3, the Act:
(a) harmonises the infringement notice framework under the Act to bring it in to line with current policy and ensure authorised officers can effectively administer fines by stating or reframing offences as strict liability or not;
(b) makes other minor amendments following the dangerous dog amendments, including:
- providing a definition of 'breeding' in the legislation, which includes the full process of breeding from insemination to birth and weaning, in line with best-practice;
- allowing for a 'Dog Control Order' to be placed on a carer for a dog as well as the keeper for a dog. For example where the keeper is temporarily overseas or where a dog attacks a neighbour's chickens but can be suitably located temporarily with a carer while the keeper finds alternate housing;
- allowing for a home impoundment direction to be placed on a carer for a dog as well as the keeper for a dog. For example where the keeper has moved overseas and the carer can appropriately and safely keep the dog at home while ownership of the dog is transferred to the carer;
- allowing for a dog to be impounded on Territory premises or another location approved by the Registrar. Currently a dog can only be impounded on Territory premises. The amendments would mean that if Domestic Animal Services (DAS) undertakes a targeted compliance program to stamp out illegal breeding it can temporarily impound dogs at a location other than the pound, for example with an animal rescue facility. This would alleviate pressure on the pound and also mean that breeding female dogs and puppies can be placed in more

appropriate facilities. Studies have found the facilities at pounds are not ideal for the welfare of puppies; and

- other minor technical amendments.

24. I understand also further changes are presently under consideration by the Legislative Assembly: see the Domestic Animals (Dangerous Dogs) Legislation Amendment Bill 2018 (ACT) put forward by Ms Lawder MLA, https://www.legislation.act.gov.au/b/db_59106/ .
25. I take the legislative actions by Government, and the timing of them, as conceding that the previous legislative framework in relation to dangerous dogs was inadequate and did not sufficiently protect public safety.
26. I note that on the information available to them at the time, and under the legislative regime as it then stood, in my opinion DAS officers acted appropriately in their engagement with Simba and Ms Klemke. More of course could have been done, but this does not mean that what was done was inadequate or falls so far below what would have been reasonable that adverse comment or finding is warranted. I certainly do not make any finding that their prior actions in any way contributed to Ms Klemke's death.
27. I further note by way of comment my concern that for two of the prior incidents DAS was aware of in relation to Simba, no follow up appears to have occurred due to resourcing issues. In a "Statement on the management of dangerous dogs in Canberra" released on 1 November 2017 Meegan Fitzharris MLA, relevantly then the Minister for City Services, said: "The ACT Government has already announced several measures to protect the community, including doubling the number of animal rangers and introduce new roles into (DAS)": see https://www.cmtedd.act.gov.au/open_government/inform/act_government_media_releases/meegan-fitzharris-mla-media-releases/2017/statement-on-the-management-of-dangerous-dogs-in-canberra . In light of that statement I think no further comment or recommendation by me is warranted.

Court Reference:	CD 306/13
Age:	43 years
Gender:	Female
Date of Death:	11/12/2013
Place of Death:	Bruce, ACT
Coroner:	P.J. Morrison
Date of Findings:	29/11/2018
Reported as:	[2018] ACTCD 19

1. Siauto Eliuta Tunumafono died on 11 December 2013 at Calvary Public Hospital, Mary Potter Circuit, Bruce in the Australian Capital Territory;
2. The manner and cause of Ms Tunumafono's death is unascertained, but was probably fatal cardiac arrhythmia; and
3. 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.

…

11. Counsel for the Territory concedes that errors were made in the treatment of Ms Tunumafono by ACTAS and ACTF&R. I read this reference to errors as being the

failure to recognise the need to defibrillate when required as identified in the reports of Dr Richardson. The evidence supports that conclusion and I so find.

12. Both Counsel Assisting and Counsel for the Territory submit that these errors were not likely to have contributed to Ms Tunumafono's death. Again, the evidence supports that conclusion and I so find.
13. I also accept the submission that a number of factors contributed to the errors, including:
    a. The apparent confusion caused by the prompts provided by the ACTF&R defibrillator;
    b. The incompatibility of the ACTF&R and ACTAS defibrillators; and
    c. The difficulty of providing treatment in a stressful environment.
14. On that basis I make no adverse comment in relation to any of the individual ACTF&R or ACTAS officers involved. However, I consider that the lack of any written ACTF&R and ACTAS protocols about defibrillation constitutes a matter of public safety within the meaning of that term in the Coroners Act 1997.
15. Subsequent to the hearing I have been notified by the Territory that changes have been made so that defibrillators used by ACTAS and ACTF&R now have compatible pads. In addition:
    a. All ACT&R and ACTAS AED devices were reconfigured or replaced shortly after Ms Tunumafono's death to provide better guidance as to when a shock is indicated.
    b. Protocols have been developed about changing defibrillators when ACTAS take over treatment from ACTF&R.
    c. ACTAS have continued to "focus heavily on improving our cardiac arrest survival since this incident, by improving our models of care around roles in resuscitation, and regular simulation training for all paramedic staff".
    d. The ACTAS staff involved in Ms Tunumafono's treatment received targeted education, and the case was presented to an internal inservice session for the broader information of ACTAS officers.
16. On their face, these measures appear to address the matter of public safety which I have found to arise in this case. In those circumstances, I consider that no further recommendation by me is necessary.
17. By way of additional comment, it is apparent that it would be desirable for all electronic treatment equipment to be synchronised to a time standard. It is not uncommon that emergency treatment will be provided from multiple sources, as was the case here. Being able to properly compare the timing of historic observations and measurements would clearly be of benefit in patient treatment, as well as assisting in any later investigation or review. However, I make no formal recommendation in this regard.

Court Reference:	CD 238/11
Age:	61 years
Gender:	Female
Date of Death:	13/09/2011
Place of Death:	Dickson, ACT
Coroner:	L.A. Walker
Date of Findings:	20/12/2018

Reported as: [2018] ACTCD 20

…

17. The medical care Dr Kingston provided to Ms Hasleby was sub-optimal.
18. Whilst noting the complexity of her presentation both medically and socially, the drug regime prescribed for Ms Hasleby was contraindicated having regard to her conditions, particularly the COAD. Despite that, no conclusion can be drawn as to the contribution of this prescription regime to Ms Hasleby's death.
19. Dr Kingston's failure to insist on a personal review of Ms Hasleby before prescribing further medication on 12 September 2011, particularly in light of the worsening hypoxia evidenced by the blood test, was inappropriate. However, it is not established that the lack of adequate medical intervention contributed to Ms Hasleby's death.
20. It is reasonable to conclude that a combination of Ms Hasleby's social situation and reluctance to engage in more proactive medical intervention reduced her prospects of a better outcome. Dr Kingston prescribed a potent cocktail of central nervous system depressant medications for a very long time. This continued in the period proximate to Ms Hasleby's death by telephone without adequate review in the presence of cogent evidence of respiratory deterioration. To this extent, an opportunity to intervene in relation to Ms Hasleby's deteriorating medical condition was lost.
21. Pursuant to s 52(1) of the *Coroners Act 1997*, I make the following findings:
    (a) The deceased is Lesley Kaye Hasleby, born on 25 August 1950. The deceased died at 39 Majura Avenue, Dickson, in the Australian Capital Territory on or around 13 September 2011.
    (b) The cause of death is respiratory failure consistent with end stage chronic obstructive airways disorder. The manner of death is unascertained.
    (c) Pursuant to s 54(2), I find that no issue of public safety arises. Whilst I find that Dr Kingston's treatment of Ms Hasleby was sub-optimal, Ms Hasleby was a difficult patient who failed to act in her own best interests. Dr Kingston's acceptance of her error indicates that she has learned from and is unlikely to replicate the errors demonstrated in her treatment of Ms Hasleby.
    (d) Noting the evidence of Dr Cox, I direct that a copy of these findings be conveyed to her and to the Royal Australian College of General Practitioners. The College may wish to provide guidance to its members on appropriate parameters for renewing prescriptions for patients without a face to face review, particularly when in possession of evidence of decline in their health status.

Court Reference:	CD 191/12
Age:	21 years
Gender:	Male
Date of Death:	21/07/2012
Place of Death:	Kingston, ACT
Coroner:	K.M. Fryar
Date of Findings:	15/02/2019
Reported as:	[2019] ACTCD 1

1. Mr Ben Catanzariti died on 21 July 2012 from head injuries suffered as a result of being struck by a concrete pouring boom whilst working at the Dockside Apartment Complex, Eastlake Parade, Kingston in the ACT.
2. A matter of public safety is found to arise in connection with this inquest.
3. It is not possible on the evidence to determine to the requisite degree the operative cause of the failure of the bolts that led to the collapse of the boom that caused Mr Catanzariti's death.
4. Assuming that the failure may have been caused by the failure of the workmanship of employees or agents of Schwing Australia Pty Ltd (on its own or in association with other factors) it is recommended that the company undertake a review of the processes that apply to the installation of bolts in machinery of this type.
5. Further to paragraph 4, above, a specific review should be conducted by Schwing Australia Pty Ltd of the methods employed to ensure individual bolts are uniformly tensioned and to ensure that load testing of booms is carried out after repairs of this type are undertaken. In this regard I note that Counsel for Schwing Australia Pty Ltd advised that such reviews have already been undertaken.
6. Assuming the failure of the bolts may have been caused by a failure of the bolt themselves (internal hydrogen embrittlement) or because of environmental hydrogen embrittlement (perhaps associated with the failure of the zinc coating), I recommend that the reports received in the coronial proceeding should be referred by WorkSafe ACT to the manufacturers and/or suppliers of the bolts for consideration as to whether bolts supplied and/or any zinc coating meet relevant industry standards both in Australia and in other countries.
7. Assuming that the failure of the bolts occurred as a result of the combination of the matters set out above it is recommended that the reports received in these proceedings should be referred by WorkSafe ACT to Safe Work Australia for consideration as to whether additional Australia-wide standards should be put in place:
    a. to ensure bolts used in the context of securing booms are safe;
    b. to ensure replacement and repair processes of such bolts are appropriate;
    c. to ensure that the cycle of replacement of these bolts is appropriate; and
    d. to require those processes to be effectively audited to ensure individual bolts are uniformly tensioned and to ensure that load testing of booms is carried out after repairs of this type are undertaken.
    e. I also recommend that WorkSafe ACT consider whether at an ACT level there are appropriate safeguards in place to address the matters referred to at paragraphs a – d, above.
8. I further recommend that the ACT develop its own guidance for those in the construction industry undertaking concrete pours in the terms suggested by Mr Reg Hobbs in his report.

Court Reference:	CD 80/17
Age:	35 years
Gender:	Male
Date of Death:	31/03/2017
Place of Death:	Tharwa, ACT
Coroner:	B.C. Boss
Date of Findings:	28/02/2019
Reported as:	[2019] ACTCD 2

10. Based on the evidence before me, I find that Michael Richard Hall died on 31 March 2017 at approximately 6.20am near the intersection of Williamsdale Road and the Monaro Highway in the ACT, as a result of head and other injuries suffered when he was struck by a car as he rode his bicycle on the Monaro Highway.

…

59. I am of the view that there is an argument that Mr Bobb was negligent in his driving. However, having regard to all the evidence before me and noting in particular the conflicting evidence in relation to Mr Hall's conspicuity for other drivers, the loss of evidence crucial to determining the conspicuity of Mr Hall's clothing and accoutrements, the physical environment of the road at the relevant location, and the high standard of negligence required by section 29, I do not have reasonable grounds for believing that Mr Bobb has committed an indictable offence.

60. I am not at liberty in the coronial jurisdiction to make a referral to the DPP in relation to summary matters. I will, however, refer the matter to the AFP for consideration as to whether a section 6 charge has been committed. All the submissions made to this inquiry will be forwarded to the AFP to assist in their consideration.

61. Mr Hall's death was avoidable, which makes the loss of this remarkable person even more keenly felt by his family and the community. It is unfortunate that the investigation into his death has been to some degree compromised by the loss of significant evidence in the form of his clothing and bicycle accoutrements. There is, however, sufficient evidence for his death to be the catalyst for changes that will enhance rider safety into the future.

62. Drawn from the facts and circumstances of Mr Hall's death I make the following recommendations:

(a) The ACT Government should conduct a review of the intersection of the Monaro Highway and Williamsdale Road to evaluate risk to road users, and a reassessment of funding priority in accordance with the review's findings.

(b) The ACT Government should define a clear outline of what constitutes a major intersection on the ACT portion of the Monaro Highway.

(c) The ACT Government should give consideration to the speed limits that should apply to major intersections along the ACT section of the Monaro Highway.

(d) Standards Australia should conduct a review of AS3562-1990 relating to bicycle lighting, and the Standard be either updated or replaced.

(e) The ACT Government should amend its relevant legislation to require a flashing rear light when riding a bicycle in low light conditions on rural roads. However, I also commend this recommendation to all Australian State and Territory Governments, for consideration of changes to the Australian Road Rules.

(f) The ACT Government should amend its relevant legislation to clarify whether bicycles require a wholly separate reflector to be on the back of the bicycle, or

whether the reflector may be integrated into the rear light. However, I also commend this recommendation to all Australian State and Territory Governments, for consideration of changes to the Australian Road Rules.

Court Reference:	CD 3/17
Age:	30 years
Gender:	Male
Date of Death:	06/01/2017
Place of Death:	Garran, ACT
Coroner:	R.M. Cook
Date of Findings:	27/03/2019

I, ROBERT MATTHEW COOK, a Coroner for the Australian Capital Territory hereby dispense with a hearing into the circumstances surrounding the death of LUKE RAYMOND NEWSOME being of the opinion, after consideration of information given to me by members of the Australian Federal Police and the medical practitioner who performed an examination at my direction, that the manner and cause of death is sufficiently disclosed and that a hearing is unnecessary.

I FIND THAT:

(1) The deceased died at The Canberra Hospital, 1 Dann Close, Garran in the Australian Capital Territory on 6 January 2017.

(2) The manner and cause of death was:

DIRECT CAUSE:

1. *Disease or condition directly leading to death:*
   (a) Severe closed head injury, due to
   (b) fall

(3) A matter of public safety was found to arise in connection with the inquest. However, I am satisfied that has been responded to by the Summernats organisers as set out in the Australian Federal Police file note as follows:

> "Since this incident the organisers for Summernats have amended the 'Entrants Terms and Conditions'. These changes reflect that it prohibits persons being seated in or on vehicles without being seated in a seat that is engineered for use in that vehicle and that the persons seated in that seat must be wearing a seatbelt. Along with restating that burnouts are prohibited within the event with the exception of certain specific events it appears that the event organisers have somewhat remedied the issues in regards to public safety."

I NOTE THAT:

(1) Cause of death was sufficiently disclosed in Supreme Court trial *R v Spong* [2018] ACTSC 129.

Court Reference: CD 204/17
Age: 92 years
Gender: Female
Date of Death: 17/09/2017
Place of Death: Garran, ACT
Coroner: L.E. Campbell
Date of Findings: 18/04/2019
Reported as: [2019] ACTCD 3

I, Lisbeth Campbell, Coroner for the Australian Capital Territory hereby dispense with a hearing into the circumstances surrounding the death of Lisa Bella Rose being of the opinion, after consideration of information given to me by members of the Australian Federal Police, the opinion of the medical practitioner who performed a post-mortem examination, and the expert review by Professor Tully Rosenfeld conducted at my direction that the manner and cause of death is sufficiently disclosed and that a hearing is unnecessary.

I find:
1 Lisa Bella Rose died at The Canberra Hospital on 17 September 2017,
2 That the manner and cause of Lisa Bella Rose's death is 'subdural haematoma as a result of a fall'; and
3 That, pursuant to s 52(4)(a)(i) of the *Coroners Act 1997*, no matter of public safety is found to arise in connection with this inquest.

Summary
4. Mrs Rose was a 92 year old resident at Mirinjani nursing home located in the suburb of Stirling in the Australian Capital Territory. She had a medical history including Parkinson's disease, schizo affective disorder, cognitive decline, hypothyroidism, chronic auto-immune thrombocytopenia, polymyalgia rheumatic, aortic valve stenosis and bronchial asthma.
5. On 11 September 2017 Mrs Rose fell at the nursing home at around 10:00 pm. The fall appears to have been caused when Mrs Rose became caught up in her nasal tubing. Mrs Rose sustained a bump to the posterior part of her head and a skin tear with some bleeding. She was found on the floor of the bathroom by Ms Fiona Lyons (a carer at the home). Ms Lyons proceeded to call the Registered Nurse ("RN"), Lady Christine Candungog who attended and administered first aid to Mrs Rose being bandaging and applying an ice pack. RN Candungog reported that Mrs Rose was conversing and appeared to be chatty during this interaction.
6. RN Elizabeth Florance assumed care for Mrs Rose from RN Candungog at shift change at around 11.00pm on 11 September. Over the course of the early hours of 12 September RN Florance conducted neurological observations of Mrs Rose on two occasions applying the Glasgow Coma scale, including "taking blood pressure, pulse

and a checking her pupils as well as the motor response in her limbs". The second set of observations were taken around 6 a.m. RN Florence noted that in both sets of observations that Mrs Rose "seemed all right at the time. The whole time she was alert and responsive".

7. On 12 September Mrs Rose was seen by Physiotherapist Elizabeth White. Ms White assessed Mrs Rose's mobility and found that she had the same mobility status as the day before. Ms White gave Mrs Rose directions for the use of a walker and seeking the assistance of staff while toileting. She asked Ms Rose about her level of pain and did not recollect that Ms Rose said she was in pain -
8. Further observations of Mrs Rose were provided by a number of other staff throughout 12 September and in each observation she was assessed to be active and alert.
9. On 13 September, around 7:30 a.m., RN Florance informed Registered Nurse Gregory Buckley that Mrs Rose had been difficult to rouse and she was asleep, which was unusual for Mrs Rose at that time of day. Mr Buckley then called GP Dr Shengwei (also known as Andy) Xie. Dr Xie examined Mrs Rose and found that she had a fever of 38 degrees and was unresponsive. She did respond to light as a stimulus and her air entry was equal, her heart sounded dual and her abdomen was soft, all of which was considered to be in the 'normal scale'.
10. RN Buckley then called Mrs Rose's daughter Christina Rose to advise her of Mrs Rose's condition. Christina then spoke with Dr Xie who advised her that he believed that Ms Rose's general deterioration might have been due to a stroke or infection. Christina attended the home and then requested an ambulance transfer of her mother to hospital. Mrs Rose was transferred to The Canberra Hospital ("TCH") around 3:00 p.m. on 13 September.
11. On admission to TCH Mrs Rose was given a CT scan which revealed a subdural haematoma. Given her medical conditions, the large haemorrhage, dementia, and her age, a decision was made by TCH staff that neurosurgical intervention was not desirable. The family consented to comfort care being provided to Mrs Rose. Mrs Rose was returned to the nursing home for comfort measures at around 4 pm on 14th September. However due to family concerns regarding care at the home, she was taken back to TCH for comfort care around 7 pm the same day. She died at TCH on 17 September 2017.
12. At my direction a post mortem report was prepared by Professor Johan Duflou who opined that the manner and cause of Mrs Rose's death was subdural haematoma as a result of a fall.

Comments:

13. The family raised concerns with the Court regarding care at the nursing home, and in particular the delay in referral to a hospital. In his post mortem report Professor Duflou notes these concerns and commented that 'the neurological state of the patient immediately post-fall and her subsequent course while at the nursing home is not clear from the provided material and therefore no comment can be made in relation to the delay in the patient being transported to hospital'.
14. Having regard to the concerns raised by the family and comments of the pathologist Police were directed to obtain statements from staff at the Nursing home. I summarise these as follows:

15. RN Candungog's handover notes included a direction for the RN to "contact family and Doctors tomorrow" (being 12 September 2019). It is evident that no referral was made on that date and that the family was not advised as to the fall until the morning of 13 September.
16. RN Florence noted that there were low staff levels on 11 and 12 September and that she was the only RN on shift during the morning of 12 September. She confirmed that she performed observations and Glasgow Coma Scale on 2 occasions but not every 15 minutes as per the home's head injury policy. RN Florance commented that "we didn't have time to do this because we were short staffed".
17. Graeme Barnes (Mirinjani service manager) expressed the view that the head injury policy was not followed to the letter by staff. The head injury policy provides for assessments to be conducted by a registered nurse every 15 minutes for the first hour, half hourly for the second hour and four hourly after that. Mr Barnes was advised by staff that policy wasn't followed because only one Registered Nurse was on shift on 11/12 September and was looking after all 124 residents of the facility at the time.

Expert review:

18. I then appointed a specialist geriatrician Professor Tully Rosenfeld to conduct an expert review of Mrs Rose's treatment recordsand provide an opinion as to the issues raised by the family and arising from the statements of staff at the nursing home.
19. In the report Professor Rosenfeld commented on the failure to refer Ms Rose to a GP immediately following the fall. He comments (at paragraph 8.16) that the "occurrence of a fall and head injuring particularly when the injury resulted in bleeding and the need for observation would, in my experience, necessitate discussion with or review by a doctor".
20. At Paragraph 8.2.1 of his report Professor Rosenfeld notes that "it is not feasible, in my opinion, to be certain of the course of events that would have occurred had the deceased been reviewed by a doctor and / or sent to the emergency department shortly following or the day after her fall". With that caveat in mind Professor Rosenfeld also indicates at paragraph 8.2.6 that "if a surgical depression was undertaken in the case of a small bleeding area, or soon after the deterioration in her status, it is more likely in my view that the Deceased would not have perished on this occasion".
21. At paragraph 8.2.10 Professor Rosenfeld further notes given Mrs Rose's age and health that "a decision to withhold surgical intervention and 'let nature proceed' may still have been taken at that point (on the Tuesday)". I consider that while the earlier referral may not have changed the ultimate outcome, at least if it had been made earlier, the family would have been in a position to be involved in the discussion and decision making around her treatment.
22. Professor Rosenfeld comments that it is "the usual and expected practice that family are notified of significant issue, particularly where a fall had occurred which led to a significant injury." He goes on to note that (at para 8.2.11) if the family been notified earlier "the family would have been more likely engaged with the decision making process, care and treatment would have been anticipated and planned, and a coroner's investigation into her death would have been avoided".

Matter of public safety:

23. It is my view that a hearing into manner and cause of death is not required. The manner and cause of death can be determined in accordance with the opinion of the forensic pathologist as 'subdural haematoma as a result of a fall'.
24. In relation to whether a matter of public safety arises, there is no conclusive evidence that a delay in referral to the hospital was causally related to Mrs Rose's death. At its highest the evidence suggests that that the failure to make the referral provided a lost opportunity for earlier intervention. I note that a finding by me that a delay in referral caused death may have significant adverse consequences for individual staff and the nursing home, and in that regard, the evidence does not rise to a level where I can be appropriately satisfied of the causation nexus. The issue is made more remote given the regular monitoring of Mrs Rose by staff on 12 September where no significant deterioration was observed.
25. Having reached the above conclusion, it follows that the failure of staff to comply adequately with the monitoring policy after a head injury, and low staffing numbers on the evening of the 11th, and the morning of 12 September 2017 are also issues that fall outside of the jurisdiction of the Court in this case. While I may express my general concern about such matters, I can make no formal finding in this regard.
26. I accordingly find that no matter of public safety arises in connection with this inquest.
27. While it is my conclusion that that the issues raised by Mrs Rose's family and discovered as part of the investigation are too remote to fall within my jurisdiction as Coroner, they are serious matters that warrant attention. In the circumstances the appropriate way for these issues to be considered is through a referral of the matter to the Aged Care Quality Commissioner. I have directed that such a referral be made, and that the Commission be provided with all coronial material obtained for this inquest.

Conclusion

28. After consideration of all the material provided to me, the manner and cause of Mrs Rose's death are clearly established. Mrs Rose suffered a subdural hematoma a result of a fall which ultimately caused her death. I extend my sympathies to Mrs Rose's family for the loss of their loved one.
29. The circumstances of Mrs Rose's death highlight some issues regarding her treatment and care after her fall. The chance of early intervention was lost by a failure of staff at the home to refer the matter to a doctor for review. That failure was compounded by the failure notify Mrs Rose's family of the fall and deprived them of the opportunity to be involved in discussions and planning regarding her treatment and care prior to her death. The concerns raised by the family in relation to those issues have now been forwarded to the Aged Care Quality Complaints Commissioner for investigation.

Court Reference:	CD 110/17
Age:	29 years
Gender:	Male
Date of Death:	13/05/2017
Place of Death:	Symonston, ACT

Coroner: G.S. Theakston
Date of Findings: 26/06/2019
Reported as: [2019] ACTCD 4

Mandatory hearing – death in custody
Reported under 102(a), (d)

…

34. The evidence at the hearing support a number of conclusions, and I accordingly make the following findings:
    (a) Mr O'Connor commenced use of methylamphetamine intravenously at an early age.
    (b) Mr O'Connor was subject to disciplinary action for possession of methylamphetamine while within the AMC.
    (c) Mr O'Connor used methylamphetamine while sharing a cell with another detainee before moving to Sentence Unit One.
    (d) There were multiple opportunities within the AMC for Mr O'Connor to receive methylamphetamine and buprenorphine in the days and hours leading up to his death.
    (e) At 6:11 pm on 13 May 2017 when Mr O'Connor visited the laundry, he was alive and well.
    (f) On 13 May 2017, Mr C and Mr O'Connor both used methylamphetamine.
    (g) At 6:55 pm on 13 May 2017 Mr O'Connor was removed from his cell unconscious, not breathing and with no detectable pulse.
35. The above medical evidence together with the above findings, lead me to conclude and find without reservation that:
    (a) Mr O'Connor died at about 7:00 pm on 13 May 2017 at the Alexander Maconochie Centre; and
    (b) Mr O'Connor's death was caused by multiple drug toxicity, being either an overdose due to methylamphetamine alone, or arising from the combination of methylamphetamine and buprenorphine.
    (c) It is likely that the methylamphetamine was self-administered between 6:11 pm and 6:55 pm on 13 May 2017 while Mr O'Connor was in his cell.
36. During the hearing it became immediately apparent that illicit drugs were available within the AMC and could be moved easily between detainees. I accept the submission of Mr O'Connor's family that the evidence supports the following conclusions:
    (a) Detainees would regularly place towels over the doors of their cell, which obscured the view into the cells by officers.
    (b) Detainees passed small items around the closed doors of the cells.
    (c) Detainees could pass items through yard fences.
    (d) Detainees, at times, moved beyond Sentenced Unit One.
    (e) When outside of their cells, detainees could pass items between each other.
    (f) Drugs and other items were able to be brought into the AMC, including through contact visits.
37. At the beginning of the hearing I indicated that the inquest would not focus on the general question about drugs entering and circulating within correctional institutions. I did so for two principal reasons.

38. The challenge of keeping illicit drugs and other prohibited items out of correctional institutions appears to be ubiquitous in nature and experienced universally across correctional institutions within Australia and beyond. Therefore any considered assessment or analysis of the problem would look at various centres, at various locations and at various times, including the range of responses employed and contemplated. To conduct an inquiry solely into what may be occurring at the AMC at the material time would at best be myopic.
39. Secondly, the challenge of keeping illicit drugs and other items out of correctional institutions takes place in the setting of ongoing evolutions of techniques to bring those items into the institutions and systems designed to keep them out. Any public inquiry about that challenge would risk publicly disclosing weaknesses in the systems used by institutions and identifying methods of infiltration that are likely to remain or become effective.
40. I note that the submissions made on behalf of the Territory contains an undertaking by the Territory that it would undertake a review into the practice of detainees passing items through cell doors.
41. I also note that the issue of drugs entering and circulating within the AMC has been touched upon by other inquiries. I will therefore only note the issue, and leave it to the Executive to investigate and manage further.
42. The Territory submitted that I should make the finding that it was unlikely that the buprenorphine found in Mr O'Connor's blood had been diverted from detainees who had been prescribed Suboxone at the AMC. This was on the basis that Suboxone is prescribed at the AMC for opiate replacement therapy and contains naloxone and buprenorphine. Mr O'Connor's blood was tested for naloxone and none was detected.
43. Prof Duflou explained that the half-life of naloxone is given as 30 to 80 minutes, and so it would be entirely possible for Suboxone to have been taken sometime previously, for example a number of hours before, and for no naloxone to be detected, but for both buprenorphine and norbuprenorphine to be detected in Mr O'Connor's blood.
44. While I accept that it remains open on the evidence that Mr O'Connor did not consume Suboxone, in the light of Prof Duflou's evidence, it would not be appropriate for me to make a definitive finding that Mr O'Connor did not consume that medication.
45. Mr O'Connor's family's final submission expresses concerns about Mr O'Connor being placed in a cell with another drug user, in circumstances where Mr O'Connor himself was trying to minimise his drug use. They suggest that there should have been a considered assessment of Mr O'Connor's situation.
46. Unfortunately, this issue was raised very late and was not explored during the hearing. There is insufficient evidence to allow me to comment about that claim in any meaningful way. For example, we do not know what assessment may have been conducted, what facts were considered and how those facts were individually weighed. I have much sympathy for Mr O'Connor's family and understand their concerns and hopes for Mr O'Connor. However, I also have difficulty in understanding how the AMC could operate other than, at times, placing detainees with drug histories in cells together. To do otherwise, would involve either detainees not sharing cells or detainees with drug histories only sharing cells with those without drug histories. It is notorious that a significant proportion of the AMC

detainee population have a history with drugs. Further, some may argue that a detainee without a drug history would themselves be placed at a heightened risk of commencing drug use when they share a cell with a detainee with a drug history.

47. For those reasons, I am not of the view that this is a matter of sufficient public safety to warrant me inquiring further into the matter and receiving additional evidence.
48. Due to the nature of the location where Mr O'Connor was moved to and treated, there was clear CCTV footage of the movements and actions of those present. During the time of the emergency up until Mr C was placed in an adjoining cell, Mr C could be observed to move freely around the immediate area of the common room and his cell. On at least three occasions he re-entered Cell 2. He was also observed to hold and place down an item which appears to have been a tobacco pouch of sorts.
49. While in retrospect it may have been better to secure Mr C as soon as possible, and there were sufficient staff to do that, it is difficult to criticise the officers present or the procedures in place at the time. The officers appropriately directed their attention to the immediate treatment of Mr O'Connor. While Mr C was free to move around the immediate area, he was still secured and still monitored to some extent by the officers present.
50. The procedures appropriately prioritise the provision of life saving treatment to detainees over the securing of a potential crime scene.
51. In the above circumstances, I make no adverse finding against any individual or the Territory about the quality of care, treatment or supervision of Mr O'Connor.
52. In the above circumstances I make no recommendation in relation to the matters of public safety discussed above.

Court Reference:	CD 10/15
Age:	47 years
Gender:	Female
Date of Death:	07/01/2015
Place of Death:	Isabella Plains, ACT
Coroner:	L.A. Walker
Date of Findings:	04/06/2019
Reported as:	[2019] ACTCD 5

2. Having held a hearing over three days, I now make the following formal findings:
   (a) The deceased, Lauren Maree Johnstone, died at 18 Jondol Place, Isabella Plains, in the Australian Capital Territory on 7 January 2015.
   (b) The manner and cause of her death was the combined toxic effect of prescription and non-prescription medications including doxylamine, tramadol, codeine, oxycodone, zopiclone and fluoxetine, lawfully prescribed or obtained.

…

49. I make no criticism of Dr Taylor or Dr Schimmelfeder for failing to have regard to the referral letter nor of their prescription of opioids for Ms Johnstone in the circumstances. Nor do I criticise Dr Di Dio for failing to raise the issue of Ms Johnstone's past medication seeking behaviour in light of her compliance with the existing medication contract and the fact that he was unaware of further surgery planned for January 2015.

50. There is no doubt that closer communication between the treating doctors may have resulted in a different outcome, for example, by denying or delaying surgery, requiring lesser pain control with non-opioid substances or prompting closer enquiry as to the use of non-prescription medications. This is speculative and ultimately a counsel of perfection. It also fails to recognise the role played by Ms Johnstone in failing to fully inform her treating doctors as to medications she was using.

…

54. I have considered a number of recommendations proposed by counsel assisting which were either supported or not opposed by Dr Di Dio, Dr Taylor and Dr Schimmelfeder. I have adopted the majority of them as follows:

(a) that the Therapeutic Drugs Authority consider whether promethazine and doxylamine are appropriately scheduled in the Poisons Standard, or whether some further form of restriction to these medications having regard to the risk of misuse (including when taken in combination with other sedating medications) is warranted;

(b) that irrespective of the response of the Therapeutic Drugs Authority, the ACT Health Minister by instrument declare the following substances to be monitored medicines for the purposes of the DORA system: tramadol, doxylamine and diazepam;

(c) that the ACT Health Minister consider widening the scope of monitored medicines under the DORA system to include the entirety of medicines listed in Schedules 3 and 4 of the Poisons Standard;

(d) in the alternative, that the ACT Health Minister consider widening the scope of monitored medicines under the DORA system to include certain prescription and over-the-counter medications that may have significant sedating or other adverse effects when taken in combination with opioids or benzodiazepines;

(e) that the ACT Health Minister consider adding functionality to the DORA system to highlight where a patient has demonstrated drug-seeking behaviour, including but not limited to, when a patient has signed a medication contract;

(f) that the ACT Health Minister consider making access to and use of the DORA system mandatory for all ACT prescribing physicians and pharmacists prior to writing and/or dispensing prescriptions;

(g) that the CAPS Clinic and Sole Vita Day Surgery alter its pre-admission forms to expressly prompt patients to list all over-the-counter medications they are either presently taking or take frequently, perhaps with examples of some common brand names;

(h) that the Royal Australian College of General Practitioners, the Australian and New Zealand College of Anaesthetists, and the Royal Australasian College of Surgeons all consider conducting information campaigns with their members to encourage specific prompting (verbally and on applicable forms) of patients on consumption of over-the-counter medications when taking a patient's history.

Court Reference:	CD 199/17
Age:	43 years
Gender:	Male
Date of Death:	04/09/2017
Place of Death:	Bruce, ACT
Coroner:	L.A. Walker

Date of Findings: 25/06/2019
Reported as: [2019] ACTCD 6

4. Having considered the brief of evidence, I now make the following formal findings:
(a) Jay Alan Paterson died on 4 September 2017 at Calvary Public Hospital, Mary Potter Circuit, Bruce in the Australian Capital Territory;
(b) The manner and cause of death of Mr Paterson are sufficiently disclosed and a hearing is unnecessary;
(c) The cause of Mr Paterson's death is hypoxic-ischaemic encephalopathy following a polypharmacy overdose and iatrogenic upper airway injury, but I make an open finding as to the manner of his death; and
(d) Pursuant to section 52(4)(a)(i) of the *Coroners Act 1997*, a matter of public safety is found to arise in connection with this inquest.

…

40. 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. As discussed above, the two issues specifically raised by Mrs Paterson for my consideration are:
(a) the general issue of easy access to opioid medications; and
(b) the actions of Dr Renshaw on 30 August 2017, both in prescribing Mr Paterson more opioids and failing to diagnose pneumonia.

41. I will also consider issues of Mr Paterson's treatment at Calvary Hospital on 31 August 2017.

…

46. On that basis I do not think any referral to AHPRA is warranted in respect of individual doctors who treated Mr Paterson in the last months of his life. I find that no matter of public safety arises in respect of the treatment of Mr Paterson by individual doctors.

47. However, the general issue raised by Mrs Paterson about access to opioid painkillers is a matter of public safety. Easy access to opioid painkillers 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 and the *Inquest into the death of Lauren Maree Johnstone* [2019] ACTCD 5.

48. The family concerns have partially been addressed during the passage of time since Mr Paterson's death. In the *Inquest into the death of Lauren Maree Johnstone* [2019] ACTCD 5 I discussed in some detail the Drugs and Poisons Information System Online Remote Access system ('DORA') and how it presently operates in the ACT to provide real-time information to prescribing doctors and pharmacists in relation to patient access to Schedule 8 medications (which includes certain opioid medications). The ACT DORA system includes information from ACT doctors and pharmacists as well as the dispensing of ACT prescriptions in NSW. Had that system been available to ACT prescribers and pharmacists in Mr Paterson's case, it may have led to them taking a different therapeutic course in respect of the treatment he received in the Australian Capital Territory.

49. However, there is no real-time prescription monitoring system available in New South Wales at the present time, despite the recommendations of many coroners over the years. Most recently, NSW Deputy State Coroner Grahame reiterated that

recommendation (among others) on 1 March 2019 in the *Inquest into the deaths of DB, RG, AH, JD, DC & AB*, which examined a series of opioid deaths which occurred in New South Wales in June 2016.

50. Although Mr Paterson's apparent reason for seeing a NSW GP is plausible, the evidence also suggests that Mr Paterson leveraged off the information disparity and differences in regulation between the two jurisdictions to obtain opioid medication more readily in New South Wales than he was able to access in the Australian Capital Territory. In the ACT, all long term opioid prescriptions require the approval of the Chief Health Officer, but, in New South Wales, this only applies to injectable opioids or where the doctor is prescribing because the patient is considered 'drug dependent'. In Mr Paterson's case, the NSW doctors who treated Mr Paterson and provided statements said that because Mr Paterson had pain needs that warranted the prescribing of opioid painkillers, they did not consider they were prescribing for a drug dependent person in the way that this term was interpreted by NSW Health. Dr Renshaw in particular carefully considered whether Mr Paterson fit the NSW definition of drug dependent. However, the delegates of the ACT Chief Pharmacist interviewed by coronial investigators when shown Mr Paterson's prescription record for 2017 said they considered Mr Paterson was engaging in drug seeking behaviour in 2017 and they had no visibility over what was occurring in NSW.

51. I share the view of NSW Deputy State Coroner Grahame, and other Australian coroners, that there is a pressing need for a real-time prescription monitoring system in New South Wales, ideally as part of a national system. A national real-time prescription monitoring system might have enabled Mr Paterson's Queanbeyan doctors to have seen the amounts of medication prescribed to him in the Australian Capital Territory, and to ensure that Mr Paterson could not leverage off the differences in regulation to obtain opioid medication in New South Wales that he was, or would have been, denied in the Australian Capital Territory.

…

59. However, Mr Paterson appears to have given coherent and reasonable reasons as to why he needed painkillers. Dr Renshaw was not to know that Mr Paterson's account of his wife having confiscated his medications was not true – indeed, this would have fitted with the account provided by Mrs Paterson to Dr Renshaw prior to the consultation of her concerns for her husband irrespective of whether Mrs Paterson stated that she had confiscated Mr Paterson's medications.

60. The other concern held by the family is that Dr Renshaw did not conduct any physical examination of Mr Paterson. Family members said later that they could hear an audible rattle in Mr Paterson's chest that day and, on admission to Calvary Hospital the next morning, Mr Paterson was reported to have pneumonia.

61. Dr Renshaw said in his statement for the coronial brief that Mr Paterson made no complaint of respiratory symptoms at the time. The notes of this consultation as discussed above also make no mention of respiratory symptoms. The respiratory symptoms identified on admission to hospital could well be the result of drug toxicity in Mr Paterson's system.

62. Accordingly, I am not satisfied that the conduct of Dr Renshaw on 30 August 2016 amounts to a matter of public safety.

…

65. The evidence suggests that, during the intubation attempts, a false track was created through the cricothyroid membrane which resulted in an extraluminal air leak into

the neck tissue which caused extensive surgical emphysema. This track was able to be confirmed and identified at autopsy. However, Professor Duflou also noted at autopsy that Mr Paterson's laryngeal cartilages were significantly stiffer, more calcified and more ossified than usual for a man of Mr Paterson's age.

66. Tracheal perforation is a known risk of intubation. Mr Paterson clearly required intubation after he displayed respiratory distress and non-invasive ventilation had failed. In the light of the autopsy findings, I consider that no matter of public safety arises in respect of the conduct of the intubation and no adverse comment or finding is warranted in respect of the physicians involved. It appears that, once the issue was identified, it was promptly remedied with corrective surgery and all appropriate care was taken in undertaking the intubation.

…

69. In accordance with my finding of a matter of public safety in relation to the easy access to opioid medications by drug dependent persons, I make the following recommendations:
    (a) There should be instituted a real-time prescription monitoring system in New South Wales, ideally as part of a national system.
    (b) Given the geographical location of the Australian Capital Territory as an island within New South Wales, NSW Health and ACT Health should develop processes and procedures in relation to dealing with drug dependent persons who seek treatment across the two jurisdictions concurrently. Such processes and procedures should address issues of information disparity and differences in regulation, which mean that opioid medication is more readily available in New South Wales than it would be to a similar patient in the Australian Capital Territory.

Court Reference:	CD 118/16
Age:	58 years
Gender:	Male
Date of Death:	22-23/05/2016
Place of Death:	Griffith, ACT
Coroner:	R.M. Cook
Date of Findings:	20/06/2019
Reported as:	[2019] ACTCD 7

Mandatory hearing – death in custody

Reported under 102(a), (d)

1 Mr Mark Anthony O'Brien died at Unit 3 of 1 Dawes Street, Griffith in the Australian Capital Territory between 6.00 pm on Sunday 22 May 2016 and 11.45 am on Monday 23 May 2016;

2 The manner and cause of Mark Anthony O'Brien's death is 'Heroin toxicity'; and

3 That, pursuant to s 52(4)(a)(i) of the *Coroners Act 1997*, no matter of public safety is found to arise in connection with this inquest.

…

27. At the time of his death, Mr O'Brien was subject to a Psychiatric Treatment Order under Division 4.4 of the *Mental Health (Treatment and Care) Act 1994*, which had been made on 10 December 2015 and granted for a period of six months.
28. Accordingly, Mr O'Brien's death falls within the definition of "Death in Custody" as set out at section 3C of the Act. As such, pursuant to section 34A(2) the Coroner must not dispense with a hearing in relation to his death.
29. Pursuant to section 74 of the Act I am required to include in the record of proceedings findings about the quality of care, treatment and supervision of the deceased should they, on balance of probabilities, be found to have contributed to the cause of Mr O'Brien's death.

…

36. There are number of issues to consider in relation to the care and treatment Mr O'Brien received in the time leading up to his death. These include (a) the management of his mental health (b) management of his prescription drug addiction and (c) the communication and coordination between the professionals caring for Mr O'Brien including his GP, the Pain Management Unit, and Mental Health Services.

A. Mental Health

37. At the time of his death Mr O'Brien was on a Psychiatric Treatment Order. The next review of the Order was schedule to occur on 2 June 2016. His treating team did not note Mr O'Brien presenting as a risk to himself or others when he was reviewed, and it appears that the depot injections of anti-psychotic medication had reduced the symptoms of his illness including, thoughts of self-harm, or persecutory delusions.
38. Throughout his stay at ASUSD (March-May 2016) Mr O'Brien was regularly reviewed by psychiatric registrar Nadine Fox and was managed by Tracey Crowe from Woden Mental Health. During that time his mental state was assessed as "stable, without psychosis" but, "at risk of deterioration" and he was not noted as being at risk of self-harm. He was assessed as being "unable to live independently due to medical issues including falls risk, medication safety, he has shown diminished capacity for self-care". These issues were the focus of his referral to the ASUSD on 5 May 2016.
39. While largely historical the medical management of Mr O'Brien's mental health appears appropriate in all the circumstances at the time and preceding his death.

Polypharmacy / drug abuse

40. Mr O'Brien's significant and long term issue with the abuse of prescription medication, in particular opioid medication, was well documented. He had been taking MS Contin, OxyContin, Oxycodone, and other opioid based prescription medication for over 20 years at the time of his death. He was also well documented as over using prescription benzodiazepines. His treating doctors were unable to effectively engage him in a process to reduce or properly manage his abuse of those medications which were prescribed for his chronic back pain. The analysis and concern regarding this abuse was long standing and consistent:
    a. In 1997 Dr Mazengarb (TCH Pain Management) was of the opinion "that dependence is a greater problem than pain management."
    b. In 2004 Dr Moulding described Mr O'Brien as "manipulative and drug seeking".
    c. In 2005 Mr O'Brien's opioids prescription was altered and prescription reduced. Within 2 months he committed a criminal offence based on drug seeking behaviours.

d. In 2007 Danny Farrow noted that it "May be difficult to curtail Mark's drug seeking behaviours as they have become entrenched over many years"-
e. In 2013 Dr Wessell wrote "When I first saw him, he was taking 4 times 11 Mg MS Contin daily. Battled him down over a couple of years to 3 daily and have struggled to keep him within that limit. He also takes up to 8 Endone and 4 Valium.
f. On 5 March 2016 Mr O'Brien was admitted to TCH after an alleged overdose of his MS Contin.
g. On 17 May 2016 Mr O'Brien self-discharged from the ASUSD because "he didn't like people interfering with his medications".

41. Mr O'Brien's last prescription of MS Contin and Endone was on 31 December 2015 from Dr Wessel. Dr Wessel authority to prescribe these medications (given by Chief Medical officer) expired on 17 March 2016.
42. During his penultimate admission to TCH, between 5 March and 22 March 2016, Mr O'Brien was withdrawn from his MS Contin (given MS Contin on 5 March then medication ceased). TCH staff continued to monitor his progress during this time and he did not display symptoms of withdrawal between 5 and 11 March. During that period Mr O'Brien refused to accept a referral to Drug and Alcohol Services at TCH.
43. On 11 March 2016, Drug and Alcohol spoke to Mr O'Brien and he denied substance abuse and indicated that he wanted to continue to take MS Contin. No Withdrawal symptoms were noted.
44. A referral to Pain Management was suggested after a successful withdrawal from opiate medication in the hospital, however he refused that referral confirming that he wanted to maintain his previous prescription of MS Contin. At one point in March he went AWOL from the hospital and attended a pharmacy in an attempt to obtain medication but was refused.
45. On 21 March the drug and alcohol unit and Dr Wessell were both contacted by TCH Staff. It was agreed that in circumstances where it seemed Mr O'Brien had been successfully withdrawn from MS Contin and was managing on Endone that he should not have his regular prescription re-introduced on discharge other than daily release of Endone. Dr Wessell advised that he should be seen by Pain Management and Mr O'Brien was offered the opportunity to have such an appointment made on 21 March which he declined. He then discharged himself against medical advice on 22 March.
46. On 23 March 2016 Dr Wessel wrote to both Pain Management and the Manuka Pharmacy. She requested that Pain Management make an appointment for Mr O'Brien and advised the pharmacy that he should continue to receive only daily dose of Endone and to limit his MS Contin from the reminder of the final prescription made in December 2015.
47. Mr O'Brien was again admitted to TCH on 30 March 2016 and he remained on the same treatment without MS Contin until he self-discharged on 17 May 2016. Although he had been taken off Benzo's during his previous admission Mr O'Brien was prescribed a further 50 valium by Dr Wessell on 11 May. On that same date she wrote to Pain Management and asked them to make an urgent appointment with Mr O'Brien who she noted was staying at ASUSD.
48. On 16 May 2016 workers from ASUSD met with Mr O'Brien to discuss the reasons for withholding medication (benzo) that day (as he seemed over sedated) and it was this discussion that seemed to be the catalyst for his self-discharge. Those workers

ensured that Mr O'Brien had access only to enough medications until follow up the following day to prevent possible overdose. Mr O'Brien was scheduled to see Dr Wessell on 18 May 2016 but did not attend for that appointment.

49. It is clear that the cessation of Mr O'Brien's opioid treatment was an attempt to address Mr O'Brien's addiction to prescription drugs which had manifested it over many years. The successful reduction of his usage whilst in hospital was then followed up by the referral to ASUSD for rehabilitation before being returned to the community.
50. It is apparent that Mr O'Brien decided to discharge himself early against advice, and once back in the community that he made no efforts to engage with services to have his medication reviewed or reassessed.
51. In the circumstances, given his history, Mr O'Brien's treating doctors may have formed the view that there was a risk that he would engage in drug seeking behaviour, and how that might be done, i.e. illicitly, would, it seems to me, have been known by the medical teams in a general sense, however it was not, I am satisfied, capable of translating into a finding that they would know or could at least assume to know that Mr O'Brien would in fact pursue heroin and consume it in that manner.
52. From the evidence it is clear that the medical management of Mr O'Brien's drug dependency was challenging for medical practitioners dealing with him. Mr O'Brien's behaviour demonstrated a continued pattern of drug seeking/abusing behaviour that a number of practitioners attempted to address over time without success. And as a consequence while his behaviour contributed directly to the manner and cause of his own death the engagement of medical service providers and their dealing with Mr O'Brien does not causally link their actions to the manner and cause of his death so as to contribute in an adverse way to the manner and cause of Mr O'Brien's death.

Public Safety

53. The final issue to consider is whether any issues of public safety arise from the manner and cause of Mr O'Brien's death. The extent and the duration of the prescription of opiate based medication to Mr O'Brien in a preliminary sense raises concerns for me in the extent of prescribed medication of that opiate based medication.
54. I am not satisfied the evidence before me reaches the standard required to the extent that it would enable me to make an adverse finding that the prescription regime underpinning the provision of the opiates to Mr O'Brien by medical providers contributed to the cause of death.
55. However, having said that, a suggestion that technology might be introduced to track pharmacotherapy treatment of a person so as to avoid over prescription would be a worthwhile aim particularly where the person is intent on seeking more and more of the drug that is being prescribed to them from various sources.
56. I find that Mr O'Brien's death was caused by a heroin overdose after Mr O'Brien self-discharged from his rehabilitation program. And that the addressing by medical and drug service providers of appropriate medication to Mr O'Brien and combined efforts to reduce his access to and reliance upon such medication leads me to conclude that in an overall sense, the pharmacotherapy treatment provided could be reasonably linked to the manner and cause of death having regard to his own actions after self-discharging.

57. Accordingly, I am satisfied that no matters of public safety arise that would attract either a recommendation or an adverse finding.

Court Reference:	CD 186/18
Age:	51 years
Gender:	Male
Date of Death:	02/08/2018
Place of Death:	Garran, ACT
Coroner:	L.A. Walker
Date of Findings:	27/06/2019
Reported as:	[2019] ACTCD 8

…

32. I find that Mr Senini inadvertently neglected to fully close the valve on an acetylene cylinder when packing his trade equipment into a sealed storage compartment on his work vehicle.
33. During the afternoon, the acetylene cylinder continued to leak acetylene gas, causing a build-up of acetylene gas in the sealed storage compartment which formed an explosive mixture with air.
34. I note that acetylene gas is flammable in air in concentrations ranging from 2.4% to 83% and has a very low ignition energy, so even low energy sparks such as static electricity can cause ignition and explosion.
35. About 4:45pm, Mr Senini drove his work vehicle to St Clare of Assisi Primary School to collect his son from after school care, unaware of the explosive mixture of acetylene gas and air in the storage compartment.
36. Mr Senini got out of his car and activated the electronic central locking system with a keyless remote control.
37. A short circuit between an exposed wire and bare metal created a spark in the storage compartment, igniting the acetylene gas mixture causing an explosion.
38. Mr Senini was standing adjacent to the storage compartment when the explosion occurred and was impacted by the full force of the explosion, suffering extensive injuries to his face, head, chest, abdomen and both arms, which were the direct cause of his death.
39. I find that Mr Senini died as the result of a tragic accident.
40. 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.
41. The Australian Standards, Code of Practice and safety information sheets applicable to the storage and transport of acetylene gas cylinders all require the cylinders to be stored and transported in well-ventilated compartments. These documents also identify the hazard of leaking acetylene forming an explosive mixture with air in an inadequately ventilated space, which can be ignited by a spark from sources including a vehicle's electrical central locking system.
42. Mr Senini's storage of an incompletely closed acetylene cylinder in the sealed storage compartment on the back of his utility did not comply with the relevant Australian Standards, Code of Practice and safety information sheets.

43. I note that on 6 August 2018 WorkSafe ACT released a Safety Alert titled 'WorkSafe ACT reminds industry about gas cylinder safety', which referenced the explosion that caused Mr Senini's death and reminded users of flammable gases of the dangers of transporting gas cylinders and the safety requirements when doing so.
44. I find that no issue of public safety arises. There is no benefit in recommendations.
45. Pursuant to s 52(1) of the *Coroners Act 1997*, I make the following formal findings:

(a) Shane Robert Senini died on 2 August 2018 at The Canberra Hospital, Dann Close, Garran in the Australian Capital Territory;

(b) The manner and cause of death of Mr Senini are sufficiently disclosed and a hearing is unnecessary;

(c) The cause of Mr Senini's death is multiple injuries caused by the accidental explosion of acetylene gas in a sealed vehicle storage compartment; and

(d) Pursuant to section 52(4)(a)(i) of the *Coroners Act 1997*, a matter of public safety is not found to arise in connection with this inquest.
