MAGISTRATES COURT TASMANIA

MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Inquest into the death of Benjamin Laurence Marshall

Ruling on scope of inquest

1. Mr Marshall, a former sailor in the Royal Australian Navy ("RAN"), died, apparently as the result of suicide in early October 2019. His death was reported pursuant to the provisions of the *Coroners Act* 1995 ("the Act") and, as the Coroner to whom the matter assigned for investigation (not initially), I decided, having regard to section 24(2) of the Act that a public inquest should be held into his death.

2. The investigation into Mr Marshall's death has been lengthy, thorough and has involved a consideration of numerous issues which may be considered relevant to the circumstances of his death. These issues include in particular whether there is any connection between his military service (between 2010 and 2017), his discharge and his death.

3. It is also noted that a Royal Commission into Defence and Veteran Suicide is currently being conducted. I have specific regard to the terms of that Commission's Letters Patent. In my view, it would be an inappropriate and inexpedient exercise of my jurisdiction to consider matters the subject of that enquiry unless they arise directly in terms of the Act.

4. After several case management conferences pursuant to rule 22 of the *Coroners Rules* 2006, held in court, at which interested parties were in attendance, counsel assisting proposed that the inquest should examine the following matters ("the Draft Scope") pursuant to section 28 of the Act:

    1) The circumstances of the initial recruitment of Mr Marshall into the RAN, including his suitability and assessment for retention;

    2) The continued retention of Mr Marshall with the RAN:

        i. Was it appropriate in all of the circumstances, including as it impacted upon Mr Marshall's mental health and ability to access mental health services;

        ii. The level and quality of health care and mental health care provided

by the Australian Defence Force ("ADF");

3) The circumstances giving rise to the accepted psychiatric condition which gave rise to his medical discharge;

4) The transitional management by the ADF to assist him to navigate the medical discharge process and transition into civilian life;

5) The assistance and advice given by both the ADF and the transitional case manager authorised pursuant to the *Military Rehabilitation and Compensation Act* 2004 (Commonwealth) ("MRCA") with respect to his transitional management regarding the income support, medical treatment, rehabilitation and related matters pursuant to the MRCA post medical discharge;

6) The level of assistance provided by the ADF and MRCA Case Manager from RSL – Defence Care (NSW), with respect to level of assistance support and advice, when transitioning from the ADF and from the Department of Veterans Affairs ("DVA") pursuant to the MRCA, leading up to and following his transitional management, discharge from the ADF and DVA decisions made.

5. Submissions were invited, and received from interested parties including the Senior Next of Kin, RSL Life Care Limited and the Commonwealth as to the Draft Scope of the inquest. I have had specific regard to the content of those submissions. This ruling is intended to finalise the scope of the inquest.

The principles to be applied

6. It is trite to observe that a Coroner's principle obligation is to make, if possible, the findings required by section 28(1) of the Act. Subordinate to that obligation is a power to make comments or recommendations, as appropriate pursuant to section 28(2) and (3) of the Act.

7. In *Liam Mead - Ruling on Evidence* dated 2 August 2019, Coroner Stanton discussed the authorities concerning the proper scope of an investigation into the circumstances of a death and the associated functions of making comments and recommendations. In his ruling at paragraph 16, His Honour said:

> *"It is well established that an inquest ought not be held solely to enable comments or recommendations to be made. The power to make such comments and*

recommendations is not free standing. The coroner has no power to conduct a roving commission of inquiry into any matter connected with the death.

Indeed, the power to comment and make recommendations is subordinate and incidental to the power to make findings relating to how deaths occurred and their causes. The powers to comment and make recommendations arise as a consequence of the prime function to make findings about how death occurred and the cause of death: Harmsworth v State Coroner [1989] VR 989 per Nathan J at 996. But once the inquest is held, although the limits on the power to comment are not easily defined, it is wide so long as it is connected with the death: Commissioner of Police v Hallenstein [1996] 2 VR 1 per Hedigan J at 7. Similarly recommendations must be made with respect to ways to prevent further deaths whenever appropriate. The reference to "further deaths" requires that the recommendations arise out of, or have some connection to, the findings in respect of this death. In Attorney General v Copper Mines of Tasmania Pty Ltd above, Blow CJ said that the duty to investigate the circumstances leading up to the death includes doing so with a view to making recommendations with respect to ways of preventing further deaths and other appropriate matters: at [45]."

8. I respectfully agree that His Honour has set out the proper approach to a coroner's power to comment and make recommendations. It is, as I said earlier, subordinate to the principle obligation to make the findings required by section 28(1). It is therefore wrong as a matter of law for an inquest to focus primarily upon the making recommendations. Findings as to who, how, where and when come first; recommendations and comments (although of course an important part of the role of the coroner) come second.

Submissions

9. On behalf of the Senior Next of Kin it is submitted that, in addition to the scope set out above the following should also be examined:

    1) Review of previous recommendations into ADF suicides by other state and territory coroners to determine whether the recommendations and findings have been considered, implemented and adopted or if not why:

        i. In particular, consideration as to the findings in the late veteran Jesse Bird and comments made by Victorian Coroner Hawkins (Bird Inquest (EOR 2017/344 and recommendations made by Coroner English who reported [sic] on the suicide of a veteran, the late Nathan Shanahan

(CEO are 216/6067) – see paragraphs 235 to 238 of the Bird inquest [sic] outlining the recommendations);

ii. Other recommendations or steps that are being taken by the Commonwealth, ADF and DVA in response to the incidents of veteran suicides noting that statistically this [male] cohort, to which the late veteran belonged, is over represented.

2) The nature and adequacy of the mental health care and treatment received by Mr Marshall in Tasmania.

10. In relation to mental health treatment, the Commonwealth submits that scope of the inquest should be expanded to 'include consideration of the nature and adequacy of mental health care and treatment received by Mr Marshall in the months before his death'.

11. To expand the scope to consider the issues in relation to Mr Marshall's treatment in Tasmania for his mental health would, in my view, lead to an unwarranted and unsustainable expansion of the inquest. It would necessitate notifying a myriad of health care professionals, seeking information and involvement of those professionals and at least doubling the time allocated for the inquest – for no discernible reason, other than a purely speculative fishing trip. If there was any evidence to suggest that Mr Marshall's treatment in this state was in some way sub-optimal, or causally related to his death, then such an approach, albeit more targeted, might be justified. But there is no such evidence. Accordingly, I cannot accept that expanding the scope as suggested is warranted.

12. In addition, I do not consider that the matters sought to be agitated by the Senior Next of Kin, in respect of reviewing of previous coronial findings and recommendations, would be within the proper scope of the inquest. Put another way, I consider it would be beyond my power to consider, those matters because to do so, I consider it would amount to, in effect, a 'roving commission of enquiry'.

Conclusion

13. In summary, applying the above principles, I am clearly satisfied that the Draft Scope is, broadly speaking, appropriately formulated in order to examine and determine the material circumstances surrounding Mr Marshall's death and the matters potentially connected with the death which may be appropriate for comments and recommendations. The only area where the Draft Scope warrants refinement is in

relation to item 6. I accept RSL Life Care and Counsel Assisting's submissions that the scope topic, as previously discussed, was predicated on a fundamental misunderstanding in relation to RSL Life Care. That body is not a government organisation. Any service it provides is both free and voluntary. It has no statutory remit and does not carry out any function under any applicable legislation. Accordingly item 6 should be reworded as follows:

6) "*The level of assistance extended to Mr Marshall by RSL NSW who provided services under the "RSL Defence Care" banner until 1 August 2020, and therefore the level of assistance provided by RSL Life Care, who provided services under the RSL Life Care Veterans Services banner from 1 August 2020 with respect to claims and support and advocacy as Mr Marshall was transitioning from the ADF and after discharge*".

Dated: 22 March 2024

Simon Cooper

Coroner