

CORONER'S COURT OF THE AUSTRALIAN CAPITAL TERRITORY

Case Title:	Inquest into the death of JACOB ALDEN PETER CAMERON
Citation:	[2021] ACTCD 7
Findings Date:	14 December 2021
Before:	Chief Coroner Walker
Decision:	See [23]-[27]
Catchwords:	CORONIAL LAW – death in care – cause and manner of death – natural cause death – whether issue with quality of care, treatment or supervision – whether matter of public safety arises
Legislation Cited:	<i>Coroners Act 1997</i> (ACT), s 13(1)(i); 34A, 52, 74 <i>Mental Health Act 2015</i> (ACT)
Appearances	Deputy Registrar S Baker-Goldsmith (Counsel Assisting)
File Number:	CD 25 of 2020

CHIEF CORONER WALKER:

1. The death of Jacob Alden Peter Cameron, aged 49, was reported to the Coroner because he died while subject to a psychiatric treatment order (PTO) under the *Mental Health Act 2015*. This brought his death within the Court's jurisdiction pursuant to s13(1)(i) of the *Coroners Act 1997* ('the Act').
2. With the concurrence of his family, I will respectfully refer to the deceased person as Jake, which is the name they knew him by.

Jurisdiction

3. When Jake died in mid-January 2020, s3C(1)(c) of the Act described his death as being a 'death in custody'.
4. Following the advocacy of a number of families who had lost loved ones in similar circumstances to Jake's death, this provision was amended. From 29 January 2020, s3BB of the Act classifies the death of a person while subject to (among other things) an order under the *Mental Health Act 2015* as a 'death in care'.
5. Whilst the nuance of this change is significant, I note that:

- a. the Coroner retains the obligation to independently investigate both deaths in care and in custody¹;
 - b. a hearing is a mandatory part of the inquest²; and
 - c. the provisions of Part 6 of the Act, which prescribes additional procedural steps and obligations of the Coroner for deaths in custody, are also expressly extended to deaths in care.
6. I consider that the changes to the Act in relation to deaths in care are procedural in nature and do not create or vary substantive rights and liabilities. On that basis, I consider that these provisions operate retrospectively.³
7. I will therefore refer to Jake's death as a death in care.

Circumstances of Death

8. Jake's mother, Debbie Cameron, provided her reflections on Jake's life, his significance to his family and the suffering he experienced from what she described as his "mental demons". I thank her for these reflections which provide some sense of the person who is being considered in this hearing. They will be retained as part of the Court record capturing something not only Jake's death but also of his life.
9. Jake was born in Oxford, England, his mother's firstborn. As both a child and adult, he was kind, gentle, loving and honest. Jake was diagnosed with schizophrenia in his early twenties. His medical treatment team considered it necessary that Jake be placed on a PTO to provide treatment for his condition. His family also felt this was helpful. An order was made by the ACAT on 4 November 2019 for a period of 6 months. It was therefore in place at the relevant time.
10. Jake was last seen alive by his mother Debbie on 18 January 2020 at the family home. He was then last seen alive by Debbie's partner on 19 January 2020.
11. The next evening, Debbie knocked on the door of Jake's residence in Reid, but there was no answer. On the day after, 21 January 2020, Debbie tried calling Jake without success. She called for assistance and met police at Jake's house. They entered through the front door and observed Jake was deceased and lying on a couch.

¹ See s 13(1)(i) in its current form.

² See s 34A in its current form.

³ See DC Pearce and RS Geddes, *Statutory Interpretation in Australia* (LexisNexis Butterworths, 8th ed, 2014), 415; *Maxwell v Murphy* (1957) 96 CLR 261.

12. Debbie and Jake's family believe that there may have been other people with Jake prior to, or in the immediate aftermath, of his death. Debbie recalls that Jake's door was unlocked when she tried it, which was unusual. She also recalls observing a handprint in blood above Jake's head, which she saw when she knelt beside him and before standing. It is uncertain how this got there. It is one of a number of matters which are unexplained and which have caused Jake's family distress.
13. The police officers who investigated this case on behalf of the Coroner say that there is no evidence confirming the involvement or presence of other people in Jake's residence. They are unable to confirm whether Jake's front door was locked or unlocked. Police believe that the bloody handprint may have been placed there after their arrival at the scene as part of checking on Jake. The investigators have been unable to assist in respect to these matters.
14. Of particular concern is that the bloody handprint was swabbed by Australian Federal Police Forensics officers, but the swabs were destroyed by police prior to testing and without reference to the Coroner. Absent other legal process, such as seizure pursuant to a criminal warrant, the Coroner has control of any samples as part of the body of the deceased person until release of the samples or destruction of them, at the Coroner's direction.
15. The AFP perform a crucial function in coronial inquests, particularly in gathering evidence at a death scene. This duty must be undertaken with the utmost care and regard to the power being exercised. That power must be exercised with sensitivity to the bereaved as required by s3BA(2)(i) and (ii) of the Act which provide:
 - (2) As far as practicable, the objects of this Act must be carried out in a way that—
 - (a) for an inquest into a person's death—recognises the following:
 - (i) the family and friends of the deceased person have an interest in having all reasonable questions about the circumstances of the person's death answered;
 - (ii) the death of a person, and an inquest into the person's death, has a significant impact on the person's family and friends
16. Although I am satisfied this failure does not prejudice my investigation on this occasion, I am conscious that this may have been an opportunity to answer some of Jake's family's questions.

Cause of Death

17. Dr Nathan Milne, forensic pathologist, conducted a post-mortem examination of Jake at the direction of Coroner Boss, who then had carriage of this matter. Dr Milne also had access to photographs taken of Jake at the death scene, which showed a band-like area of discolouration evident on Jake's neck.
18. Dr Milne excluded head or neck injury, or any other traumatic injury, following both external and internal examination. There was evidence of heart disease and a degree of post-mortem change. Toxicology testing identified alcohol present in Jake's system at a level of 0.300g per 100mL of blood,⁴ as well as methadone and evidence of past consumption of Valium.
19. Dr Milne considered two possible causes of Jake's death. He was unable to exclude methadone and alcohol toxicity as a cause of death. However, given it was likely Jake had significant tolerance to the effects of methadone, and that the drug and alcohol levels in his system may have been affected by post-mortem redistribution, he preferred dilated cardiomyopathy as the more likely cause of Jake's death. He considered the marks on Jake's neck were most likely the result of insect predation.
20. Debbie was concerned that the marks on Jake's neck may have been the result of an attempted hanging. Coroner Boss authorised Professor Duflou, an highly experienced forensic pathologist, to review the post mortem results and scene evidence.
21. Professor Duflou opined that Jake displayed no injuries which would typically be associated with hanging; there was no evidence of neck compression of any type. He agreed with Dr Milne that the most likely cause of Jake's death having regard to the physical signs and the circumstances was dilated cardiomyopathy due to chronic alcoholism. He also noted the significant decompositional changes evident both at the scene and at autopsy.
22. Whilst I do not discount Jake's family's concerns about the possible attendance of others at Jake's home before or after his death, given the lack of clear evidence, I make no findings about these issues. Importantly, I am satisfied as to the medical explanation which discounts the involvement of another in Jake's death.

Formal Findings

23. This is a mandatory hearing pursuant to s34A(2) of the Act. That is why these proceedings have been held and determined in public despite there being no witnesses called. The course is adopted with the consent of Jake's family.

⁴ Which is six times the legal driving limit in the ACT for alcohol in a person's system.

24. I am required by s52(1) of the Act to make findings as to the identity of the deceased person, when and where they died, and the manner and cause of their death. I am also required by s52(4)(a) of the Act to state whether a matter of public safety is found to arise in connection with the inquest, and if I find such a matter, I may comment upon it.
25. Further, as this is a death in care, I am required by s74 of the Act to include in the record of these proceedings findings about the quality of care, treatment and supervision of Jake that, in my opinion, contributed to his cause of death.
26. I find that:
 - a. Jacob Alden Peter Cameron died on or about 20 January 2020 at 3/44 Elimatta Street, Reid in the Australian Capital Territory;
 - b. The manner and cause of Jake's death is dilated cardiomyopathy due to chronic alcoholism;
 - c. Pursuant to s52(4)(a)(i) of the *Coroners Act 1997*, no matter of public safety is found to arise in connection with this inquest; and
 - d. Nothing about the quality of care, treatment or supervision of Jake under his PTO contributed to his death.
27. I direct that my findings are to be published on the Court's website in due course.
28. I direct that my 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.
29. I extend my condolences to Jake's family and friends.

I certify that the preceding twenty-nine [29] numbered paragraphs are a true copy of the findings of her Honour Chief Coroner Walker.

Associate: S Corish

Date: 14 December 2021