ACT Coroner's Court Annual Report

2021-2022

ACT Coroner's Court
Annual Report 2021/2022

The ACT Coroner's Court acknowledges and pays respect to the past, present and future traditional custodians and elders of this Territory and the continuation of cultural, spiritual and educational practices of Aboriginal and Torres Strait Islander peoples.

Warning: Aboriginal and Torres Strait Islander readers are warned that the following report may contain the names of deceased persons.

Strawberry tree and dedication plaque planted by Chief Coroner Walker 2019 at the Forensic Medicine Centre.

ACT Coroner's Court
Annual Report 2021/2022

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Mr Shane Rattenbury, MLA
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ACT Legislative Assembly
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Dear Attorney-General

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 of the 2021/22 financial year.

Yours sincerely

Lorraine Walker
Chief Coroner

Date: 22 December 2022

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Chief Coroner's Foreword

At the time of my appointment as a coroner of the Australian Capital Territory, our population was 367,500. Our coronial system was supported by 2 part-time pathologists, three part-time technicians operating out of an ancient facility in Kingston. Nearing 100 per cent of coronial matters involved an invasive post-mortem examination. There were two administrative assistants who fielded all enquiries and addressed familial distress. Counsel assisting were provided by the Office of the Director of Public Prosecutions. There was no psychological support offered to those affected by the coronial process.

The ACT is now home to 467,000. We are a fast-growing city. The coronial jurisdiction has come a very long way. We now have in-house counsel assisting, a team of staff at our purpose-built Forensic Medical Facility, a team of administrative and legal support staff, and a full-time family liaison officer. Repeated calls were made in this annual report, and more recently from the community, for the appointment of a judicial officer who could attend to coronial matters ahead of other court duties, rather than as an adjunct to them. In this reporting period, the government made that appointment. We welcomed Magistrate/Coroner Ken Archer to the role in March 2022.

The Court is committed to improving efficiency in resolution of coronial matters and to strengthening restorative practices in order to provide a more sensitive and meaningful processes for families and others involved in this process, whilst striving to maintain vigorous investigation of matters of concern to public safety. Court staff are currently involved in a government-funded facilitated process with community representatives to explore how those ends can best be achieved. There is room for significant improvement in the processes and efficiency of the Court.

Magistrate Archer and the coronial team are currently focused on reducing the backlog of coronial matters that have remained incomplete for an unacceptable period of time whilst maintaining the throughput of new referrals in a timely manner.

Despite the significant improvements which have been achieved in the coronial jurisdiction over the last 10 years, and the positive direction in which it is heading, there are still areas of real vulnerability. These include the current necessary reliance on a fly-in, fly-out forensic pathologist, Professor Jo

Duflou, without whose goodwill and commitment, the coronial service would have struggled mightily. The lack of local, timely access to services such as MRI and CT scanning, and quick-turnaround drug-testing, hampers less invasive, timely resolution of coronial medical investigation. The Court must partner with interstate services in order to be in a position to provide a professional, reliable pathology service going forward.

Infrastructure at the Forensic Medical Facility must be reviewed as to its fitness for purpose against national standards. Consideration should be given to a more suitable physical environment for coronial hearings than the Magistrates Court, particularly in light of community demand for a restorative process.

The ACT community would benefit from the embedding of police coronial investigators within the Court to better facilitate and integrate the investigative processes between the two organisations.

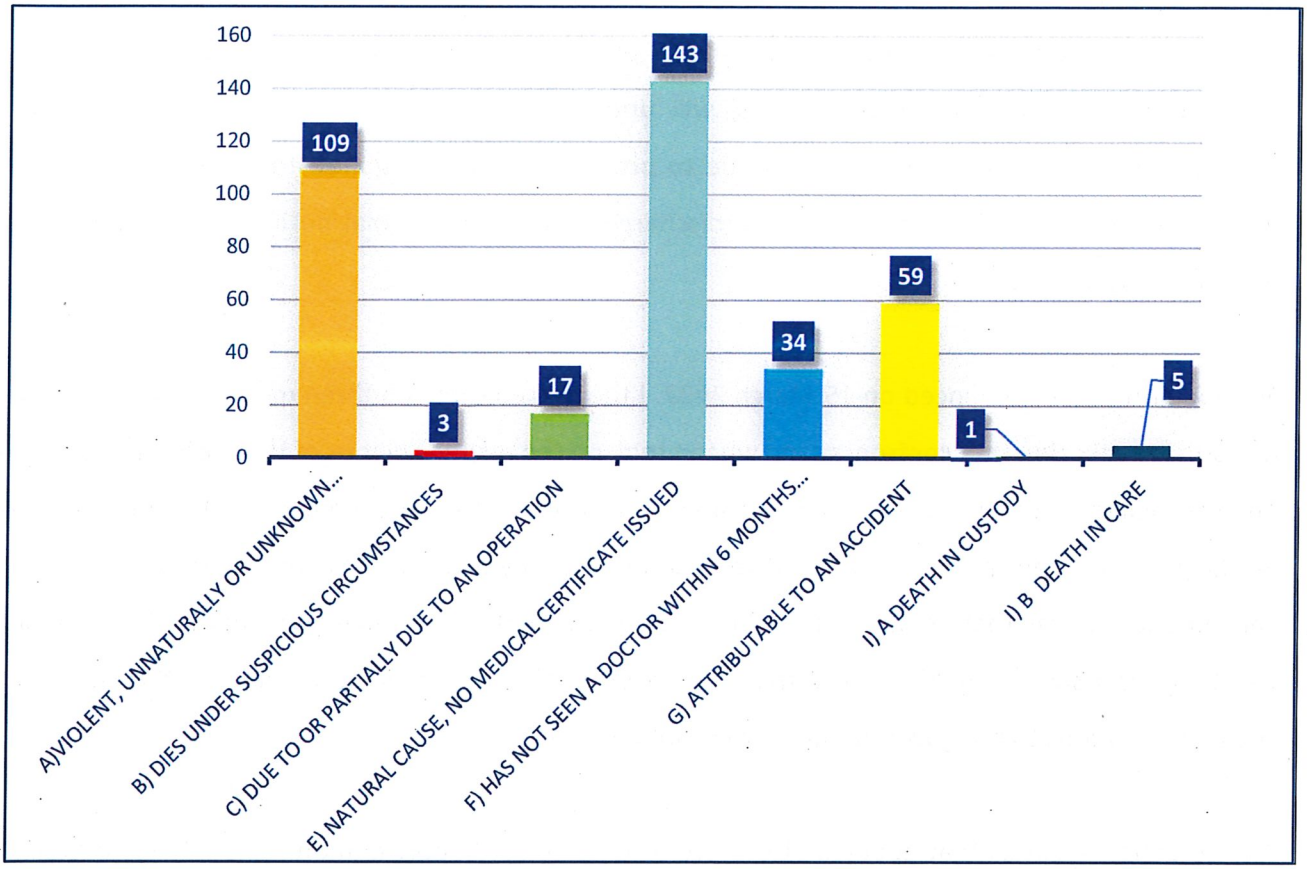
I will work with Coroner Archer to pursue these priorities.

I acknowledge the dedication of Coroner Archer and all staff who are involved in the coronial process: the police and forensic medical officers who are the Court's "first responders", staff at the FMC, administrators, managers and lawyers. I am impressed by their dedication and the respect and care they have for the deceased, their loved ones and all who are required to engage with this challenging and important work.

Performance overview at a glance

373	354	95%	21%
New matters	Matters finalised	Closure rate	Backlog indicator*

Coroner's jurisdiction in relation to deaths**



Inquests finalised by hearing: 5

Recommendations made: 13

Matters referred to the Attorney General: 6

Responses received to recommendations: 6

*Report on Government Services Section 7 Courts Effectiveness 7.12 backlog indicators. This is the percentage of pending matters over 24 months old. https://www.pc.gov.au/ongoing/report-on-government-services/2022/justice/courts

** 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. Matters may be referred under multiple heads of jurisdiction.

Observations of Coroner Ken Archer

My appointment as what is styled as the dedicated coroner reflects a commitment made by the Government to address community concerns as to how the functions of the Coroner's Court were being discharged, both in relation to the time taken for findings to be made and the lack of appropriate levels of communication between the Court and families affected by reportable deaths. The intention is that one coroner, rather than all magistrates, will undertake the investigation of reportable deaths. Magistrates acting as coroners will continue to provide the input required to ensure the statutory responsibilities of the Coroner's Court are discharged outside of normal business hours and during periods of my absence.

My appointment commenced on 15 March 2022. I therefore reflect on three months of the reporting period. The situation that confronted me when I took up the responsibilities of the position was mixed. The coronial team within the larger Magistrates Court is very small. It is comprised of a group of hard working and resilient people, dedicated to ensuring that my investigations of reportable deaths are carried out in a way that provides an explanation of why that person died and whether that person's death raises issues of public safety that should be explored and, if necessary, be the subject of recommendations to the government for relevant change.

The statistical analysis that appears elsewhere in the Annual Report demonstrates that the Court is efficient in arriving at findings in most cases; usually those involving findings that death was due to natural causes. The forensic pathology services in the ACT are provided under contract. Autopsy reports, which are high in quality, are generated efficiently which facilitates this outcome.

It is in respect of cases where the cause of death cannot be readily attributed to natural causes, or otherwise raise systemic or public safety issues, that the Court has increasingly struggled to discharge its statutory functions. At the time of taking up my appointment, open cases ranged as far back as 2015. There were 44 incomplete investigations from deaths that occurred in the period 2016 to 2019. Many of these cases involved deaths occurring in hospital settings. As a class, those cases are complex, often requiring expert advice from medical specialists. The cases consume the time and resources of the Court

in a fashion that is significantly disproportionate to their number. It is the area where family dissatisfaction is most evident and where families are, because of the passing of time, anxious to have answered their reasonable questions asked about the circumstances of their loved one's death. Over time the resources required to address that backlog will continue to cause other cases to be resolved in time frames inconsistent with national benchmarks of acceptable performance. Delays in providing findings, when combined with a lack of communication with families about the progress of investigations, adds to the trauma suffered as result of the loss of a loved one. Simply put, the processes of the court have not been trauma informed.

In published findings in respect of a death that had occurred in 2016, I wrote:

> *The disposition of the inquest into Mrs Vance's death has taken an inexcusably long period of time. Section 3BA of the Act requires inquests to be carried out in way that recognises that the death of a person and an inquest into the person's death, has a significant impact on the person's family and friends. That statutory obligation has not been discharged in this case.*

Supplementation of funding is required to provide proper support to the new coroner position. Funding has been provided on an ongoing basis for a Family Liaison Officer, who is tasked with communicating with families about the coronial process. Consistent with considerations of safety, the capacity of a single person to do that in relation to over 350 new families each financial year, as well as families involved in older investigations year is to be questioned. At the time of writing there is permanent funding for only one lawyer/investigator. The proper funding of lawyer/ investigator positions is critical to my ability to comply with my statutory obligations.

An independent facilitator has been appointed to explore how the processes of the court can be made more restorative – to ensure that coronial processes do something to alleviate the trauma that has been experienced through the death of a family member or friend. Adequate resources (people) are foundational to that aspiration.

There are other vulnerabilities in the coronial process that will require the government's future attention. Autopsy services are provided by a single contractor. If that person becomes unavailable,

there is no capacity or arrangement that presently exists for that service to be provided, other than on an ad hoc basis. The Forensic Medicine Centre in Phillip has undergone a limited refurbishment but is nearing the end of its operational life.

The Coronial Counselling Service is provided by Relationship Australia under contract administered by the ACT Health Directorate. Whilst the services provided under the contract are of a high standard, the location of contract with an agency not related to the coronial jurisdiction makes identification of appropriate priorities difficult, and the achieving of equity in the use of funds impossible. Contract monies are expended quickly within the contract year and the community is effectively without a counselling service for the balance of the term of the contract for that year. In my view, and consistent with the practice everywhere else in Australia, counsellors should form part of the coroner's staffing complement at court.

The support provided by the AFP to the investigative functions of the coroner requires review. Best practice suggests that specialist police investigators should form part of the Coroners Court and should be co-located with the coroner's staff.

Similar considerations apply to functions associated with the review of child deaths, family violence deaths and suicide prevention.

I acknowledge the support received from the Chief Coroner and from fellow magistrates (coroners) and from coroners elsewhere in Australia. Their support has been most welcome.

About the Coroner's Court

The Court's function, powers and responsibilities are set out in the *Coroner's Act 1997* (the Act). The coroner's function under the Act is to hold inquests into deaths which occurred, or are suspected to have occurred, in particular circumstances. The Coroner is required to make findings, primarily the identity of the deceased person and the cause of their death. A related function of the Court is prevention of future harm to the community. The Act allows the Coroner to make recommendations based on their findings as to the prevention of deaths, the promotion of public health and safety, the administration of justice and the need for any other entity to investigate or review circumstances and facts.

The Act requires the Coroner to have regard to the significant impact that the death of a loved one may have on their family and friends. The Coroner is required to have regard to cultural beliefs and practices. The Court aims to provide a service which acknowledges these beliefs and practices and accommodates them as far as is possible, consistent with other legal considerations.

The Coroner is also required to inquire into and make findings and recommendations about the origin and cause of fires that have damaged property, and disasters, in certain circumstances.

Our staff

The Court is supported by a dedicated team of legal, administrative and technical officers. The team comprises one permanent legal officer and two temporary legal officers, an administrative officer/associate to Coroner Archer, an officer who is responsible for managing the court registry and Forensic Medicine Centre (**FMC**), two administrative officers responsible for registry services, a Family Liaison Officer, two technical officers and three casual technical officers who are based at the FMC. This is the greatest level of resourcing the Court has yet experienced which should pay dividends in terms of future efficiency and an improved quality of service to the community.

Coronial investigators

Section 59 of the Act provides that the Coroner may appoint any person to assist them 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. Nationally, police take the lead investigative role for coroners and 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. A standing request has been made to the ACT Chief Police Officer. Specific requests are made as required for particularly complex or sensitive and those requiring a greater level of resources.

The AFP also provides a dedicated unit – the ACT Coronial Liaison Unit – whose members are the first point of contact in relation to possible reportable deaths. They provide initial reports of deaths to the Coroner and subsequently perform co-ordination, liaison and investigative tasks as required. Primary investigatory responsibility for coronial fires not involving the death of a person falls to the ACT Emergency Services Agency (ESA) through either ACT Fire and Rescue or ACT Rural Fire Service. The ESA assists the Court to identify fires of significance and to investigate them as required.

Worksafe ACT also co-operates with the coronial investigative function in relevant matters, having regard to individual statutory obligations of each.

A therapeutic approach

The role of the Coroner is both investigative and judicial. The Court continues to develop therapeutic and restorative approaches to the exercise of its functions The Court aims to facilitate positive engagement and limit unnecessary harm that may flow from involvement in the coronial process. The availability of the Family Liaison Officer, the provision of coronial counselling services, and the move to more open sharing of information about investigations are examples of this therapeutic approach. The Court has also trialed more innovative forms of hearing, including round table and concurrent expert evidence, which have facilitated greater participation and outcomes to which all participants can contribute. Most notable of these was the inquest into the death of Blake Corney, in which Blake's parents were able to actively engage with the process, including the hearing, on an equal footing with

government organisations, leading to some positive outcomes from that extremely tragic circumstance.

In the next reporting period and in conjunction with other stakeholders, the Court will work with an independent facilitator to explore opportunities to implement changes that will better address the needs and wellbeing of those engaged with, and affected by, the work of the Coroner's Court.

Coronial counselling services

The Coroners and staff of the Court are acutely aware of the grief and distress associated with any death, but particularly unexpected or unexplained death. Families and loved ones find that the coronial process itself may be difficult and may aggravate their grief. The ACT Health Directorate continues to fund Relationships Australia (Canberra Region) to operate the ACT coronial counselling services. This service has been operating successfully for a number of years now and is highly valued by the Court and those who use it. However, in 2021/22, the need for counselling services significantly outweighed their availability for persons impacted by the coronial process.

Community engagement

During the 2021/22 year, the Court has continued to engage with various stakeholders to enhance training and facilitate exposure to coronial processes. These include ANU medical students, the Department of Foreign Affairs and Trade, Australian Federal Police, Canberra Institute of Technology, Disaster Victim Identification Committee (a multi-agency task group chaired by the Chief Coroner, supported by the Australian Federal Police), Inspector General of the Australian Defence Forces, the Justice and Community Safety Directorate, ACT Coronial Reform Group, ACT Human Rights Commission, the National Coronial Information System, Canberra Health Services, Calvary Hospital, ACT Government Analytical Laboratory, ACT Ambulance Service, Donate Life and ACT Fire and Rescue.

During the reporting period, the Court has engaged with a number of working groups and committees to improve information sharing and death prevention, including the newly formed Family Violence Death Review Committee, the ACT Child & Young Person Death Review Committee, the ACT Suicide

Prevention Data and Evaluation Working Group (chaired by Professors Batterham and Calear from the Centre for Mental Health Research) , the National Deaths in Custody Working Group, the ACT Suicide Prevention Co-ordinating Committee, the Aboriginal and Torres Strait Islander suicide prevention working group, and the Australian Institute of Health and Welfare suicide register project.

Observers

During 2021/2022 reporting period, 422 observers attended the FMC for various purposes (see Table 1 – Observers attending the FMC). All observers attend with the approval of the Court and approval from the deceased's next-of-kin.

Table 1: Observers attending the FMC		
ANU Medical Students	53	Observe PM
Department of Foreign Affairs & Trade	47	Discussion/Tour/View deceased
AFP Recruits	204	Discussion/Tour/View deceased
AFP PSO Recruits	89	Discussion/Tour/View deceased
Joint Military Police Unit (ADF)	23	Discussion/Tour/View deceased
Canberra Hospital Staff	2	Observe PM
British Consulate	4	Discussion/Tour
TOTAL	**422**	

Our projects

ACT suicide register

I am pleased to announce that due to the generous seed funding from the Australian Institute of Health and Welfare (AIHW) and invaluable technical support from the Victorian Coroner's Court and the National Coronial Information System, the Court introduced a suicide register in 2021/22. This has provided the Court with the ability to monitor and report on real time data which can be analysed to identify patterns and potential issues of public safety. The register captures data of demographics, intent, psycho-social factors, physical health and interactions with mental health and assistance organisations. Work has commenced on back-capturing reports of the now available data. Reports are provided to AIHW to feed into the national data sets surrounding deaths by suicide.

Accessible information for persons impacted by the coronial process

The Court is working to provide more accessible information to persons impacted by the coronial process. It has developed two information videos titled 'A Guide to Coroner's Court' and 'Coroner's Court Hearings', available on the Coroner's Court website. The guides can be viewed at https://www.courts.act.gov.au/magistrates/about-the-courts/coroners-court/information-for-family-and-friends.

Additional videos are planned to explain the work of the FMC and providing guidance for coronial and forensic investigators. The Court's website will continue to be updated with detailed information for families, friends and witnesses in coronial inquests.

Performance

Coronial cases lodged in 2021/22 remain steady from the previous year and represent a 24% increase over five years (see Table 2: Coronial cases lodged by financial year). Referrals to the Coroner represent 17% of all deaths registered in the ACT[1], whilst admissions to the FMC represent 22.3% of all deaths within the ACT[2].

Table 2: Coronial Cases lodged by financial year						
Type	**2021-2022**	2020-2021	2019-2020	2018-2019	2017-2018	2016-2017
Deaths	**370**	369	347	313	305	299
Fires	**3**	0	0	1	3	0
Disasters	**0**	0	0	0	0	0
Total cases	**373**	369	347	314	308	299
Yearly percentage increase	**1%**	6.3%	10.2%	2.3%	2.0%	3.0%

This upwards trend is accompanied by significant increases in admissions to the Forensic Medical Centre (FMC) for the deaths of persons who fall outside the jurisdiction of the ACT Coroner. These cases include those in which a medical practitioner does not issue a medical certificate certifying the cause of death until sometime after the death, and referrals on behalf of the NSW coroner (see Table 3: Total admissions to FMC).

On average, the FMC receives 47 admissions per month, increased from 41 monthly admissions in the last reporting period.

Not all coronial inquests involve admission to the FMC; missing persons, unidentified skeletal remains, or cases in which a postmortem is not required will be reflected in coronial referrals but not FMC admissions.

[1] Based on population of 453,300 with a standardised death rate of 4.6 deaths per 1000 population- ACT currently has the lowest standardised death rate in Australia see Deaths, Australia, 2021 | Australian Bureau of Statistics (abs.gov.au)

[2] As above.

Table 3: Total admissions to FMC			
	ACT	NSW	Total
Coronial admissions	363	70	433
Medical certificate	98	17	115
Hospital requested postmortems	4	0	4
Long term storage	-	-	15
Total Admissions	**465**	**87**	**567**

The reasons underlying the increase of admissions to FMC are not easily identified. It is perhaps a symptom of the pressures on the health system and medical practitioners generally. Medical practitioners are increasingly unable to attend at home deaths or issue the required certificates in a short time frame. In such cases, people who die of natural causes are admitted to the FMC to allow families time to make arrangements directly with funeral homes.

This may also reflect that work needs to be done to educate doctors as to the role of the Coroner and the requirements surrounding the issuing a medical certificate in natural causes death cases.

Timeliness indicators

Over the reporting year, the Court has maintained a steady rate of performance, achieving above national levels against its performance indicators.

The national benchmark[3] is a finalisation rate of 90% of matters in under 12 months. The Court exceeded this target, maintaining a finalisation rate of 95% for matters referred during the reporting period[4].

This rate remained close to that of the previous reporting period. However, there has been an increase in matters outstanding between 12 and 24 months (see Table 4: Pending cases by financial year). There does appear to have been some impact from the COVID-19 pandemic in terms of increased matters not finalized within 12 months, likely reflecting the Magistrates Court focus on addressing criminal

[3] 7 Courts - Report on Government Services 2022 - Productivity Commission (pc.gov.au)

[4] This figure will vary slightly from figures reported in Report on Government Services due to two systems changes to the way data is reported in June and July 2022, as a result of the update to the National Coronial Information system and the new addition of the ACT suicide register and a data correction in September 2022.

backlogs, in particular those in custody. Older matters also tend to be inherently more complex and require input from sources outside the Court, such as experts, and were thus more impacted by pandemic flow on. Instability in staffing support available to the Court during that period also impacted delay in these more complex matters.

"Pending" case figures include matters where related criminal charges are on foot or contemplated and either the inquest is paused pursuant to sections 58 and 58A of the Act, or the Coroner has determined that it would be inappropriate to continue with the inquest until criminal proceedings or an interstate inquest is finalised. In the 2021/2022 reporting period, there are 20 matters which fall into this category. Seven of these matters have been pending for more than 24 months. There are a further 13 matters which relate to missing persons or unidentified remains.

(*See* Chart 1: Timeliness of pending matters, Chart 2: Categorisation of matters pending between 12-24 months, and Chart 3: Categorisation of matters pending more than 24 months).

	Table 4: Pending cases by financial year				
Time Pending	**2021/2022**	2020/2021	2019/2020	2018/2019	2017/2018
< 12 months	**169**	170	73	66	92
> 12 months but < 24 months	**39**	23	20	31	38
> 24 months	**54**	58	47	52	46
Total Pending	**258**	251	140	158	176

Chart 1

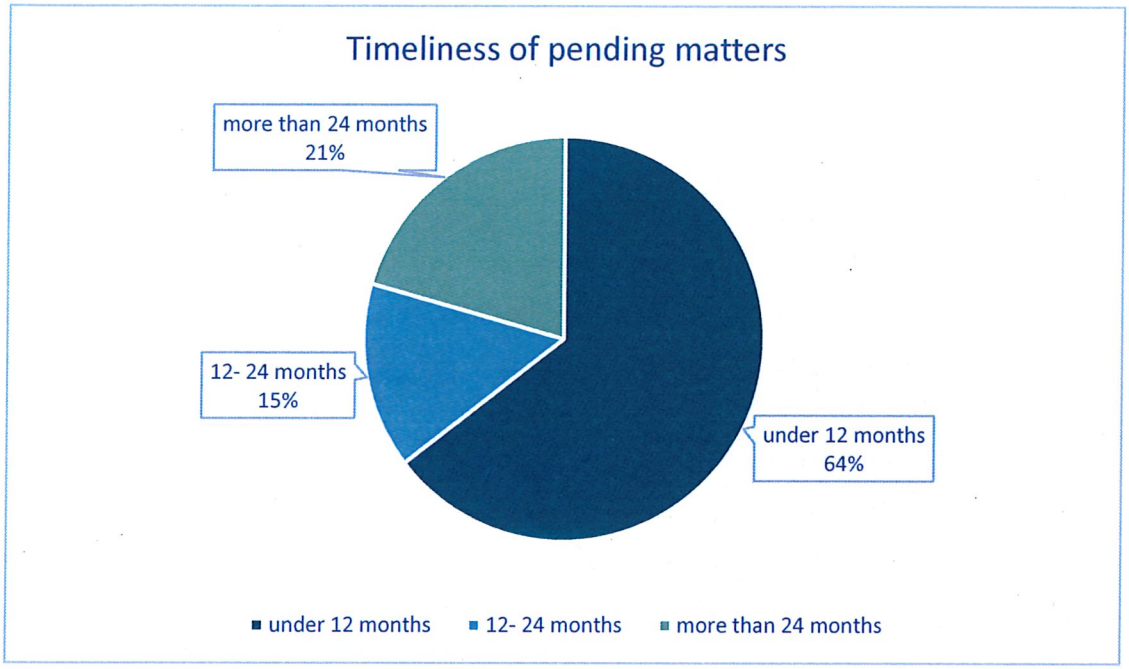


Chart 2

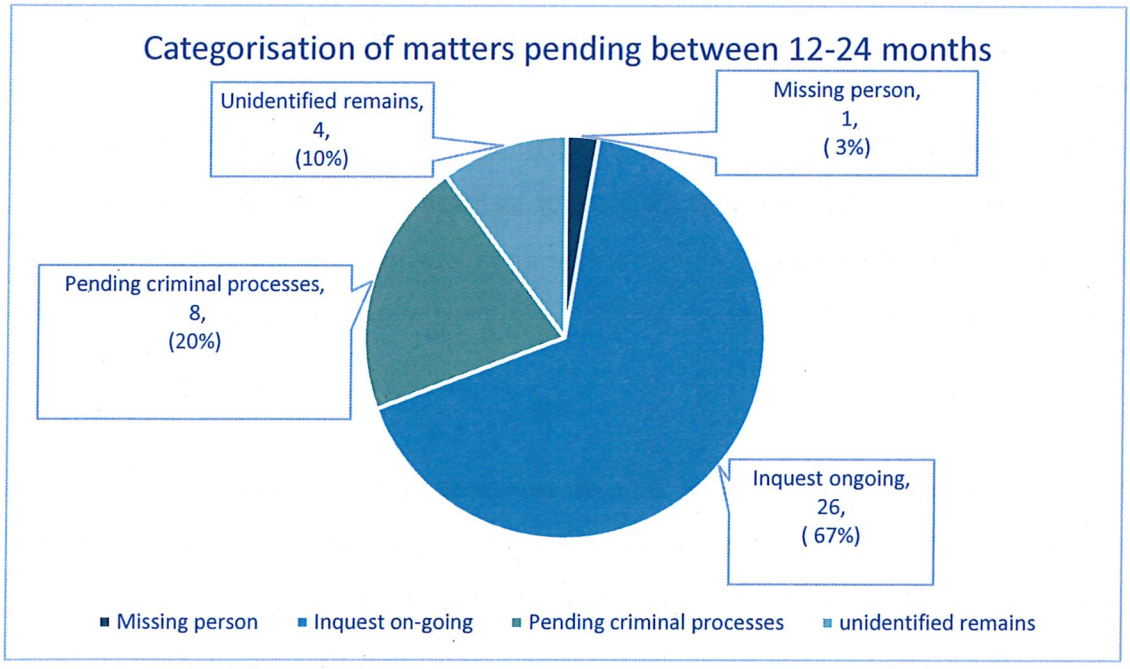
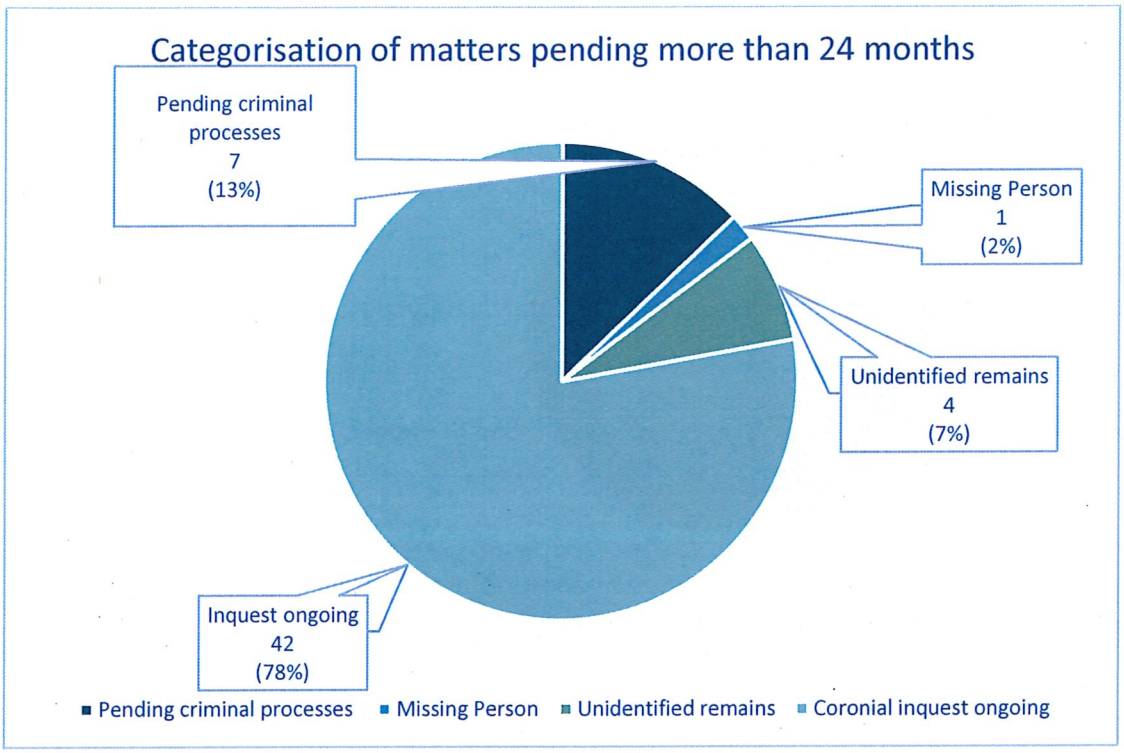


Chart 3



FMC timeliness

Despite the increase in admissions to the FMC, the average time from admission to completion of postmortem examination was 2.5 days. The average time for a person to remain in the care of the FMC was 10.75 days. This figure is impacted by a small number of cases where the storage of a deceased person exceeded 100 days or more. The reasons for this extended storage are addressed elsewhere in this report.

The FMC sets a key performance indicator of 80% of completed postmortems within 5 days of admission. In 2021/22, 85.1% of postmortem examinations were completed within 5 days of admission (see Table 5: Length of time from admission to postmortem (PM)). Whilst this is still above the key performance level, it is 8% less than the previous reporting period reflecting the increase in overall admissions and difficulties in staffing and pathologist availability. This included interstate travel restrictions arising from COVID-19. In providing postmortem services to the NSW Coroner, and hospital postmortems by request, the pathologists and technical staff conducted a total of 437 postmortems –

an additional 74 procedures above those referred to the ACT Coroner. Table 5 reports on all postmortems – combining the ACT and NSW Coronial jurisdictions.

Table 5: Length of time from admission to postmortem (PM)						
	2021/2022		2020/2021		2019/2020	
	PM	%	PM	%	PM	%
5 days or less	375	85.1%	380	93.36%	373	94.7%
More than 5 days	62	14.9%	25	6.1%	21	5.3%

Extended storage of deceased

The increased number of admissions has also led to an increase in the number of deceased people requiring long term storage. This need arises when there is no one willing or able to make arrangements for burial or cremation of the deceased. The FMC is the only facility in the ACT able to provide this service. COVID-19 also impacted on families' ability to make funeral arrangements, particularly when next of kin reside interstate or overseas. This is reflected in the average period spent in the FMC.

Legislative amendments to the *Public Trustee and Guardian Act 1985*[5] effective June 2021 give the Public Trustee and Guardian the power and responsibility to, among other things, make arrangements for the disposal of the body of an unclaimed deceased person. This development should reduce the number of extended stays at the FMC.

[5] See section 13A

Reporting requirements under section 102 of the Act

Section 102 of the Act requires the reporting of particulars about reports prepared by coroners into deaths in care or deaths in custody, **notices given under s34A(3),** the findings and recommendations contained in reports after inquest or inquiry and the responses of agencies to those reports.

Deaths in care or deaths in custody

Pursuant to section 74 of the Act, coroners holding an inquest into a death in care or death in custody must include in a record of the proceedings of the inquest 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. Pursuant to section 76 of the Act, agencies are required to respond to those findings within three months of receipt of those findings and provide a copy of the response to the responsible Minister and the coroner.

There were no reports prepared by coroners into deaths in custody during the reporting period.

There was one death in custody reported during 2021/22. This matter is set for hearing in the 2022/23 reporting year.

There were four hearings in relation to death in care matters. Particulars of these reports can be found at page 21.

Notices given under section 34A(3) (Decision not to conduct hearing)

The Act draws a distinction between "inquests" and "hearings". An inquest is conducted in relation to every death referred to the coroner. The decision to hold a hearing as part of that inquest is discretionary. 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 to 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 2021/2022 year, there were 345 notices given by Coroners under section 34A (3). There were no applications made to the Chief Coroner under section 64.

Recommendations made under section 57(3) (Report after inquest or inquiry)

Section 57 of the Act relevantly provides that a coroner may report to the Attorney-General on an inquest or an inquiry into a fire held by the coroner. A coroner must report to the Attorney-General on an inquiry into a disaster.

There are four matters reported after inquest or inquiry, with recommendations arising in two of these matters. Referrals made under section 57 and responses received in this reporting period are at page 22.

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 findings to the Legislative Assembly or publication of reasons on the court's website). Where the deceased person is Aboriginal or Torres Strait Islander or their name has not been otherwise publicised, the name of the deceased person is withheld.

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

Reports prepared by coroners into deaths in care and findings contained in the reports

S 74 - Reports prepared by coroners into deaths in care and findings contained in the reports

Matter Name	Date	Coroner	Recommendations
ACTCD 1/2022 Christopher Dean Brice	Hearing date(s) 24 February 2022 30 June 2022	Coroner Morrison	<u>General recommendations in respect of the ACT mental health scheme.</u> ACT Government review the NSW IDAT Program in the context of its pursuit of the Productivity Commission recommendations. Reiterates the observations made in the *Inquest into the death of Kaitlin McGill* [2020] ACTCD 7
ACTCD 7/2021 Jacob Alden Peter Cameron	Hearing date 14 December 2021	Chief Coroner Walker	<u>Recommendations about the investigations of deaths</u> Observations about the investigation of this matter be brought to the attention of the Chief Police Officer, under whose auspices officers of the AFP are authorised to act as investigators for the Coroner.
ACTCD 8/2021 Brandon Geoffrey Sager	Hearing date 21 December 2021	Chief Coroner Walker	**<u>Nil recommendations</u>** Pursuant to s52(4)(a)(i) of the *Coroners Act 1997*, a matter of public safety is found to arise in connection with this inquest, being non-ligature-proof door handles at Brian Hennessy Rehabilitation Centre, but that the matter has been addressed, therefore no further recommendations arising.
ACTCD 9/2021 Joan Chetcuti	Hearing date 21 December 2021	Coroner Taylor	**<u>Nil recommendations</u>** No matter of public safety arises There are no matters relating to the quality of care, treatment or supervision of Ms Chetcuti by staff at Calvary Hospital that contributed to her death.

Referrals made to the Attorney-General under section 57 and responses received

Referrals under section 57 which were made in the previous reporting period and a response this reporting period, under section 76.

Matter	Referred	Response from Agency
ACTCD 8/15 ACTCD 61/2015 ACTCD 164/2016 ACTCD 281/2016 Bearham, Fisher & ors joint hearing	Coroner Hunter referred 4 March 2021 to Attorney- General	Minister for Families and Community Services response 8 October 2021 Government response to Coroner's report - Inquiry into the death of Anthony Leigh Bearham, Nicola Joy Fisher and others. (nla.gov.au)
ACTCD 70/2016 Kaitlin O'Keefe McGill	Coroner Morrison Referred 7 May 2021 to Attorney- General	Minister for Mental Health tabled response 5 August 2021 LIST_Government-Response-to-Coronial-recommendation-from-the-Inquest-in-the-Death-of-Kaitlin-OKeefe-McGill.pdf (act.gov.au)
ACTCD 33/2016 Bradyn Dillon	Coroner Hunter referred 29 April 21 to Attorney-General	Minister for Families and Community Services response 11 November 2021 Government response to the Coroner's Report into the death of Bradyn Dillon (act.gov.au)
ACTCD 2/2021 Homegrown Me (ire inquest)	Coroner Theakston referred 29 April 2021 to Attorney- General	Minster for Sustainable Building and Construction Response November 2021 Coroners-recommendation-from-the-Inquiry-into-the-origin-of-the-Homegrown-Me-explosion-Government-Response.pdf (act.gov.au)

Referrals under section 57 which were made in this reporting period and a response received in this reporting period under section 76

Matter	Referred	Response from Agency
ACTCD 4/2021 Passenger H	Coroner Theakston 2 August 2021 to Attorney- General	Minister for Transport and City Services 10 February 2022 LIST_Response-to-the-Coroners-Inquiry-into-the-Death-of-Passenger-H.pdf (act.gov.au)
ACTCD 6/2021 Blake Corney	Chief Coroner Walker 15 November 2021 to Attorney- General	Minister for Transport and City Services May 2022 LIST_Coroners-Report-Inquest-into-the-Death-of-Blake-Andrew-Corney-Government-Response.pdf (act.gov.au)

Referrals under section 57 which were made in this reporting period and a response has not been received in this reporting period under section 76

Matter	Referred	Response from Agency
ACTCD 1/2022 Dean Christopher Brice	Coroner Morrison Referred 30 June 2022 to Attorney General Ministers for Mental Health and Canberra Health Services and Australian Institute of Criminology	Response due 30 September 2022