MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

(These findings have been de-identified in relation to the name of the deceased, family, friends, and others by direction of the Coroner pursuant to s57(1)(c) of the Coroners Act 1995)

I, Simon Cooper, Coroner, having investigated the death of HJ

Find, pursuant to Section 28(1) of the *Coroners Act* 1995, that

a) The identity of the deceased is HJ;

b) HJ died in the circumstances set out further in this finding;

c) The cause of HJ's death was starvation; and

d) HJ died between 9 December 2021 and 8 January 2022 at Unit 1/5 Broadview Crescent, Bridgewater, Tasmania.

1. In making the above findings I have had regard to the evidence gained in the comprehensive investigation into HJ's death. The evidence includes:

- Police Report of Death for the Coroner;
- Affidavit is establishing identity and life extinct;
- Report – Dr Donald Ritchey, Forensic Pathologist;
- Report – Forensic Science Service Tasmania;
- Medical Records – Tasmanian Health Service;
- Patient Care Record – Ambulance Tasmania;
- Records – Centrecare Evolve Housing;
- Letter Commissioner of Police, dated 14 February 2023;
- Affidavit – KN, sworn 8 January 2022;
- Affidavit – Luke Budd, police officer (rank not stated) 14 March 2022;
- Affidavit – Constable Allison Blackwell, sworn 11 March 2022 ;
- Affidavit – Adrian Williams, police officer (rank not stated), sworn 1 May 2022;
- Affidavits – Sergeant Robert Bessell, sworn 29 January 2022 and 7 April 2022; and
- Body worn camera footage.

Introduction

2. HJ had a lengthy and well-documented history of mental illness. At the time of her death she was 71 years of age and living alone in a unit in Broadview Crescent, Bridgewater.
3. She rented the unit from Centrecare Evolve. It was surrounded by chest high grass. The unit's garden was full of rubbish. The blinds were permanently down.
4. HJ's existence was that of a hermit. She was estranged from family and had no friends. Her life was dominated by her mental illness and her resulting paranoia.
5. Her brother, KN, was probably the person closest to her and said it was 10 years since HJ had let him into her unit. He also said she rarely, if ever, answered her phone.

The role of the coroner

6. Before considering the circumstances of HJ's death it is necessary to say something about the general role of the coroner. In Tasmania, a coroner has jurisdiction to investigate any death that occurs in Tasmania and the cause of which is unknown. At the time HJ's death was reported to me, the cause was unknown.
7. When carrying out an investigation into any death, a coroner performs a role very different to other judicial officers. The coroner's role is inquisitorial. The coroner's job might be best described as a quest for the truth, rather than a contest between parties to either prove or disprove a case. When conducting an investigation into a death, a coroner is required to thoroughly investigate the death and answer the questions (if possible) that section 28(1) of the *Coroners Act* 1995 asks. Those questions include who the deceased was, how they died, the cause of the person's death, and where and when the person died. It is settled law that this process requires a coroner to make various findings, but without apportioning legal or moral blame for the death.
8. The job of the coroner is to make findings of fact about the death from which others may draw conclusions. A coroner may, if she or he thinks fit, make comments about the death or, in appropriate circumstances, recommendations to prevent similar deaths in the future.
9. It is important to recognise that a coroner does not punish or award compensation to anyone. Punishment and/or compensation are for other proceedings, in other courts, if appropriate. Nor does a coroner charge people with crimes or offences arising out of a death that is the subject of investigation.

10. As was noted above, one matter that the *Coroners Act* 1995 requires, is a finding (if possible) as to how the death occurred. 'How' has been determined to mean 'by what means and in what circumstances', a phrase which involves the application of the ordinary concepts of legal causation. Therefore a coroner is required to consider the particular circumstances surrounding the particular death so as to discharge the obligation imposed by section 28(1)(b) upon her or him.
11. It is also important to recognise that a degree of caution must necessarily attend this aspect of the coroners function. Self-evidently, the analysis involves a consideration of all the circumstances involving the death including decisions that were made at the time that may or may not have impacted upon the ultimate outcome. Coroners have the distinct advantage of knowing exactly what occurred when making that assessment – something others involved with the deceased person do not enjoy.
12. The standard of proof at an inquest is the civil standard. This means that where findings of fact are made, a coroner needs to be satisfied on the balance of probabilities as to the existence of those facts. However, if an investigation reaches a stage where findings being made may reflect adversely upon an individual (or other legal entity), it is well-settled that the standard applicable is that expressed in *Briginshaw v Briginshaw*,[1] that is, that the task of deciding whether a serious allegation against anyone is proved should be approached with a good deal of caution.
13. The final matter that should be highlighted is the fact that the coronial process, (whether or not an inquest is held), is subject to the requirement to afford procedural fairness. A coroner must ensure that any person (and the term 'person' means legal person, which includes any legal entity) who might be the subject of an adverse finding or comment is made aware of that possibility and given the opportunity to fully put their side of the story forward for consideration.

Circumstances of HJ's death

14. On 9 December 2021, Police from Bridgewater Station were tasked by the Police Radio Despatch Service (RDS) to attend HJ's unit in relation to what is known as a 'concern for welfare' check. A neighbour had telephoned RDS concerned that he had not seen HJ for approximately two weeks.
15. Three officers arrived at HJ's unit just before 5.00 pm. Their interaction with HJ was all captured on body worn camera. HJ did not answer the knocks at her door. Accordingly, two of the officers forced entry into the unit through the back door. They

[1] (1938) 60 CLR 336.

found HJ inside. She was obviously malnourished and frail. Her hair, grey in colour was matted into large clumps. Her eyes were glazed. In her discussions with the police, captured on body worn camera, HJ made no sense. She spoke rapidly of various conspiracies involving the police, people from China, Isis and Jesus. It is abundantly plain viewing the footage, which frankly is uncomfortable to watch, that HJ was gravely ill - both mentally and physically.

16. However, without contacting an ambulance, the police left, apparently having reached the view that HJ did not require immediate medical attention. Centrecare was apparently contacted and advised repairs needed to be performed to the unit's door.
17. Police then returned to the station and some paperwork was submitted. One of the officers said in an affidavit dealing with what occurred on 9 December 2021 that her:

> *"Intention on leaving HJ's residence was to submit an Atlas Street Check. [She] intended to outline police involvement and HJ's well-being. It was [her] understanding that by submitting this report the appropriate services such as CAT[2] and Centrecare Evolve would be contacted and HJ would receive the appropriate attention. [She] returned to the Bridgewater Police Station and submitted this report prior to concluding [her] shift."*[3]

18. The evidence is that a report was duly submitted. And there the matter rested. Nothing (other than the submission of the report) was done as a consequence of the attendance by police. In particular no contact was made with HJ by any representative of any organisation until police officers found her dead in her unit. Another officer present on 9 December 2021 explained in his affidavit that following HJ's death he became aware that 'there is no mechanism for the report to be forwarded…[and no way] for Mental Health Services or other appropriate agencies to be informed'.[4]
19. On 7 January 2022, KN, gravely concerned for his sister's welfare, went to her unit. He said there were no lights on and no sounds of life. HJ did not answer his knocks on the door. KN went to the Bridgewater Police Station. At the station he rang the buzzer and "was told to wait on someone might come out and if they don't to stay close to his phone costs someone might ring back." He waited for half an hour or so but no one came, so he left and went home. No one rang back.[5]

---

[2] CAT [actually CATT] is a reference to the Crisis Assessment Treatment Team.
[3] Affidavit – Constable Alison Blackwell, sworn 5 May 2022.
[4] Affidavit – Adrian Francis Williams [police officer – rank not stated], sworn 1 May 2022.
[5] Affidavit – KN, sworn 8 January 2022, paragraph 27.

20. The following morning, KN rang the police again. This time police responded and went to HJ's unit, forced entry and found her dead.
21. Paramedics from Ambulance Tasmania attended to confirm the fact of HJ's death. In the Ambulance Tasmania Electronic Patient Care Record the following is recorded:

> *"House completely empty of any food and contains very few items. Fridge completely empty except for [a] dirty empty cup. Pt does not appear to be eating food. Laundry had 4 x garbage bags, visible chocolate biscuit packet – bags not opened the scene being preserved by 41. Pt appears to have been living in situation not suitable for mental health state – unable to self-care with no follow-up."*[6]

Investigation

22. The fact of HJ's death was reported in accordance with the provisions of the *Coroners Act* 1995. HJ's body was formally identified by her brother KN and then transported by mortuary ambulance to the Royal Hobart Hospital.
23. At the hospital mortuary highly experienced forensic pathologist, Dr Donald Ritchey performed an autopsy. Dr Ritchey did not find any evidence of violent injury. Relevantly there were no skull fractures, intracranial collections of blood or scalp contusions. HJ's neck muscles, hyoid bone and thyroid cartilage were all intact.
24. In addition at autopsy Dr Ritchey found a large tumour within HJ's urinary bladder that was locally invasive but had not spread beyond that area. However, I am quite satisfied that that tumour did not cause or contribute to HJ's death.
25. The cause of HJ's death was obviously starvation. She was found to weigh just 35 kg, had minimal subcutaneous and body fat, significant atrophication of her organs and clear evidence of starvation ketosis with post-mortem peripheral blood acetone of 60 mg/L.

Discussion

26. HJ's lonely death, of starvation, in the suburbs of an Australian capital city, raises several issues. First, the decision by attending police on 9 December 2021 not to call an ambulance to at least enable a mental state assessment to be carried out was, in my view, wrong. Second, the apparent inaction by HJ's landlord, when called by police to repair the door damaged when entry was forced is difficult to understand. Third, the fact that the submission of an internal report by police actually achieved nothing to assist an obviously gravely ill person is very concerning.

---

[6] Ambulance Tasmania Electronic Patient Care Record.

27. This finding was sent in draft to Tasmania Police for comment. I was assisted by the response from the Commissioner. In that response it was identified that the "belief of the attending officer that a Street Check would generate a notification to Mental Health Services [was] a misunderstanding by an individual, not a belief embedded across the organisation". In addition the Commissioner identified that specific instructions are required to be included in the Tasmania Police Manual in relation to contact being made with Mental Health Services for advice and referral whenever there are concerns by Tasmania Police personnel about the mental health person with whom police have had contact. I was also advised that the relevant part of the Tasmania Police Manual is to be updated accordingly, with correspondence was sent to all police commands reinforcing the need to call Mental Health Services when necessary and highlighting that the police information system does not have the capability to send notifications automatically as was believed to be the case in relation to HJ.

Comments and Recommendations

28. Given Tasmania Police's response to the specific issues arising from HJ's death, I do not consider it is necessary for me to make any further comment or recommendation pursuant to Section 28 of the *Coroners Act* 1995. I note that, but for the response from Tasmania Police, I would have been minded to make a formal recommendation that Tasmania Police urgently review its procedures to ensure that upon submission of any internal report detailing concerns in relation to the mental health and wellbeing of a member of the public the appropriate external agencies are notified.
29. I convey my sincere condolences to the family and loved ones of HJ.

Dated: 3 April 2023 at Hobart in the State of Tasmania.

Simon Cooper
Coroner