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

Mr Shane Rattenbury, MLA
Attorney-General
ACT Legislative Assembly
GPO Box 1020
CANBERRA ACT 2601

Dear Attorney-General

CORONER'S REPORT 2020/21

Section 102 of the *Coroners Act 1997* provides that 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.

Please find enclosed the annual report of the Court for the 2020/21 year.

Yours sincerely

Lorraine Walker
Chief Coroner
22 December 2021

ACT CORONERS COURT

ANNUAL REPORT 2020/21

[Coroners Act, section 102]

Issued at the direction of
Chief Coroner Lorraine Walker

December 2021

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Coroners Act 1997 (Excerpt)

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.

Amendments to the Coroners Act

In January 2021, amendments to the Act came into effect to better respond to the needs of families engaging in the coronial system and to make it easier for the Court to implement restorative approaches in its daily practice. These amendments acknowledged the significant impact that an inquest or inquiry may have on the family and friends of a deceased person and are intended to enable better engagement of families and friends in the process. Cultural considerations are also taken into account and respected.

Importantly, the amendments created a definition of 'death in care' which applies to deaths where a person was subject to an order under the *Mental Health Act 2015* or section 309 of the *Crimes Act 1900.* Step-parents were also included in the definition of 'member of the immediate family'.

WORK LOAD STATISTICS

Cases Lodged

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

Table 1: Cases Lodged				
Type	**2020-2021**	2019-2020	2018-2019	2017-2018
Deaths	**369**	346	313	305
Fires	**0**	0	2	3
Disasters	**0**	0	0	0
Total cases	**369**	346	315	308
Yearly percentage increase	**6.3%**	10.2%	2.3%	2.0%

The Coroner's Court again experienced a large increase in the percentage of cases lodged this financial year of 6.3 percent, up from an increase of 10.2 percent in the 2019/2020 financial year. These figures

represent an increase in cases lodged of approximately 21 percent over a 5-year period. This increase from the previous financial year cannot be explained by population growth alone[1].

Notably, the Court received reports of:

- 59 deaths of NSW residents which occurred within the ACT (just under 16% of the total of coronial matters). This is a decrease from 76 reports from the previous financial year.
- A total of 498 admissions to the Forensic Medicine Centre, including 13 post-mortems conducted on behalf of hospitals and 69 admissions for deceased who were subsequently determined to be outside the jurisdiction of the Coroner.

Type of Referral

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

Of particular note, legislative amendments to section 13(1)(i) passed in January 2021 allow for a distinction between a death 'in custody' and a death 'in care'. This head of jurisdiction refers to deceased who were in a health facility or under a psychiatric treatment order at their time of death ('death in care'), as opposed to deceased who were detained either by police or in a corrections facility at the time of their death ('death in custody').

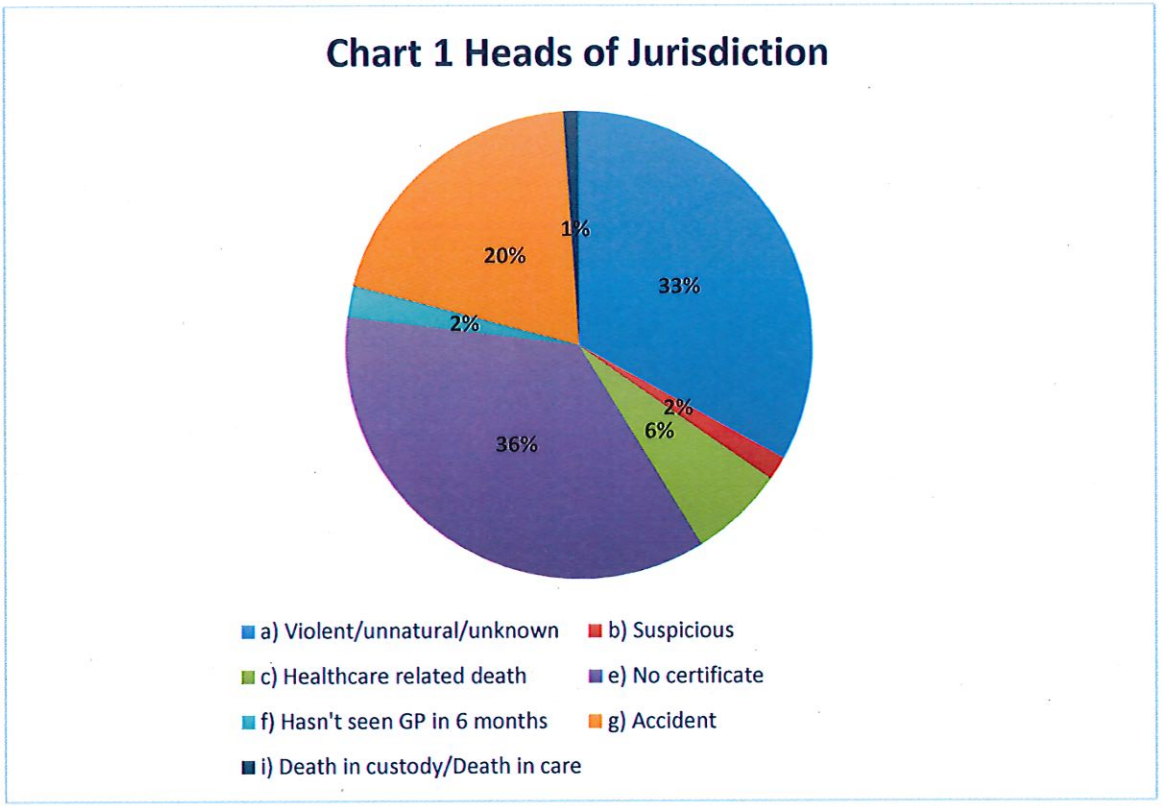
Table 2: Heads of Jurisdiction

	2020-2021	2019/20	2018/19	2017/18	2016/17
(a) Violent/unnatural/unknown	**122(33%)**	122(35%)	86 (27%)	101(32%)	61 (19%)
(b) Suspicious	**6 (1.6%)**	3 (1%)	1 (0.3%)	5 (2%)	10 (3%)
(c) Health-care related death	**24 (6.5%)**	8 (2%)	28 (9%)	17 (5%)	21 (6%)
(d) Chief Coroner own motion health care related death	**0**	3 (1%)	2 (0.6%)	0	0
(e) No certificate	**132 (36%)**	139 (40%)	139(44%)	130(41%)	157(48%)
(f) Hasn't seen GP in 6 months	**8 (2.1%)**	10 (3%)	8 (3%)	7 (2%)	8 (2%)
(g) Accident	**73 (20%)**	56 (16%)	46 (15%)	49 (16%)	66 (20%)
(h) Attorney-General direction	**0**	0	0	0	0
(i) Death in care	**3 (>1%)**	0	0	0	0
(i) Death in custody	**1(>1%)**	6 (2%)	2 (0.6%)	7 (2%)	3 (1%)

[1] Australian Bureau of Statistics reports at 31 March 2021 a population increase of 0.4% retrieved from National, state and territory population, March 2021 | Australian Bureau of Statistics (abs.gov.au)

Referrals to the coroner of deceased persons for whom no certificate identifying cause of death was provided remains the leading head of jurisdiction (132 referrals), closely followed by violent/unnatural/unknown deaths (122 referrals). Notably deaths by accident (73 referrals) increased by 20 percent from the previous year.

As I note every year, these figures need to be considered in context. Firstly, these numbers reflect only the basis on which a matter is referred to the coroner by police and do not reflect the ultimate findings made by a coroner. Secondly, matters may be referred under multiple heads of jurisdiction.



Hearings / Attendances

The Court maintained a steady hearing schedule, with several complex and lengthy matters finalised: see Table 3

Table 3: Attendances					
	2020/21	2019/20	2018/19	2017/18	2016/17
No. of hearings	**8**	15	8	6	8
No. of attendances	**73**	46	49	50	57
Attendance indicator	**12.5**	3.1	6.1	8.3	7.1
Hearing time (days)	**73**	55	27	37	28

Relevantly, 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 a hearing was held. It is a very raw number: a 15-minute directions hearing is recorded in 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. The Coronial Court was affected by the delays in hearings caused by the pause on hearing matters in the first half of 2020 due to COVID-19 restrictions.

Cases Finalised

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

Table 4: Cases Finalised					
Type	**2020/21**	2019/20	2018/19	2017/18	2016/17
With a Hearing	**3**	15	8	6	8
Deaths	**3**	15	8	6	8
Fires	**0**	0	0	0	0
Disasters	**0**	0	0	0	0
By Chambers decision	**252**	344	333	294	297
Deaths	**252**	340	330	294	297
Fires	**1**	4	3	0	0

Disasters	**0**	0	0	0	0
Total Cases	**256**	359	341	300	305
% Hearing Rate	**1.2%**	4.2%	2.3%	2.0%	2.6%

Matters which resolved without the need to proceed to hearing constitute 98.9% of all inquests finalised in the 2020/21 year.

Timeliness

The coronial unit saw a 6 percent increase in coronial deaths ('lodgements') from the previous year, which amounts to a 20 percent increase in the number of lodgements since 2017/18. Despite best efforts and additional resourcing, there was a decline in the number of matters that were finalised in 2020/21, with approximately 70 percent of matters finalised against the number of lodgements. This decline from previous years can be attributed, in part, to the overall increase in lodgements and a large number of matters (approximately 50) which were finalised by the coroner but were pending communication with the family member prior to formal closure of the file. The increased focus in 2020/21 on a therapeutic model for coronial matters provided families with a further opportunity to consider the findings of the coroner prior to formal closure which resulted in some delay. Since 30 June 2021, approximately 145 matters have been formally closed which is expected to result in a significant improvement in finalisations for 2021/22.

A high volume of staff turnover in the very small coronial unit resulted in a number of positions not occupied for periods of time and which required additional training for new legal and administrative officers. Temporary legal officers were recruited in the second half of the year to assist with the backlog. The positive effects of these temporary positions are more likely to be reflected in the next financial year statistics.

In 2020/21, the coronial team also prioritised closing matters of higher complexity. Matters such as the inquest into the death of Bradyn Dillon comprised 30 days of hearing time across 2019 and 2020 and the four inpatient deaths in 2015 and 2016 at the Adult Mental Health Unit at The Canberra Hospital were finalised.

The impact of COVID-19 caused delays not only to hearing dates, but also in the redeployment of resources across the affected stake holders including the Australian Federal Police, ACT Health Directorate and expert report writers.

COVID-19 also impacted the courts' ability to access specialist services to provide expert opinion in a range of areas, and where it has been possible to secure expert review, reports have often been delayed due to the demands and the redeployment of resources.

Additional difficulties in resourcing have further impacted the ability to finalise matters. This is most clearly seen in matters which are pending under 12 months, but nevertheless taking longer than usual times to finalise. This reporting period has seen the finalisation of 12 matters that had been outstanding over 24 months or longer and a further two that were outstanding over 12 months.

Unfortunately, matters came in at a faster rate than they were able to be finalised.

The yearly increase creates a pressure each year to close files at a rate faster than new matters are referred- or on average to finalise 7 matters a week to keep up with the incoming matters. Even closing at this rate does not address the older, more complex matters that cannot be finalised on the results of the post-mortem alone. The community, family and loved ones expect (and generally receive) a coronial process that not only answers their questions about the circumstances of the death of their loved one, but one that applies careful consideration and at times, requires further investigations of matters of public safety arising from the circumstances of the death.

These impacts can be seen throughout the pending finalisation numbers: see Table 5.

Table 5: Pending Cases

Time Pending	**2020/21**	2019/2020	2018/19	2017/18
< 12 months	**170**	73	66	92
> 12 months but < 24 months	**23**	20	31	38
> 24 months	**58**	47	52	46
Total Pending	**251**	140	158	176

Pending cases figures include matters where related criminal charges are on foot or contemplated and: either the inquest is formally statutorily paused under sections 58 and 58A of the Act; or a Coroner has otherwise decided that it would be inappropriate to continue with the inquest until after the finalisation of the criminal proceedings or investigation (either in the ACT or elsewhere) or after the finalisation of an interstate inquest. In the 2020/21 year there are 20 matters which fall into this category, which is 8% of total pending matters.

The national benchmark is for coroner's courts to finalise 90% of matters in under 12 months. The Court was able to meet and exceed this target, maintaining a finalisation rate of 96% for matters referred during the reporting period. Even these matters on average experienced a three-month delay in comparison to the 2019/2020 reporting period. This was often the unavoidable result of delays across the system, in particular wait times for toxicology results, delay in accessing expert reports, and the redeployment of policing resources to other areas of operations: see Table 6 and Table 7.

Table 6: On-time Case Processing Indicator				
	2020/21	**2019/20**	**2018/19**	**2017/18**
Percentage %	96	88	88	91

The median number of days from report to finalisation of a matter this financial year was 97 days. see Table 7.

Table 7 Median number of days to finalisation				
	2020/21	**2019/20**	**2018/19**	**2017/18**
Days	**97**	60	76	92

As previously mentioned, the reduced availability of sitting dates and the workload pressures of each coroner (who also sit as magistrates) affected the number of hearings held. The recent announcement of a dedicated coroner to begin in the second half of the next reporting period is a very welcome addition and will significantly improve the availability of a coroner to conduct hearings and finalise inquests.

The hearings which were finalised were complex, lengthy and represent the culmination of years of work. This year saw the finalisation of the highly complex and difficult series of deaths- a single inquest into four deaths at the Canberra Hospital Mental Health Unit. These matters have for the past reporting periods been our longest outstanding matters and I am pleased that they were finalised in this reporting period. These findings and recommendations of Coroner Hunter were published on 4 March 2021. This matter has had a flow on effect resulting in finalisation of a number of matters which were stayed pending the outcome. Amongst other benefits from this process is a wholesale review of ligature points in mental health facilities which has the potential to significantly reduce deaths in those facilities.

The other matter finalised which has been outstanding and required an intensity of resources, effort and deeply affected the Canberra community was the finalisation of the inquest into the death of

Bradyn Dillion. This inquest began in 2018 and continued to hear evidence throughout 2019 and 2020. The findings and recommendations of Coroner Hunter were published on 29 April 2021.

FORENSIC MEDICINE CENTRE (FMC)

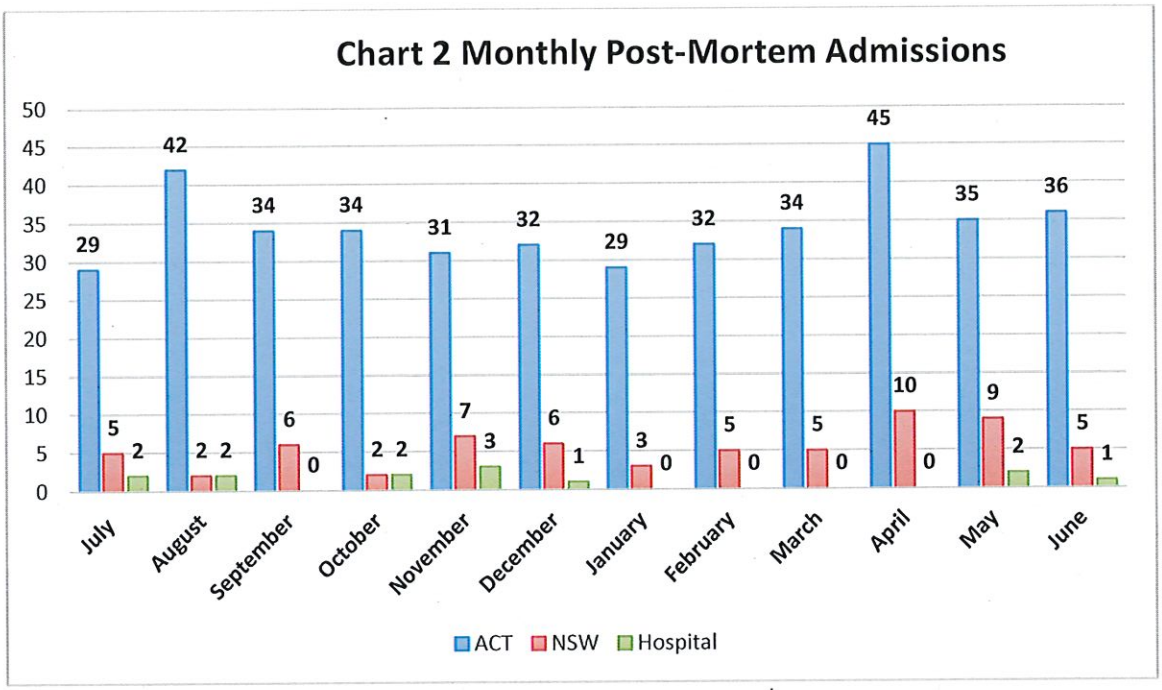
Workload Statistics

The Forensic Medicine Centre (**FMC**) admitted 498 cases during the 2020/21 reporting period, an increase of 5% on the previous year. There were 69 Medical Certificate Cause of Death (**MCCD**) issued (60 for ACT and nine (9) for NSW) for which the admission was not referred to the coroner and which are therefore not included in the statistic for the Coroner's Court. This usually occurs when there is a delay in obtaining a MCCD and the deceased person is transported to the FMC pending a treating medical practitioner issuing a MCCD. There were also nine (9) admissions for temporary storage of deceased persons (five (5) for The Canberra Hospital, two (2) for Calvary Hospital, and two (2) for community assistance): Total admissions are out lined in Table 8.

Table 8: Total Admissions to FMC

	ACT	NSW	TOTAL
Coronial admissions	348	59	**407**
Medical certificate	60	9	**69**
Hospital requested non-coronial post-mortems	13	0	**13**
Temporary storage	9	0	**9**
TOTAL ADMISSIONS	**430**	**68**	**498**

There was an average of 34 coronial admissions per month See: Chart 2



The total number of post-mortems conducted at the FMC is higher than the previous reporting periods. This is due to an increase in ACT cases, as the number of NSW cases decreased from last reporting period. Not all post-mortems require internal procedures to be conducted to determine the cause of death. The FMC routinely makes use of medical imaging equipment such as CT scans and X-rays where imaging may provide conclusive evidence of the cause of death or assist in determining the cause of death. In some coronial cases, a post-mortem may not be conducted as cause of death is determined from the medical records. This is most likely when the has been extensive medical intervention, detailed records and the cause of death is clearly articulated within the records. It is likely that this figure will increase with the appointment of a dedicated coroner who will be able to engage in "triage" of matters with the forensic pathologist early in the referral. Presently, approximately 60% of all post-mortems conducted require internal procedures to assist in determining the cause of death. This is a significant reduction form historical figures which were in the high 90% range. Chart 3 demonstrates the percentage of internal, external and medical-records review for coronial cases for ACT and NSW.

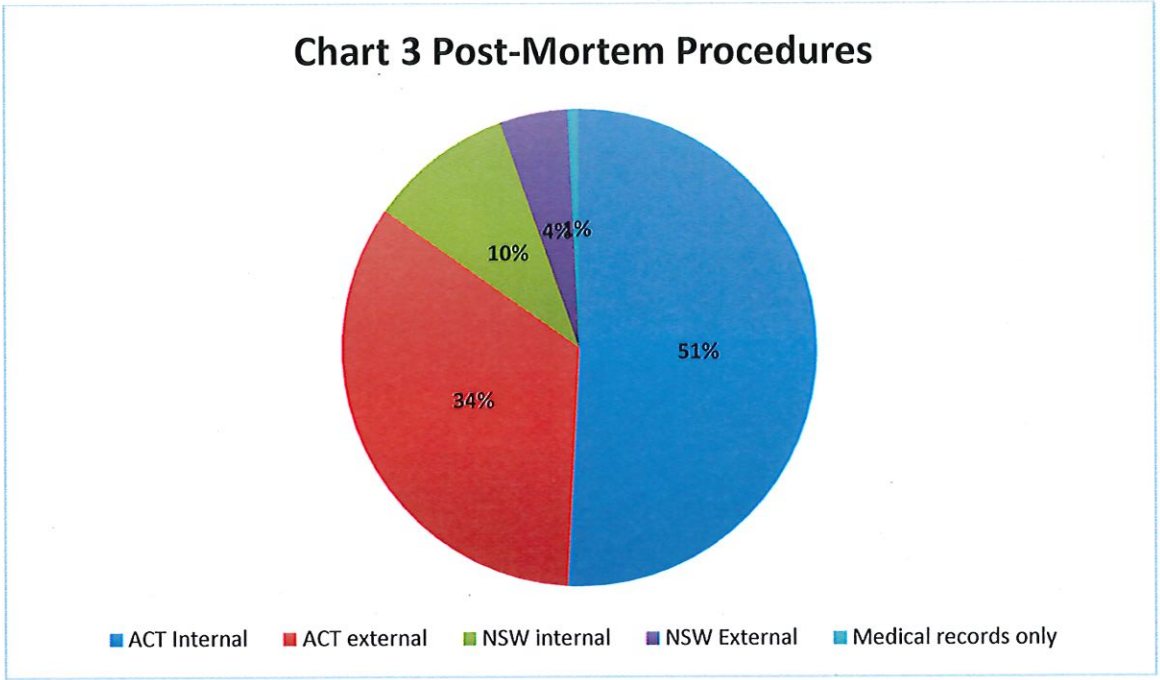


Table 9 shows the year-on-year comparison of admissions. Whilst the NSW admissions have remained quite stable and have decreased over the past three (3) years, the ACT has seen a steady increase in coronial matters each year.

Table 9: Annual Coronial Cases Admissions			
Year	**ACT**	**NSW**	**TOTAL**
2016/17	297	51	348
2017/18	301	56	357
2018/19	301	73	374
2019/20	338	64	402
2020/21	**348**	**59**	**407**

The period of admission to the FMC to post-mortem number of days was 2.54 and 2 days respectively. Overall, the average total time at the FMC was 9.3 days, with a median of 5 days. There were 22 cases that were in the FMC for greater than 30 days. Longer stays in the FMC arise in cases awaiting formal identification and cases awaiting pending arrangements for destitute cremations. Again, the effects of COVID-19 were seen in the delay of transfers out of the care of the FMC, particularly for interstate or overseas transfers and funerals.

With the number of coronial matters steadily increasing year-on-year, there is a need to review the capacity of the FMC to hold deceased persons for any length of time. During the COVID-19 lockdown

periods, the FMC procured temporary storage facilities to be utilised in the event of an increase in deaths arising from the pandemic. Fortunately, these facilities have not been utilised to date, however it does indicate that the FMC has limited capacity to continue to hold a growing number of deceased persons. The FMC has set a Key Performance Index (KPI) of 80% of cases having either an autopsy or medical review within 5 days or less from admission to the facility. In the financial year 2019-2020 this KPI was achieved in 93.36% of cases. On 26 occasions the post-mortem (**PM**) was performed on the day of admission. Table 11 reflects this KPI.

Table 11: Percent of cases receiving PM in 5 days		
Admission to PM	**Number**	**Percent %**
5 days or less	380	93.36%
More than 5 days	25	6.1%

Pathologists

Professor Johan Duflou continues to provide his services as a consultant forensic pathologist on a fee-for-service basis. the majority of the pathology services on a fee for service basis. Dr Sanjiv Jain, an anatomical pathologist also provides continuing services on the same basis. No additional forensic pathology services were engaged during this reporting period.

Mortuary Technicians

The majority of assistance in theatre is performed by permanent FMC staff; however, the FMC continues to rely on the services of casually employed mortuary technicians to assist with theatre work.

Toxicology

In 2020/21, 177 ACT cases underwent toxicology analysis (47.96%). Of these 126 were performed at ACTGAL and 17 were sent to Victorian Institute for Forensic Medicine (VIFM) and 34 to NSW Forensic and Analytical Science Service (FASS) for overnight screening. VIFM and FASS are used when rapid results are required as they perform an overnight screening which detects more than 300 common drugs and poisons and provide verbal results the following day. This is followed up with a formal report after quantitative analysis is performed. In 2020/21 FASS and VIFM services were used in more routine cases, due to the delay in local laboratory services. There were two (2) ACT cases sent to FASS in NSW for testing (due to specific analysis required). Of the 59 NSW cases, 35 required toxicology analysis (59.3%). Toxicology results had an average return of result of 36.61 days, and median return

of 34 days. This represents an average increase of six (6) days. These results are usually the last piece of information that the pathologist waits on before they can submit their final post-mortem report for consideration by the coroner.

Observers

In the Coronial Practice Direction No.2 of 2018, I committed to reporting each year the number and identity of the applicants/observers at the FMC in each year. During 2020/21 there were a total of 471 observers who attended the FMC for various purposes: see Table 14. All observers attend with the approval of the Court and the approval from the deceased's next-of-kin.

Table 14: Observers Attending the FMC		
ANU Medical Students	39	Observe PM
Department of Foreign Affairs & Trade (DFAT)	101	Discussion/Tour/View deceased
AFP Forensics Gradual Exposure	9	Gradual Exposure
AFP Recruits	176	Discussion/Tour/View deceased
AFP PSO Recruits	125	Discussion/Tour/View deceased
Goulburn Coroners court	2	Discussion/Tour
Canberra Institute of Technology (CIT)	19	Discussion/Tour/View deceased
TOTAL	**471**	

Not all observers viewed a post-mortem as this was only done if relevant to their field, such as medical students and forensic services trainees. All observers were given an overview of the coronial process and the role of the FMC within that process. They were then given a tour of the facility. Most observers viewed a deceased person, for many of whom this was their first time viewing a deceased. The aim of this was to introduce observers to deceased persons in a controlled environment in preparation for when their duties required them to work with deceased or their families.

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

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

- Phase 5 – Exposure to a decomposed body in field/at FMC

Imaging

The FMC continues to utilise imaging services at The Canberra Hospital. Computerised Tomography (CT) scans are conducted out of hours at TCH, and X-rays are done at the FMC by TCH Imaging staff. There were 56 cases that had a CT done at TCH. There were three (3) cases that had an X-Ray done and one (1) case where both CT and X-Ray were done.

We continue to engage the services Dr Derek Glenn to report on routine cases and Dr Mohamed Nasreddine is engaged to report on suspicious and complex cases.

STAFFING AND RESOURCES

Coroners

The ACT Coroner's Court receives no specifically allocated resourcing for the performance of judicial coronial functions. Every magistrate retains an active coronial case load, but aspects of that case load are necessarily discharged as a secondary priority with duties as a magistrate commanding more immediate attention. 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, and in very difficult circumstances where the first half of the reporting period was impacted by court wide backlogs created by the emergency measures in place to manage COVID-19.

I am grateful for the announcement of funding for a dedicated coroner and look forward to what might be achieved with the increase in resourcing and ability to dedicate the attention and time required to finalise complex and sensitive matters in a much-reduced time frame.

Administrative and legal staff

The administrative and legal support 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 and a legal director who at times is also appointed as counsel assisting the coroner.

Family Liaison Officer

Last reporting period, the Coroner's Court welcomed the announcement of funding for the appointment of a Family Liaison Officer to work within the Coroner's Court to assist families and next of kin through the coronial process. This trial has received very positive feedback from families who have had the benefit of this service. It remains a challenge to ensure each family is provided with the support needed through what can sometimes be a difficult and complex legal process. Despite not being fully funded into the future at this stage, the court will continue with the development of the role and seek to apply the lessons learnt from the initial 12 months since the commencement of the role. I look forward to the future development of this role.

Suicide Register

After receiving a generous offer of grant funding from the Australian Institute of Health and Wellbeing (AIHW), the Coroner's Court employed full time project officer on a short-term basis to develop a suicide register- a searchable database of deaths by suicide in the ACT.

This will produce the ability to monitor real time data, historically capture deaths by suicide, and can indicate trends, similarities, common issues and early warning of potential issues of public safety. It will contribute to suicide prevention research and interventions both at the territory and national level.

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 *s39*), in the event of a death in custody a coroner must appoint a Counsel Assisting for the purpose of the inquest (see *s72*).

Part of the rationale for appointing a legal director 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 2020/21 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, which enables the costs to be minimised and has proven beneficial to the appointed lead counsel.

Coroner's Investigators

Section 59 of the Coroners Act provides that a Coroner may appoint any person to assist the coroner in the investigation of any matter relating to an inquest or inquiry. Section 63 provides that Coroners may request the assistance of police in conducting an investigation. The common law also recognises that Coroners may call on police assistance.

Investigations are conducted generally by members of the ACT Policing arm of the Australian Federal Police, including specialist areas if required. There is some blurring of the boundaries with the criminal investigation function which can be problematic, although thankfully more commonly in theory than in practice.

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 at the court or by the coroner. I would be interested in working with the Chief Police Officer to explore an embedded police presence to work more closely with the newly appointed dedicated coroner in due course.

Primary investigatory responsibility for coronial fires not involving the death of a person falls to the ACT Emergency Services Agency through either ACT Fire and Rescue or ACT Rural Fire Service. These organisations also provide an invaluable service to the Coroner's Court.

Worksafe ACT has also readily supported the coronial investigative function in relevant matters.

ENGAGEMENT AND EDUCATION

Support services in the community

All coroners are acutely aware that grieving families can find the coronial process difficult and distressing. Relationships Australia Canberra Region continued to be funded in 2020/21 by ACT Health to operate the ACT Coronial Counselling Service to provide intensive therapeutic counselling, psychoeducation, 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. During 2020/21 there has been an increase in need for counselling services, and I call on ACT Health to review its funding of the program, with a view to increasing these valuable services.

Direct Engagement

During the 2020/21 year, the Court and its staff continued to be 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 Coroner's legal and support team also engage 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.

In November 2021, as part of the JACS coronial restorative reform initiative, staff from the coronial unit and I met with members of the ACT community to obtain an understanding of the various cultural and religious beliefs with respect to the death of a loved one and to provide the community leaders with further information of the coronial process.

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 no new CPDs during this reporting period.

COVID-19 PREPAREDNESS AND RESPONSE

The public health emergency declared on 16 March 2020 continued throughout 2020/21. The interim Coronial Practice Direction issued on 6 April 2020 remained in force for the duration of the year. Under the CPD, when a deceased person was admitted to the FMC with any recent flu like symptoms, a nasopharyngeal swab was taken and submitted to ACT Pathology. All tests returned a negative result. As mentioned above, the FMC was identified as a facility which had the capacity to store non-coronial deceased persons in the event of a delay in burials or cremations due to the number of deaths or unavailability of funeral or crematorium staff. Temporary racks were placed into cool room facilities to accommodate a larger number of deceased persons if required.

MANDATORY REPORTING

Section 102(2) of the Act requires certain particulars to be reported in my report.

Section 102(2)(a) matters – Reports into 'Deaths in Custody'

For the purposes of the Act 'deaths in custody' are those deaths of persons that occur in certain specified circumstances listed in section 3C. Under paragraph 34A(2)(a), a coroner must not dispense with a hearing into a death of a person if the coroner has reasonable grounds for believing that the person died in custody. Accordingly, a hearing is held for all deaths in custody.

In the 2020/21 year, there were ten (10) inquests into deaths in custody/deaths in care finalised by a coroner:

- Kaitlin O'Keefe McGill (CD 70 of 2016);
- Anthony Caristo (CD 246 of 2017);
- Angela Parragi (CD 172 of 2019);
- Name Suppressed (CD 181 of 2020); (*unpublished*)
- Daniel James Clement (CD 11 of 2020);
- Name Suppressed (CD 7 of 2021) (*unpublished*); and
- **Joint Hearing** Anthony Leigh Bearham (CD 8 of 2015) Nicola Joy Fisher (CD 61 of 2015) Christina Belle Douch (CD 164 of 2016) and Ken Alexander Lucas (CD 281 of 2016).

Summaries of these inquests, and the findings made, are reported in the selected case notes section below.

[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.]

Section 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 or may not be held. When a Coroner decides not to conduct a hearing into a death, section 34A(3) of the Act 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 2020/2021 year, there were 256 notices given by Coroners under section 34A(3), in respect of 255 deaths and 1 fire. (There were no inquiries into disasters finalised in the 2020/21 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 *s64* in respect of matters finalised in this year.

Section 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, section 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, would improve public safety. Sections 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 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 2020/2021 year, the following section 57 reports were made to the Attorney-General and tabled in the Legislative Assembly within the reporting period:

- Teresa Erika Foce (CD 98 of 2018)
    - Referred to Attorney-General 24 September 2020. Presented by Minister Steele to the legislative assembly 20 April 2021
- Kaitlin O'Keefe McGill (CD 70 of 2016)
    - Referred to Attorney-General 7 May 2021. Not presented within the current reporting period
- Joint Hearing Anthony Leigh Bearham (CD 8 of 2015) Nicola Joy Fisher (CD 61 of 2015) and others
    - Referred to Attorney General. Not presented within the current reporting period.
- Homegrown Me (fire inquest) CF 2 of 2018
    - Referred to Attorney-General 29 April 2021. Not presented within the current reporting period
- Bradyn Dillon (CD 33 of 2016)
    - Referred to the Attorney- General 29 April 2021. Not presented within the current reporting period

Referrals under section 57 which were made in the previous reporting period and presented during this reporting period:

- Joanne Lovelock (CD 261 of 2015) referred 5 March 2020. Presented by Minister Gentleman 20 August 2020;
- Jandy Shea (CD 60 of 2018) referred 24 September 2019.Presented by Minister Gentleman 23 July 2020; and
- Filippo Onarata (CD 234 of 2018) referred 10 January 2020. Presented by Minister Gentleman 31 March 2021.

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

Under section 74 of the Act, 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 under section 75 of the Act. 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 10 inquests into deaths in custody finalised by a coroner in the 2020/21 year:

- Kaitlin O'Keefe Mcgill (CD 70 of 2016);
- Anthony Caristo (CD 246 of 2017);
- Angela Parragi (CD 172 of 2019);
- Name Suppressed (CD 181 of 2020) *unpublished*);
- Daniel James Clement (CD 11 of 2020);
- Name Suppressed (CD 7 of 2021) (*unpublished*);
- **Joint Hearing** Anthony Leigh Bearham (CD 8 of 2015) Nicola Joy Fisher (CD 61 of 2015) Christina Belle Douch (CD 164 of 2016) and Ken Alexander Lucas (CD 281 of 2016)

The Government responses to these Coroners' reports have not yet been tabled during this reporting period.

SELECTED CASE NOTES

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

The name of a deceased person is included in the case note where a hearing has been held in which the name of the person has been made public, or where other action is taken which results in the publication of the deceased's name (such as presentation of coronial reports to the Legislative Assembly or publication of reasons on the court's 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.

Section102(2)(a) matters – reports into 'deaths in custody'

Court Reference:	Kaitlin O'Keefe-McGill CD 70 of 2016
Age:	34
Gender:	Female
Date of Death:	23 March 2016
Place of Death:	Garran, ACT
Coroner:	Morrison
Date of Findings:	10 December 2020

Reported as: [2020] ACTCD 7 Inquest into the death of Kaitlin O'Keefe McGill

1. Kaitlin O'Keefe McGill was a 34-year-old woman who was found deceased on 23 March 2016 at her residence in Garran. Ms McGill had suffered with mental health issues for several years and since 2002 had been subject to a number of Psychiatric Treatment Orders. At the time of her death, Ms McGill was subject to a Psychiatric Treatment Order (PTO) made by the ACT Civil and Administrative Tribunal under the *Mental Health (Treatment and Care) Act 1994* (as it then was) on 12 November 2015, for a period of 6 months. Under the law as it then stood, as Ms McGill died while subject to an order under mental health legislation, her death is to be treated as a death in custody for the purposes of the *Coroners Act 1997*.
2. Under section 34A of the *Coroners Act 1997*, I cannot dispense with the holding of a hearing as part of the inquest into Ms McGill's death.

3. A hearing was held for that purpose on 29 November 2018. The ACT Government Solicitor sought and was granted leave to appear on behalf of the Territory. Ms Baker-Goldsmith, Counsel Assisting me, tendered the brief and called no witnesses. There was no factual dispute about the manner and cause of Ms McGill's death.

4. Counsel Assisting noted that in addition to the formal findings of fact I must make under section 52(1) of the *Coroners Act 1997*, I was obliged to:

    a. under section 52(4), make findings about whether a matter of public safety was found to arise; and

    b. under section 74, include findings about quality of care, treatment and supervision of Ms McGill if in my opinion, they contributed to the cause of Ms McGill's death.

5. Counsel Assisting submitted that no matter of public safety arose, that there was no evidentiary basis for the making of a finding that the quality of care, treatment and supervision provided to Ms McGill contributed to the cause of her death and that no adverse comment was warranted against ACT Mental Health or any of its clinicians.

6. Counsel Assisting nevertheless submitted that I consider making a recommendation in this case. The recommendation proposed by Counsel Assisting is, in effect, about the desirability of dissemination of information to the family of persons subject to a PTO.

7. The recommendation from Counsel Assisting was made against the background of concerns expressed by Ms McGill's family that they were not given key information which might have allowed them to help Kaitlin, assist in facilitating proper treatment and address her risk factors.

8. Counsel Assisting referred me to a recommendation along similar lines made by Coroner Dingwall in the *Inquest into the death of Mark Rodney Jolliffe* [2015] ACTCD 2.

9. Counsel for the Territory sought an adjournment of the hearing to allow the Territory to make submissions about the recommendation pressed by Counsel Assisting. Initial submissions were filed at the Court in December 2018.

10. In part, those submissions directed my attention to review processes (then underway) into the *Mental Health Act 2015* (the successor to the *Mental Health (Treatment and Care) Act 1994*) and went on to say that, in those circumstances, any recommendation by the Coroner was unnecessary.

11. In March 2020 I directed that Counsel for the Territory be contacted to ascertain the outcome of those review processes. Further submissions on that point by the Territory were filed in July 2020.

12. The submissions are to the effect that the review processes which took place did not touch on the subject matter of the recommendation proposed by Counsel Assisting.

13. The Territory did however maintain its original position that comments and recommendations in relation to the *Mental Health Act 2005* were unnecessary.

14. When I adjourned the hearing I said that it was uncertain whether it would be necessary to reconvene for further evidence or submissions or if I would be in a position to deliver my decision without needing to do so. I have determined on the basis of the submissions made that I am able to finalise my decision without a further hearing. I have done so and I deliver my decision and written reasons in this document.

15. I find formally that Kaitlin O'Keefe McGill died at 6/5 Garran Place, Garran in the Australian Capital Territory between 21 and 22 March 2016. The manner and cause of death was morphine toxicity (the morphine probably ingested as heroin), and her death was accidental.

16. I accept the submissions that a matter of public safety is not found to arise in connection with the inquest and I find accordingly. I accept also that there is no evidentiary basis for the making of a finding that the quality of care, treatment and supervision provided to Ms McGill contributed to the cause of her death and I find accordingly.

17. Section 3BA(1)(d)(ii) of the *Coroners Act 1997* provides that one of the objects of the legislation is to allow a Coroner to make recommendations about the promotion of general public health and safety. A Coroner's power to make recommendations is not limited to cases where a matter of public safety is found to arise.

18. At the time of her death Ms McGill was subject to a PTO made by the ACAT on 12 November 2015 (by way of a 6 month extension of the pre-existing order under *Mental Health (Treatment and Care) Act 1994.* That Act specified that certain conditions must be satisfied before such an order may be made.

19. Those conditions are along the lines of but not identical to the conditions which apply under the current legislative scheme for the making of such orders.

20. The current legislative scheme for the making of psychiatric treatment orders appears in s58 of the *Mental Health Act* 2015.

21. The pre-conditions appearing there for the making of a PTO are, in summary:

    a. The person has a mental illness; (s 58(2)(a))

    b. The person does not have decision-making capacity about treatment; or does have that capacity but refuses treatment; (s 58(2)(b))

    c. There are reasonable grounds to believe that, because of the person's mental illness:

        i. the person is likely to do serious harm to themselves or someone else; or

        ii. is likely to suffer serious mental or physical deterioration; (s 58(2)(c))

    d. The proposed treatment is likely to reduce the harm or deterioration referred to or improve the person's psychiatric condition; (s 58(2)(e))

    e. The proposed treatment under the PTO cannot be adequately provided in a way involving less restriction of the persons freedom of choice and movement. (s 58(2)g))

22. In addition, where there is decision-making capacity but a refusal to consent to treatment, the ACAT must be satisfied that likely harm to the person, or deterioration of their condition, is of such a serious nature that it outweighs the person's right to refuse to give consent. (s 58)(2)(d))

23. It is apparent from the structure of the legislative schemes (both past and present) that, in the circumstances prescribed in the legislation, a person's right to receive treatment is treated as paramount. It is given priority over, for example, a right to refuse treatment, and rights of freedom of choice and movement.

24. It can be seen that the statutory criteria recognise that these other rights should not be permitted to stand in the way of the delivery of what is determined to be appropriate treatment.

25. The recommendation pressed for by Counsel Assisting is based upon reasoning that, a fortiori, what would otherwise be the right of a person with a mental illness to decide about giving information to others (in particular close family members) about their treatment ought not to stand in the way of the delivery of appropriate treatment.

26. It is important to note that the submissions of Counsel Assisting do not press that there needs to be some balancing of the right of privacy of a person with a mental illness against the wishes of family members to be informed about treatment.

27. Rather the submissions is expressed as requiring that, in appropriate cases, the right of a person with a mental illness to receive the most effective treatment under a PTO must take priority over that person's right of privacy.

28. The evidence in this case discloses that members of the McGill family were engaged by ACT mental health workers to assist in treatment by bringing Ms McGill to appointments and reinforcing treatment instructions of clinicians, yet were not given key information about Ms McGill's condition and treatment. There is not in this case any evidence about the difference which the involvement of Ms McGill's family may have made to the cause of her ultimate death by illicit drug overdose. Of necessity such evidence would be difficult to obtain and would deal with problematic hypotheticals.

29. The Territory did not support the proposed recommendation by Counsel Assisting on several bases.

30. The first is that I could not be satisfied that Ms McGill's death was directly connected to the lack of her family's involvement in the case. I agree. However, Counsel Assisting submitted there is at least a possibility that Ms McGill's treatment outcomes and ultimate death may have been avoided had more information been provided to her family, to enable them to assist in the provision of treatment to her. I accept that there is at least such a possibility and that it is not fanciful.

31. The second basis for the Territory's objection was that Ms McGill's PTO was made pursuant to the *Mental Health (Treatment and Care) Act 1994*, which has now been replaced by the *Mental Health Act 2015*. Counsel for the Territory submitted in their initial submissions that the new legislation made a number of changes such as advance agreements and advance consent directives; that these options were not readily available to Ms McGill given her death shortly after the commencement of the new legislation; and that the legislation should be given time in a real world setting for the operation of the legislation to be tested. However, Counsel also agreed that disclosure of information against the wishes of a consumer is generally unlawful, and the new legislation does not change the situation that a consumer can decide to prevent information sharing with others including family who care for or support them.

32. Thirdly, Counsel for the Territory submitted in their initial submissions that two reviews of the operation of the *Mental Health Act 2015* were already underway or scheduled, and that the matters intended to be canvassed by the proposed recommendation would, "to a great extent", be addressed in those processes without the need for a further process at added expense. Counsel provided further detail about the procedures for and outcome of those review processes in their most recent submissions. It is clear that these reviews did not consider the issue of information disclosure to carers, apparently because the issue was not raised with the reviewers.

33. In the context of persons with a mental illness, the question of disclosure of patient and treatment information requires the weighing of competing interests. As indicated earlier, they are not however the competing interests of different persons.

34. Rather, the balancing exercise required is properly approached as weighing:

    a. the patient's right to privacy; and

    b. the patient's right to receive optimal treatment where doing so calls for involving family members or others, despite the way in which the patient's mental illness might compromise their own decision-making around disclosure of their condition and/or treatment.

35. Where, such as in this case, family members are engaged by ACT mental health workers to assist in providing treatment despite the patient's directions to withhold information from others, I consider that a more nuanced approach to information disclosure is likely to be beneficial to the patient. Given the strong regulatory privacy protections and other prohibitions against disclosure of patient information without lawful authority or consent, a new approach might well require law reform.

36. The decision-making around when, and to whom, disclosure contrary to a patient's wishes should be made would not be straightforward. The same could be said of much of the decision making around the treatment of persons with a mental illness. Where however there are family members willing and able to assist, and whose assistance is likely to be useful in achieving the best outcomes for the person, such difficulties should not stand in the way of the design of a legislative scheme which would permit disclosure to enable that assistance.

37. In those circumstances, while no matter of public safety arises, I consider it is appropriate to make a recommendation, albeit in a slightly altered from than that proposed by Counsel Assisting. I recommend that the ACT Government consult families and carers of persons subject to PTOs, as well as those subject to such orders, to explore the desirability of legislative or procedural reform about information dissemination to family and carers to support the care and treatment of persons subject to such orders.

38. I place on record that the recommendation I make is consistent with the recommendations made in the Productivity Commission's *Mental Health Inquiry Report*, Volume 1, No. 95 (30 June 2020) and in particular:

    (a) the expressed aim for a person-centred mental health system the features of which include "[p]articipation of the consumer's family or carer actively sought to add to the value and effectiveness of the clinical or support service;"[2] and

    (b) embracing the concept of the personal recovery of an individual within their family, carer, community and cultural context, rather than a narrow focus on clinical recovery — as endorsed by Australian health ministers.[3]

39. I direct that these findings be published on the Coroner's Court website.

40. I extend my condolences to Ms McGill's family and friends.

[2] Productivity Commission, *Mental Health Inquiry Report*, (Final Report No 95, 30 June 2020) vol 1, 6.

Court Reference:	Anthony Caristo CD 246 of 2017
Age:	54 years
Gender:	Male
Date of Death:	31 October 2017
Place of Death:	Belconnen, ACT
Coroner:	J.M. Stewart
Date of Findings:	25 September 2020

Reported as: [2020] ACTCD 9 Inquest into the death of ANTHONY ROMANAS CARISTO

(Excerpt of findings- full copy of finding can be found at courts.act/gov.au/magistrates/decisions/inquest-into-the-death-of-anthony-romanas-caristo)

1. Anthony Romanas Caristo passed away on 31 October 2017 in tragic circumstances that gave rise to the need for a hearing as part of the inquest into his death. That is because Mr Caristo died whilst he was deemed to be in the custody of the Australian Capital Territory ("ACT") Police ("ACTPOL").
2. Mr Caristo enjoyed the love of his daughter and his immediate family. At the time prior to his death his behaviour was becoming erratic. His family relationships had become strained. He displayed unusual behaviours such as selling prized possessions. It seems clear that his mental health had become disturbed and that he was spiralling into an unwellness assisted by illicit drugs.
3. It is not a purpose of this inquest and hearing to besmirch Mr Caristo's character or to pass moral judgement on his behaviour leading up to his death. Many people fall prey to illicit drug use, and it is the experience of this Court that psychological ill-health often goes hand in hand with a vulnerability to illicit drug use. It was upon this background that a combination of events led to Anthony Caristo's death.
4. In very broad summary, on 31 October 2017, after a neighbour had raised alarm about noise, Mr Caristo was found by ACTPOL in his home. He was mostly laying on his back behind broken windows. His blood was visibly smeared all over the front rooms in quite a horrifically confronting manner. He had obviously severed one of his fingers and was apparently cutting at himself with a large knife.
5. The ACTPOL officers who attended could not communicate with him in any meaningful way. In order to assist him, those officers needed to ensure that they could safely enter the house. That meant isolating him from the knife or vice versa. The combined circumstances of his

surroundings and the presence of the knife in those circumstances placed ACTPOL or ACT Ambulance Service ("ACTAS") members at risk in terms of their occupational health and safety.

6. Mr Caristo was subjected to a single electrical charge using a police-issued taser.
7. Mr Caristo went into cardiac arrest shortly after the taser was deployed and could not be resuscitated by ACTAS members. His autopsy revealed that he had imbibed a lethal dose of methamphetamines, had suffered an amputation of one of his fingers, had several lacerations to his limbs and had died from a cardiac arrest.

SCOPE OF INQUEST

8. Prior to commencement of the hearing [4] the scope of this inquest was specified, and a 'Final Issues List' was distributed by the Court to parties in the following terms:

Events of the day

a. Chronology of events
b. Information known to attending police as to the deceased's antecedents, alerts and mental health
c. Availability of CEWs for first attenders
d. Decision to enter – lawfulness of entry
e. Availability of Specialist Response Group (SRG)
f. Use of force assessments
    i. Availability of alternatives
    ii. Assessment of risks that were presented
    iii. Safety of AFP members and members of the public
g. Deployment of the TASER
    i. Justification
    ii. Proportionality of the response
    iii. Assessment of the manner in which the device was operated
    iv. Position of the deceased at the time the device was deployed
    v. Determination of whether use in question was consistent with operational guidance
h. Post tasering care
    i. Use of handcuffs

[4] 25 July 2019.

ii. Medical care

Autopsy findings as to cause of death

a. Consideration of cause of death in light of the use of a TASER

Issues Concerning the use of Tasers

a. the TASER brand x2 model
    i. operational features
    ii. use of expired cartridges
    iii. functionality of the device used
    iv. video recording system
b. Training of AFP operational police in use of the device
    i. Adequacy of training
        1. Justification of use
        2. Associated health risks
    ii. Use of TASERS on those exhibiting signs of mental illness or intoxication

Guidelines for the use of TASERS in the ACT

a. Comparative analysis of TASER governance, policies and procedures in use in the ACT
b. Recommendations for changes to procedures

Outcomes of internal reviews

a. The incident
b. Auditing of operational safety of CEW assets including cartridges

9. My findings are confined to these issues and some other preliminary matters. Where I have not made a finding or a comment on issues it is because they became irrelevant or were not able to be the subject of evidence.

...

P. SUMMARY OF COMMENTS

174. I find that there are no reasons to make comments or findings critical of Constables Love of Constable Kneen or Sergeant Macklin.

175. Comment: The AFP governance and training in relation to tasers should be reviewed with a view to enhance identifying and understanding:

a. The inherent risk involved in taser use in respect of vulnerable groups such as those psychotic, those intoxicated, those suffering mental ill-health, pregnant women and children;
b. The criterion for taser use;
c. The use of negotiators;
d. Taser use restrictions;
e. Post use medical care on a tasered person;
f. Post use observation of a tasered person;
g. Positional asphyxia risk;
h. Post use rough handing of tasered person;
i. What excited delirium syndrome (EDS) is and the particular vulnerabilities that may be experienced by those suffering from EDS or with some or all of the symptoms or behaviours consistent with it; and
j. Communication strategies in all of the above situations.

176. Comment: I recommend that the AFP review the governance and training it provides in relation to taser usage and to report back to me within 12 months as to what changes have been made.

177. The Caristo family submissions on the review of CO 3 and use of tasers should be considered by the AFP.

178. I recommend that standard reporting should occur in all cases involving the use of force and that ad hoc exceptions to that requirement should not be allowed under any circumstances.

179. I recommend that the AFP conduct a review or audit of the communications response on that day to identify whether any systemic issues arise from the apparent failure of process and report back to me within 12 months.

Q. CONDOLENCES AND THANKS

181. I take the opportunity to express the sincere condolences of the Court to the family and friends of Mr Caristo. Little that I can say or write can salve their deep grief. What I can say is that I have been mindful of their deep love and affection for Anthony and have not forgotten their sadness and concerns expressed to me during the hearing.

182. I thank Mr Archer, Counsel Assisting the Coroner, for his more than competent assistance in the hearing and comprehensive written submissions.

183. I thank the parties for their very helpful and thoughtful written submissions.

184. I thank Constable Beere and the team of investigators that she worked with who produced an independent and excellent investigation.

Court Reference:	Angela Parragi CD 172 of 2019
Age:	31 years
Gender:	Female
Date of Death:	6 August 2019
Place of Death:	Garran, ACT
Coroner:	G.S. Theakston
Date of Findings:	21 September 2020
Reported as:	[2020] ACTCD 10 Inquest into the death of ANGELA PARRAGI

1. Angela Parragi died on 6 August 2019 at the Canberra Hospital, Yamba Drive, Garran in the Australian Capital Territory.
2. The manner and cause of Ms Parragi's death was complications of anorexia nervosa.

3. Police have advised that there are no suspicious circumstances.

4. No matter of public safety arises in this matter.

5. There is no basis under section 74 that the quality of care, treatment or supervision of Ms Parragi under her Community Care Order contributed to the cause of her death.

6. However, in accordance with the expert report of Professor Large, and noting the recent work done and intended to be done by ACT Government in this space, I recommend that ACT Health explore with NSW Health ways of improving access, and pathways, to inpatient specialist public beds for ACT patients with severe eating disorders, where necessary.

Court Reference:	Name suppressed CD 181/20
Age:	45 years
Gender:	female
Date of Death:	13/06/2020
Place of Death:	Franklin, ACT
Coroner:	L.E Campbell
Date of Findings:	15/06/2021
Reported as:	N/A

1. The deceased is *name suppressed*
2. The deceased died on or about 13 June 2020 at, (*address supressed*), Franklin in the Australian Capital Territory.
3. The cause of death is toxicity caused by Olanzapine.
4. The manner of death is the self-ingestion of Olanzapine, with the intention of taking her own life.
5. A matter of public safety is not found to arise in connection with the inquest.
6. There is nothing about the quality of care, treatment and supervision of the deceased while subject to the Psychiatric Treatment Order made on 6 February 2020 which contributed to the cause of death.

I Note that :

7. The Police Officers conducting investigations on my behalf have reported that no suspicious circumstances have been disclosed by their enquiries.

Court Reference:	Daniel James Clement CD 11 of 2020
Age:	30 years
Gender:	Male
Date of Death:	between 31 May 2017 and 11 November 2017
Place of Death:	Stromlo, ACT
Coroner:	L.A.Walker
Date of Findings:	14 December 2020
Reported as:	[2020] ACTCD 11 Inquest into the death of DANIEL JAMES CLEMENT

1. Daniel James Clement was born on 5 May 1987 in Shepparton, Victoria, to his mother Lee Wormald and his father David Clement. He was the youngest of four children, having two older sisters and an older brother. His mother and siblings moved to the ACT in the year 2000, when Daniel was 13.
2. In about 2004 he commenced an apprenticeship as an upholsterer. Daniel later abandoned this in favour of some work in the recycling industry, but that was not to last. No doubt as a result of his emerging mental health challenges, Daniel struggled to maintain employment and ultimately received the Disability Support Pension for a significant portion of his adult years.
3. In March 2005, Daniel suffered a significant head injury whilst riding his bicycle. He ran into a pedestrian and then hit a retaining wall. He suffered a fracture to his face which resulted in his jaw being surgically repaired.
4. In 2007, Daniel went briefly to live with his father in Victoria, but that arrangement did not last. He soon returned to live with his mother at Chapman in the ACT. His older sister Melissa, with whom Daniel seemed to get on and who was very supportive of him, lived with them there also. This home was Daniel's base.
5. Daniel's mental health was deteriorating and in 2010 he was diagnosed with schizophrenia. That awful condition plagued him for the remainder of his life. He suffered with psychotic delusions and hallucinations. Likely because of that experience, he became a user of illicit drugs including lysergic acid diethylamide (LSD), cannabis and some bushland substances with certain hallucinogenic effects. He also binge drank alcohol on occasions, and he was a heavy smoker.
6. Daniel was last seen by his mother on 31 May 2017, wearing dark jeans and a hooded jumper. She noticed in the days that followed that Daniel's black backpack was gone.

7. On 21 September 2017, Daniel's Psychiatric Treatment Order was revoked by the ACT Civil and Administrative Tribunal due to Daniel being unlocatable.
8. On 26 September 2017, Ms Wormald reported Daniel missing. Police attended at her home to take a full report of the circumstances. She told them that Daniel received about $800 a fortnight from Centrelink and that his National Australia Bank account had not been accessed for months.
9. Constable Benjamin Folkes of the Australian Federal Police assessed the level of risk to Daniel to be high. Checks were made at the Canberra Hospital, the Calvary Hospital, the Queanbeyan Hospital, and with both New South Wales and Victoria police. A 'look out to be kept for' notice was disseminated to all ACT policing members.

...

10. On 11 November 2017, Daniel's body was discovered by four kayakers on the Murrumbidgee River in the ACT.

...

Cause and Manner of Death

32 Daniel's body was in very poor condition when he was found. Visual identification was not feasible. DNA analysis was conducted comparing samples taken at autopsy with those from a razor used by Daniel at his mother's home.

33 I am satisfied following that analysis that the remains recovered were in fact Daniel's, noting that the DNA report author concluded that there was "extremely strong support" for that hypothesis.

34 A toxicological analysis of samples taken from Daniel's remains disclosed the presence of tetrahydrocannabinol, zuclopenthixol (clopixol), and ethyl alcohol. An autopsy report prepared by Professor Johan Duflou makes the following observations in respect to the toxicological analysis: "toxicological testing revealed the presence of appropriate levels of antipsychotic medication, as well as a presence of cannabis. A small amount of alcohol was detected, likely the consequence of post-mortem production. However, it should be noted [I interpolate based on information provided by ACT Mental Health Services] that the deceased was known to consume many drugs, such as LSD and various herbal substances, most of which would not be detectable in routine toxicological testing – this would be even more so the case given the amount of decomposition present in this case".

35 I note that the herbal substances Daniel was known to use included datura seeds or flowers and calea zacatechichi, both of which are available in local bushland or roadside areas. These substances are known for their hallucinogenic effects and have been used in shamanistic and other rituals for centuries, if not millennia. These substances can range in toxicity and are known to have been fatal, even in small doses.

36 Following careful examination, Dr Duflou was unable to ascertain the cause of Daniel's death. He made a medical finding of "unascertained". The pathology summary provided noted "1. advanced

decompositional change with skeletonisation and adipocere formation; 2. likely pulmonary emphysema; and 3. no evidence of peri-mortem trauma to body".

37 Whilst the circumstances do not allow me to conclude what caused Daniel's death, reassuringly, there is no suggestion of third-party intervention or foul play. There is also no evidence of a natural disease process having reached a stage which would have caused Daniel's death, nor can I conclude that any substance use was responsible.

38 Sadly, the last weeks of Daniel's life remain a mystery. The timing of Daniel's passing also remains unknown and must be framed by the last sighting and the discovery of his remains.

Formal Findings

39 The deceased is Daniel James Clement, born 5 May 1987 and deceased between 31 May 2017 and 11 November 2017.

40 He died near Bulgar Creek, on the Murrumbidgee River in the Stromlo area of the Australian Capital Territory.

41 His cause of death is unascertained. The manner of death is likely misadventure.

42 I find no issue of public safety arising.

I extend my deep condolences to his family.

Court Reference:	Name Supressed CD 7 of 2021
Age:	64 years
Gender:	Male
Date of Death:	Between 1 January and 6 January 2021
Place of Death:	Reid , ACT
Coroner:	J.T. Lawton
Date of Findings:	26 March 2021
Reported as:	N/A

1. The deceased is *Name Supressed*, born on 15 June 1957.
2. The deceased died between 1 January 2021 and 6 January 2021 at (*address suppressed*), Reid, in the Australian Capital Territory.
3. The cause of death is acute infective exacerbation of pulmonary emphysema.
4. The manner of death is natural.
5. A matter of public safety is not found to arise in connection with the inquest.
6. There is nothing about the quality of care, treatment and supervision of the deceased while subject to the Psychiatric Treatment Order made on 30 July 2020 which contributed to his death.

I NOTE THAT:

1. The Police Officers conducting investigations on my behalf have reported that no suspicious circumstances have been disclosed by their enquiries.

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

Court Reference:	Teresa Erika Foce CD 98 of 2018
Age:	63 years
Gender:	Female
Date of Death:	24 April 20218
Place of Death:	Bruce, ACT
Coroner:	L.A.Walker
Date of Findings:	24 September 2020
Reported as:	[2020] ACTCD 8 Inquest into the death of TERESA ERIKA FOCE

1. Dr Teresa Erika Foce, a 63 year old woman died on 24 April 2018 at the Canberra Hospital, in the Australian Capital Territory (ACT);
2. The manner and cause of death of Dr Foce are sufficiently disclosed and a hearing is unnecessary;
3. The manner of Dr Foce's death was an accident between a builder's trailer and a bicycle she was riding on 7 April 2018, where neither was at fault. The cause of Dr Foce's death was a head injury caused from that collision; and

   Pursuant to s 52(4)(a)(i) of the Coroners Act 1997, a matter of public safety has been found to arise in connection with this inquest, which has subsequently been addressed by the ACT Government. I do not consider any further action is required. I do however make a recommendation to ACT Government.

Events leading up to Dr Foce's death

4. While ordinarily employed as a psychiatrist in the ACT and New South Wales, Dr Teresa Foce was also a keen and experienced cyclist. In early 2018, she and her partner, Mr Michael Kearney, were planning to undertake a riding tour together overseas. They commenced preparing for the tour and would often ride together on training rides around the southern part of the ACT from their home in Tuggeranong.
5. At approximately 9 a.m. on 7 April 2018, Dr Foce and Mr Kearney commenced a training ride from their Tuggeranong home. The course of their journey took them south towards Tharwa.
6. At about 9:30. a.m. Dr Foce and Mr Kearney were riding along Tharwa Drive in Conder, initially both in the designated bicycle lane on the side of the roadway.

7. About eighty metres before the roundabout on Tharwa Drive with Mentone View, Dr Foce left the bicycle lane on the roadway and mounted the off-road path that runs beside Tharwa Drive. The bicycle lane on the roadway ends at this point and requires cyclists to exit on to the off-road path. This path was co-shared with pedestrians but is clearly signed as a bicycle path as cyclists exit the bicycle lane on the roadway. It is separated from the roadway by a gutter and grassed median strip. The path has a bitumen coating and a painted line dividing it into two lanes.
8. Mr Kearney continued to ride along Tharwa Drive on the roadway, ahead of Dr Foce.
9. Mr Kearney reached the next roundabout on Woodcock Drive and Box Hill Avenue where he stopped and turned around to see where Dr Foce was. She was not behind him.
10. Mr Kearney backtracked to the roundabout at Tharwa Drive and Mentone View. He found Dr Foce on the road unconscious, with a number of bystanders assisting her. She had collided with a builder's utility and attached trailer. One of the bystanders had contacted the ACT Ambulance Service.
11. Dr Foce was transported by ambulance to the Canberra Hospital. As a result of the collision, Dr Foce sustained significant brain injuries. On 23 April 2018 Dr Foce's family consented to her becoming an organ donor, following the medical opinion of her treating doctors that she had '*a poor prognosis with significant neurological deficits at best. The lack of progress over the past week...clarified this.*'
12. On 24 April 2018, Dr Foce died as a result of her injuries.
13. A postmortem examination of Dr Foce was directed by Coroner Fryar, who originally had carriage of this inquest. Professor Duflou undertook that examination and opined that Dr Foce died as the result of head injuries. Professor Duflou noted that '*[e]xamination of the deceased was limited to an external examination. This revealed healing injuries to the body and evidence of extensive neurosurgical and intensive care intervention. No unexpected injuries were identified.*[5]'

<u>Immediate Action taken by ACT Government</u>

14. All road transport accidents in the ACT are reviewed by Transport Canberra, the directorate responsible for road safety. On 30 April 2018, Mr Michael Day, Road Engineer, Transport Canberra, prepared a report relating to the condition of the road and path. He noted that "*there was gravel on the off-road path which appeared to have been washed off the adjacent*

5 Report of Professor Johan Duflou dated 27 April 2018 at page 3.

nature reserve, and also damage to the surface of the path itself around the location that Ms Foce may have lost control".

15. On 2 May 2018, Coroner Fryar wrote to Mr Shane Rattenbury MLA, ACT Minister for Road Safety, to consider immediately addressing the recommendations made in the report prepared by Mr Day. In particular, Coroner Fryar recommended that:

> *..the path be swept, damage to the path be repaired, and consideration be given to installing some sort of arrangement to prevent further gravel being washed onto the road. I also ask that you consider introducing guard rails or barriers between the path and the roundabout along the south bound approach.*

16. On 27 June 2018, Mr Mick Gentleman MLA, then the Acting Minister for Transport and City Services, wrote to Coroner Fryer and advised that the measures recommended by Mr Day had been implemented.

Investigation

17. Police attended and inspected the scene on the morning of the collision. Photographs taken by Senior Constable Smith and Senior Constable Potts shows skid marks in gravel and tyre marks on the offroad bicycle path that I infer were caused by Dr Foce as she tried to brake to avoid colliding with the builder's trailer. It is apparent from those photographs that gravel had fallen on to the bicycle path which impacted on Dr Foce's ability to brake as she tried to cross Mentone View.

...

18. Additional information was provided by the Territory on 20 August 2019 which disclosed that on 3 April 2014, a complaint was received from an unknown source that '*the bicycle path at the corner of Tharwa Drive and Mentone View keeps filling up with dirt. This makes it incredibly dangerous on a bicycle, since you come down the hill at speed (off the road or the path) are braking and suddenly hit this corner filled with dirt...Could the dirt please be removed and the issue looked into*'. The records indicate that in response to this complaint, the path was cleaned on 15 April 2014.

Submissions by Mr Kearney and response

19. On 4 September 2018, the Coroner's Court received correspondence from Dr Foce's partner, Mr Michael Kearney, who requested that the Coroner:

    a. investigate the circumstances of the accident; and
    b. consider the civil design of the on-road cycling/bicycle path at the roundabout/intersection and its impact on cyclist safety;
    c. if appropriate, explore these issues though a public hearing.

20. The facts surrounding the manner and cause of Dr Foce's death are evident on the information before me. I do not consider a hearing would assist me in finding any additional information about the circumstances of the events that relate to the manner of Dr Foce's death, and specifically, any additional details about the day of the accident.
21. I acknowledge Mr Kearney's concern as to the safety of cyclists using bicycle paths in the ACT, however, the issue of cycling safety generally is too amorphous for the court to consider in the context of this inquest. I note the prompt response to the particular concern raised by Coroner Fryar. I also conclude that it is appropriate for me to make a recommendation to the ACT Government regarding the maintenance of bicycle paths in the Territory.
22. I also note with sadness that the court has recently been informed by lawyers assisting Mr Kearney that he too has since passed away in unrelated circumstances.

Findings

23. I find that Dr Foce died on 24 April 2018 as a result of a head injury sustained from a collision while turning into Mentone View, Conder in the Australian Capital Territory, in which she and her bicycle collided with a builder's trailer being towed by a utility.
24. The accident was not the result of any inappropriate act or omission by Mr Crockett, the utility driver.
25. Given police photographs and the views of Mr Kearney concerning how Dr Foce's bicycle would have handled as it went over the gravel, as well as the glasses Dr Foce was wearing at the time she was riding, I consider these factors, along with the state of the bicycle path, would have contributed to the collision.
26. I am satisfied that since the accident, the steps the Territory has taken to improve public safety on this bicycle path, namely, sweeping the bicycle path shortly after the accident, repairing the path and building a retaining wall, so as to ensure that gravel from the nearby reserve is unlikely to be swept on to the bicycle path again, alleviates any foreseeable future public

safety matters arising from this incident. As such, I do not consider there are any other aspects of public safety arise in relation to this matter.

27. However, given this location was previously known to have issues with debris on the path, I recommend that, if no such program presently exists, the ACT Government institute a regular audit program for its off-road bicycle paths to ensure that they are appropriately maintained and there are no obstructions or risk of obstruction from the surrounding environment (such as gravel, dirt or trees). If such a program exists, I recommend it be reviewed to ensure that inspections occur at sufficient frequency so as to minimise the risk that a path becomes and remains obstructed to a level that may be dangerous to persons using the path.
28. I direct that these findings be published on the Coroner's Court website, together with any responses provided by the Territory.
29. I extend my condolences to Dr Foce's family and friends, particularly those further affected by Mr Kearney's passing

Court References:	CD 8 of 2015
	CD 61 of 2015
	CD 164 of 2016
	CD 281 of 2016
Ages:	26 years
	49 years
	60 years
	56 years
Genders:	Male
	Female
	Female
	Male
Dates of Death:	6 January 2015
	20 March 2015
	6 July 2016
	14 November 2016
Places of Death:,	Garran ACT
Coroner:	M.A. Hunter
Date of Findings:	4 March 2021

Reported as: [2021] ACTCD Inquest into the deaths of ANTHONY LEIGH BEARHAM, NICOLA JOY FISHER, CHRISTINE BELLE DOUCH and KEN ALEXANDER LUCAS

The finding in this inquest are extensive, the below is an extract. Complete findings can be found at:

Inquest into the deaths of Anthony Leigh Bearham, Nicola Joy Fisher, Christine Belle Douch and Ken Alexander Lucas - ACT Magistrates Court

1. There were several deaths by suicide between January 2015 and December 2016 at the Adult Mental Health Unit on The Canberra Hospital Campus. I was asked to conduct Inquests into the deaths of four in-patients at The Canberra Hospital Campus. Three of those deaths were by hanging and one was by jumping from an elevated floor to the ground floor of The Canberra Hospital.
2. All four deceased had been previously treated for their mental illness. All four died within a few days of admission to either the Medical Assessment and Planning Unit (MAPU), Mental Health Assessment Unit (MHAU) or the Adult Mental Health Unit (AMHU).

3. Two different mechanism for the three hanging deaths were used. One mechanism was the tying of a ligature to the outside door handle (described as a non-ligature point handle) and slinging the ligature over the other side of the door to be used as a hanging point. The other mechanism was to tie a big knot in the ligature and sling it over the door wedging it between the door jam and the door to use as a hanging point.
4. The inquest was held in two phases. The first phase comprised of hearing the circumstances of each individual death. The second phase arose out of issues raised in relation to protocols within the hospital. This phase focused on whether those protocols were followed in the first instance and secondly whether they were adequate in the circumstances.
5. In the first phase I examined the circumstances of each individual death. In the second phase I heard evidence from experts in relation to several matters. These matters involved protocols, review of the mechanism used by the deceased to suicide by hanging, review and changes to protocols since the deaths and reconfiguring of the accommodation in the Adult Mental Health Unit since the deaths.
6. In the first phase I heard evidence of the circumstances surrounding all four deaths. I also heard from the families of the deceased in relation to the prior history of mental illness suffered by their loved ones as well as their expressions of grief. The Court was deeply moved by the grief expressed by the families as well as the frustration and pain identified by the families over the loss of their loved ones whilst in the care of ACT Health.
7. The Court took evidence over eleven Hearing days throughout 2018. The Court received numerous volumes of material which included statement from relevant witnesses, the Coroner's investigator, medical records, expert reports and hospital protocols in relation to the four inquests. Two site views were conducted as well as an informal examination of the area where Ms Douch died.
8. The facilities, particularly in relation to ligature points, were examined at length. The hospital protocols were also examined, particularly in relation to patient observations, handovers and nursing duties in general.
9. I have already made preliminary findings as to the manner and cause of each of the deceased.

....

Recommendations

1224. I find that there are matters of public safety which arise from this inquest. I also find matters going to the administration of justice which arise out of this inquest:

1225. In relation to those matters I make the following recommendations:

(a) That a review of the MOU between TCH and the AFP be conducted, with a view to simplifying and clarifying the process of Police having access to staff who are potential witnesses where a death occurs.

(b) That a review of TCH Operational Procedure 'When Death Occurs' be made with a view to incorporating policy and procedure. As well as clear directions that staff should be encouraged to engage with Police investigating a death at the TCH campus on behalf of the Coroner.

(c) That there be a review of policy and procedure in relation to dangerous items brought in by patients (particularly those at risk of suicide), including clear procedures for searching of patients for those items and clear procedures for when resistance to those searches is met.

(d) That there be a review of possible technological equipment for monitoring of at-risk patients, such as pulse oximeters and CCTV in general areas of the facility.

(e) Review training in relation to the 'at-risk observation' policy and procedure to ensure staff understand the reasoning behind the policy and the importance of its adherence to it.

(f) TCH finalise the MHSSU Operational Procedure as soon as practicable, having regard to the evidence lead in this inquest and the suggestions for changes and additional training put forward in respect of this and the AMHU Operational Procedure

(g) That MHJHADS should consult with its staff and review its training packages to ensure that the training provided is appropriate and fit for purpose.

...

Findings

Anthony Leigh Bearham

I formally find that:

1226. Anthony Leigh Robert Bearham born 30 December 1989, died on 6 January 2015, at 15:41 hours in the Intensive Care Unit at The Canberra Hospital, Garran, aged 26 years. Cause of death was hypoxic brain injury caused by attempting to hang himself from the door of a toilet in the Social Spine of the Adult Mental Health Unit (AMHU) at The Canberra Hospital on 4 January 2015 between 23:00 hours and 23:46 hours. Mr Bearham was successfully resuscitated on 4 January 2015 but ultimately succumbed on 6 January 2015 from injuries sustained as a result of the hanging. There was no third-party involvement in his death.

Nicola Joy Fisher

I formally find that:

1227. Nicola Joy Fisher was born on 8 December 1966 and died on 20 March 2015 at a point between 08:40 hours and 09:43 hours. Ms Fisher was 49 years of age. Ms Fisher was found hanging by a dressing gown belt, wedged on top of the ensuite bathroom door in room 5 of the Mental Health Assessment Unit, at The Canberra Hospital Garran. Her death was caused by hanging which was self-inflicted. There was no third-party involvement in her death.

Christine Belle Douch

I formally find that:

1228. Christine Belle Douch born 8 July 1956, died on 6 July 2016 at 21:40 hours from haemothorax and severe blunt chest injuries due to intentionally falling from the third floor onto the second-floor atrium of The Canberra Hospital, Garran on 5 July 2016 at 21:36 hours. Ms Douch was 59 years of age. There was no third-party involvement in her death.

Ken Alexander Lucas

I formally find that:

1229. Ken Alexander Lucas born 19 June 1960 died on 17 November 2016 at 19:30 hours in the Intensive Care Unit at The Canberra Hospital, Garran, from global cerebral hypoxia. Mr Lucas was 56 years old. His death was caused by Mr Lucas attempting to hang himself from the door of the ensuite in Room G40 of the Adult Mental Health Unit at The Canberra Hospital on 12 November 2016 between 21:00 hours and 22:00 hours. Mr Lucas was successfully resuscitated on 12 November but ultimately succumbed on 17 November 2016 from injuries sustained as a result of the hanging. There was no third-party involvement in his death.

Court Reference:	CD 33 of 2016 Bradyn Stuart Dillion
Age:	9 years
Gender:	Male
Date of Death:	15 February 2016
Place of Death:	Gordon, ACT
Coroner:	M.A.Hunter
Date of Findings:	29 April 2021

Reported as: [2021] ACTCD 3 Inquest into the death of Bradyn Stuart Dillon
The findings in this inquest are extensive, the below is an extract. Complete findings can be found at:

Inquest into the death of Bradyn Stuart Dillon - ACT Magistrates Court

1. Bradyn Dillon was murdered by his father Graham Dillon on 15 February 2016.

Purpose of Coronial Inquest

2. The purpose of a coronial inquest is to independently investigate a death which is referable pursuant to the legislation. The coroner must where possible ascertain the identity of the deceased person, the manner and cause of the death of the person. Included in that finding is the medical cause of the death and the circumstances surrounding the death. Circumstances may include the background and surrounding circumstances to give context to the death if possible.
3. Clearly the legislation confines those findings in respect to those circumstances, to be sufficiently proximate and causally relevant to the death and not merely all circumstances which might form part of a narrative accommodating any death.[6]
4. There is a broader purpose for coronial investigation and that relates to matters of Public Safety which is to

'contribute to the reduction of the number of preventable deaths through the investigation findings and the making of recommendations by the coroners, generally referred to as the 'prevention role'".[7]

5. The evidence in this inquest comprised of 30 hearing days, taking oral evidence from 31 witnesses, 14 folders of material from the AFP investigation team, which included statements, records of interview and the autopsy report. There was also over 5000 pages of material which had been subpoenaed. That material was contained on a USB which was tendered in evidence.

[6] Harmsworth v The State Coroner [1989] VR 989 (cited at [55] inquest into the death of Luke Batty 2015)

[7] Inquest into the Death of Luke Geoffrey Batty 2015

There were 149 exhibits tendered in the proceedings. The transcript of the proceedings comprised 2516 pages.

6. Given the enormity of the evidence before me, including oral evidence and materials tendered in evidence, I formed the view that it was important to summarise the statements and oral evidence given by each witness.
7. I also had the benefit of having three reports tendered in evidence before me. The 'K' Review[8] was an internal review initiated by CYPS specifically in relation to Bradyn's death and conducted within 10 days of his death. The Muir report was conducted shortly after Bradyn's death. This was an external review to review the documents associated with Bradyn's death. Finally, the Glanfield Inquiry, which looked broadly at the care and protection systems. Each of the reviews made recommendations, which I have considered very carefully. I have attached as an annexure to my findings, the Glanfield Inquiry.

...

Comments about Filicide and Domestic Violence in General

3606. Last week there was a news report that a father had killed his 9-month-old daughter by jumping off a cliff. Two women were reportedly killed by their male partners in Queensland, this month the inquest into the death of the Jack and Jennifer Edwards was handed down. Their father followed Jennifer home from school and shot them both whilst they were cowering in their bedroom.

3607. One year ago, Hannah Clarke and her three children died at the hands of her ex-husband, the children's father. Luke Batty died in 2014 as a result of his father beating him to death. In the ACT we had an attempted filicide of two children by their mother in 2019.

3608. All of those deaths were as a result of family violence.

3609. This inquest is about family violence resulting in filicide. I note counsel for the Territory in his comments at paragraph 66 of his submissions referred to the inquest and the death of Luke Batty. In that inquest his Honour Judge Gray, the then State coroner, opined that having heard from the experts the crime of filicide was a rarity. I would like to think that was true however given very recent news of father's killing their children it is unfortunately, not such a rarity at all.[9]

[8] Report Author name suppressed by order of the Coroner

[9] The murder of Luke Batty, the murder of Jack and Jennifer Edwards, the murder of Hannah Clark and her three children, the suspected murder of Kobi Shepherdson. The attempted filicide of two children in the ACT in 2019.

Comments about SK and UN

3610. I found SK to be a very impressive witness. She was able to give accurate and concessionary evidence when required. It was clear that despite her desperate attempts to engage with various agencies about her well-founded fears for her children's safety, those concerns fell on deaf ears.

3611. SK said she felt that she was looked down on by those agencies and in my view having considered all the evidence that was probably true. It would appear that this was one reason why she was not able to get the help that she so desperately needed to help her children.

3612. I would like to commend SK and how she did everything in her power to save the children, unfortunately she was not listened to by those who should have listened to her. Ironically as it turned out SK was required to corroborate her version, yet the perpetrator was never asked to corroborate his allegations about SK. That is not an unusual phenomenon. I note what her Honour, the State Coroner for NSW, said in her findings in relation to Jennifer and Jack Edwards about women not being believed when they make complaints about domestic violence.[10]

3613. UN was a very impressive witness who gave a good history of the historical abuse she suffered at the hands of Graham Dillon. UN was treated with the same lack of respect that SK experienced, perhaps for the same reason. The evidence before me suggests that both witnesses were not believed. The reason, it seems to me, was because of what appears to have been concerns that UN and SK had ulterior motives when making these reports, such as to enhance their success in future family law proceedings. There were no family law proceedings on foot for either SK or UN, and nobody made enquiries to establish that fact. The real situation was that both women were extremely concerned for the safety and welfare of the children. That reason was clearly well founded.

3614. The history of abuse perpetrated against these two women was horrific. Graham Dillon was controlling, manipulative and violent in the extreme, behaviour that is not untypical of violent men perpetrating significant domestic violence against women and their children. Graham Dillon was cunning with his abuse, so as to ensure that both women would not confide with anyone because of his extreme behaviour and their resulting fear.

3615. As history shows us, that behaviour was also deployed by Graham Dillon in relation to both Bradyn and JL.

[10] Inquest into the deaths of John, Jack and Jennifer Edwards [49].

3616. Bradyn was a quiet and extremely polite little boy. His teachers were very fond of him and described him as courteous and respectful. Bradyn was a child who contributed positively in group situations.

3617. His teachers said that he "*consistently contributes to a safe and welcoming class environment and that he consistently contributes to a safe and welcoming playground environment*". I lament that we as a society could not contribute to his safety.

Condolences

3618. I wish to express to SK and JL the courts condolences and sympathy for the loss of Bradyn in these terrible circumstances. By all accounts he was a delightful little boy whose life was cut short by a sadistic monster who was his father.

3619. I would also like to convey that his death was not in vain and there is a legacy that he leaves with us as a community.

3620. That legacy includes learning from the circumstances surrounding Bradyn's death so that frontline workers get better training in relation to domestic violence. To also find solutions to reduce the scourge of domestic violence upon our community **Findings**

3621. Bradyn Stuart Dillon was born 25 October 2006 at Royal Hobart Hospital Hobart.

3622. Bradyn Stuart Dillon died on 15 February 2016 at 20:25 hours at Calvary Hospital Bruce in the ACT, aged 9 years and 4 months.

3623. Death was caused from a closed head injury; the closed head injury was caused by sustained repeated blunt impact injuries over a period of time which were non accidental in nature. The closed head injury was secondary to these repeated impacts.

3624. Graham Dillon, Bradyn's father, caused the closed head injury by sustained, repeated blunt impact injuries inflicted upon his son Bradyn, which ultimately led to his death.

3625. Graham Dillon was able to inflict sustained violence upon Bradyn (and JL) by deliberately and increasingly isolating them from their community from late August 2015 until Bradyn's death.

Recommendations

3626. I find that there is an issue of public safety in connection to the death of Bradyn Dillon pursuant to s52 (4) of the Coroners Act 1997. In relation to s57(3) of the Coroners Act 1997 I make the following recommendations:

CYPS

(1) Renewed training initiative with a focus on

i. strengthening the understanding and application of risk assessment, including cumulative harm.
ii. strengthening the understanding and application of legislative thresholds in informing decision making.
iii. strengthening the understanding of forensic interviewing of children and parents.
iv. the role of supervision, to include provision of improved quality assurance of decision making and administrative functions.

(2) Continue funding for the induction training package for new frontline workers.

(3) Funding and investment in training front line managers and team leaders to develop and strengthen skills in risk analysis and quality assurance.

(4) Consider legislative changes in relation to the definition of how a child concern report is defined from a 'caller defined model to an 'intake defined model'.

(5) Funding a greater number of staff at the intake level of CYPS.

(6) Funding to be provided for junior staff in intake to develop and enhance their skills in front line work which includes risk assessment and cumulative harm.

(7) Consider the establishment of an Intake Consultation Team for complex cases.

(8) Continue funding of the Case Analysis Team with a view to increasing staff numbers .

(9) Funding to engage a team of trainers in relation to providing mandatory reporters with skills to identify matter which require reporting to CYPS and those which could be referred to appropriate community organisations.

(10)Consider legislative changes to include that mandatory reporters are advised of the outcome of their reports.

ACT Education Directorate

3627. Improvement of school tracking system to strengthen Part 6.1A of the Education Act 2004

(11)Adopt a formal process

i. to require parents to advise the school where a child is being unenrolled to give details of where the child will be enrolled, or home schooled.
ii. where a child, the subject of CYPS involvement, has been unenrolled, to alert CYPS that the child has been unenrolled and the name of the school where they will be enrolled or the address for home schooling.

iii. obliging the Education Directorate to contact the new school to confirm enrolment and if enrolment is not confirmed then the Education Directorate must make a mandatory report to CYPS of that fact.

iv. making child tracking in the ACT to be mandatory for all schools.

(12)To adopt and implement the National Schools Reform Agreement 'Unique Student Identifier' (USI) for the purposes of having a national information exchange scheme.

(13)To participate in the management of the interjurisdictional data transfer scheme project through the Education Council of Australia.

Information Sharing Between Organisations and Interjurisdictionally

(14)Expand the usage of the Connect 4 Safety Federal initiative to incorporate a health service provider component .

(15)Continue to evolve the relationships between CYPS, ACT Education, SACAT DVCS and other community organisations through the use of liaison officers.

(16)Enhance information sharing between CYPS and ACT Education in relation to real time enrolment data and identification of children at risk in conjunction with the proposal for mandatory child tracking.

(17)Recommend that the Attorney General at the next meeting of State and Territory Attorneys General, raise with his counterparts the establishment of a national data base for children at risk.

3628. I endorse, and invite the ACT Government to implement, the recommendations from the Glanfield, Muir and K reports and invite the implementation of those recommendations which have not yet been implemented.

Court Reference:	**HomegrownMe CF 2 of 2018**
Date of Fire:	15 February 2016
Place of Fire:	Gordon, ACT
Coroner:	G.S.Theakston
Date of Findings:	29 April 2021
Reported as:	[2021] ACTCD 2 HomegrownMe Pty Ltd

1. On the evening of 24 October 2018 there was an explosion at a commercial kitchen in Fyshwick. Four young men were seriously burned.
2. The incident was reported to me as the duty Coroner and I decided to exercise jurisdiction under s 18(2) of the *Coroners Act 1997* (ACT). WorkSafe ACT conducted an investigation and provided the Court with a comprehensive brief of evidence.
3. This incident raises a number of issues, including: the cause of the explosion; the injuries suffered by those present; and a matter of public safety.
4. I will initially describe the general situation and the circumstances of the night on which the explosion occurred and then address the above issues

...

24. This incident arose due to the existence of an uncapped gas line. That line was connected to a supply of gas and located adjacent to other gas fittings that were used on a frequent basis. The uncapped fitting was located in a confined space, used by people and near an ignition source. The valve to that gas line amounted to a single point of failure that, if turned on, would almost certainly lead to a gas explosion. The initial gas works had been certified by a licensed gasfitter, and a plate evidencing that certification remained fixed to the kitchen notwithstanding the subsequent removal of the hotplate and the creation of the hazard.
25. The owner of the kitchen had appropriately engaged a gas appliance worker on two occasions in relation to the adjacent oven and does not appear to have received any advice or warning about the uncapped gas line. The appliance gas workers attended to the oven repair as requested but did not inspect the adjacent gas fittings.
26. The *Gas Safety Regulation 2001* (ACT), regs 6 and 10 require any disconnected gas line to be capped. The reasons for that are obvious. The capping of such lines provides a simple and reliable measure to prevent the inadvertent release of flammable gas. Once the line is capped it would not matter whether someone move an upstream gas valve to the 'on' position. This is particularly important for confined spaces, occupied by people and proximate to an ignition source.

27. The regulatory regime requires that approved gas appliances be disconnected only by licensed gasfitters: see the *Construction Occupations (Licensing) Act 2004* (ACT), ss 7, 12 and 84, and the *Gas Safety Act 2000* (ACT), ss 6E and 6F. A licensed gasfitter would be aware of the need to cap a disconnected gas outlet. In this case it remains unclear who precisely removed the hotplate. In any event the uncapped disconnection occurred well after the compliance plate had been affixed and in circumstances where it may not have been obvious to the owner of the kitchen that the gas piping system was no longer compliant. Accordingly, the existence of the compliance plate following the removal of the hotplate would have been misleading to the new owner.
28. The regulatory scheme does not contemplate the periodic inspection and re-issuing of compliance plates. In the absence of such an arrangement, there would be utility in consumer information being added to the compliance plate. That information could include a statement that it is dangerous for an unlicensed person to modify the gas piping system or install or disconnect a gas appliance to the gas piping system, and that it may from time to time be appropriate to have the gas piping system and gas appliances inspected by a licensed gasfitter and gas appliance worker
29. **I recommend** that the Construction Occupations Registrar consider including the above information in any recommended compliance plate, as anticipated by the *Gas Safety Regulation 2001*, reg 18.