

## CORONER'S COURT OF THE AUSTRALIAN CAPITAL TERRITORY

**Case Title:** Inquest into the death of Nathan Booth

**Citation:** [2025] ACTCD 3

**Hearing Date:** 29 – 31 May 2024, 5 December 2024

**Decision Date:** 30 April 2025

**Before:** Coroner K J Archer

**Decision:** [112], [117], [130]-[155], [156]

**Catchwords:** **CORONIAL LAW** – Death of Aboriginal man – opioid addiction and methadone use – death in remote location – inquest after missing persons investigation – possible third party involvement – expert evidence – movement of a body through water – death by hypothermia – restorative coronial processes – appropriate scope of recommendations made after an inquest

**Legislation Cited:** *Coroners Act 1997* (ACT) ss 3BA 13, 34A, 51A 52, 57

**Cases Cited:** *Inquest into the death of Joshua* [2023] ACTCD 2

**Texts Cited:** *Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families ('Bringing them Home')* (1997).  
*Royal Commission into Aboriginal Deaths in Custody* (Final Report, April 1991).  
*ACT Coronial Restorative Reform Process and Summary Report ('the Legge Report')* (May, 2024).  
*Coronial Responses to Suicides of Aboriginal and Torres Strait Islander People* (October 2023).

**File Number:** CD 283 of 2019

## **CORONER ARCHER:**

### **Part 1 – Introduction**

1. On 2 September 2019, Nathan Booth's mother went to the Tuggeranong Police Station and reported Nathan missing. Nathan, at the time of his disappearance, was 40 years old. He was an Aboriginal man who had spent most of his life in the Canberra area. He was last seen by people who knew him on 27 June 2019. Sudden and sometimes extended absences from his home were, for Nathan, not unusual. However, this absence was different. He had not been present at the celebration of his 40th birthday on 15 July 2019. The significance of this day was not just because it was a milestone birthday. Nathan's Aunt, Ms Coral King, who was a central figure in Nathan's life and upbringing, happened to share this birthday with him. Nathan knew that this day was special to her, as it was the date that Nathan was born, and the day Coral King's Dad had passed away. He always had made a point of being with his Aunt on this day.
2. No report was made to police until 2 September 2019, but the unease of the family grew as time passed. Rumours began to spread within the community that he may have been harmed.
3. When the matter was reported to the Australian Federal Police ('AFP'), a missing persons investigation began. Given the length of his absence and Nathan's background, the report was allocated a 'high risk' rating, and the investigation was allocated to the Homicide Team. Little headway was made in establishing Nathan's movements and whereabouts. Many of the usual means of establishing a person's whereabouts were absent. Nathan didn't have a phone. He wasn't on social media. He didn't carry a bus pass. He didn't own a car. He wasn't employed. He didn't have a credit card, so he didn't leave a trail of credit card purchases.
4. By 11 September 2019, investigators had discovered that at 1500 hours on 27 June 2019 Nathan had obtained a dose of methadone at the Canberra Hospital (TCH), dispensed by a machine that operated by an iris scan. No trace was found of Nathan after he left TCH. CCTV cameras were present outside the methadone clinic. The footage had been overwritten before investigating police attended at TCH after the missing person report had been received.
5. Nathan's body was found on 1 December 2019 at a remote spot on the Murrumbidgee River.
6. The central theme of the coronial process in addressing the findings that I was required to make as to the manner and cause of Nathan's death, was examining the intersection

between known facts concerning the nature of Nathan's connection to the community in which he lived and the geographical isolation of the spot where his body was found.

## **Part 2 – Jurisdiction**

7. Given the circumstances in which Nathan died were unknown, his death fell within the terms of s 13(1)(a) of the *Coroners Act 1997* (ACT) ('the Act'). The relevant Coroner was required to hold an inquest into the manner and cause of his death.

## **Part 3 – Required Findings**

8. Section 52 of the Act sets out the findings I am required to make. Relevantly, that section of the Act provides:

### **52 Coroner's findings**

- (1) A coroner holding an inquest must find, if possible—
  - (a) the identity of the deceased; and
  - (b) when and where the death happened; and
  - (c) the manner and cause of death; and
  - (d) in the case of the suspected death of a person—that the person has died.

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- (2) The coroner, in the coroner's findings—
  - (a) must—
    - (i) state whether a matter of public safety is found to arise in connection with the inquest or inquiry; and
    - (ii) if a matter of public safety is found to arise—comment on the matter; and
  - (b) may comment on any matter about the administration of justice connected with the inquest or inquiry

9. To find a 'cause' of death in any given case, a Coroner is required to consider what physiologically produced that result. Separately, a finding as to the 'manner' of death involves a consideration of the circumstances in which the death took place.
10. As is detailed below, the evidence before me allows me to find what the cause of Nathan's death was. The evidence does not allow me to say what the manner of his death was.

## **Part 4 - An Outline of The Coronial Process**

11. Once Nathan was found, his family wanted to learn how he had died and why his body came to be in such a remote location. It fell to an ACT Coroner to conduct an investigation to answer those questions.
12. In the ACT, that investigative process is referred to as an 'inquest'. Unfortunately, by the time I became the dedicated Coroner in March 2022, that coronial investigation had not

been adequately progressed. Findings of 'misadventure' had been foreshadowed by the Court against the background of an investigation that had largely been treated as complete soon after the autopsy process.

13. There are presently no specific legislation or Practice Directions that give direction or guidance to Coroners as to how inquests into the deaths of Aboriginal people should be conducted. The Act does permit a flexible approach. Section 3BA(2) of the Act enjoins every Coroner to conduct inquests in a way that -

- (a) ... 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;
  - (iii) that where appropriate, members of the immediate family of the deceased person should be given the earliest opportunity to participate in, and be kept informed of the particulars and progress of, the inquest into the person's death;
  - (iv) that different cultures have different beliefs and practices about death that should, where possible, be respected; and
- (b) maintains the inquisitorial, non-adversarial nature of the Coroner's Court, and its function to inquire into and publicly examine the causes of death, fire and disaster.

14. A conscious attempt was made during the inquest process to give expression to those principles.

15. The expression 'restorative' is often used to describe a developing trend in coronial jurisprudence. However, what a restorative coronial process looks like has never been clearly described and its content may vary from case to case depending on the circumstances of the death, the number of interested parties and how contestable the issues in the inquest process are. The learned author Dr Ian Freckleton described the general trend towards therapeutic, restorative processes in the coronial system in these terms (references deleted):

Therapeutic jurisprudence has emphasised the harmfulness of exclusion and alienation of participants to the legal process. Conversely, it has stressed the therapeutic advantages to their being included, given a meaningful voice and treated as integral to the matters traversed by courts. This is more than the chance just to author a statement. It often includes the need to say what most concerns the participant, freed of some of the confining strictures of the rules of evidence within the adversary system. Family members have identified their need to receive prompt and sensitive communication about coronial processes of investigation and their wish to have opportunities to express their perspectives about a death, what caused it and what occurred in its aftermath. Addressing the needs of grieving

relatives includes provision of information in a culturally and religiously sensitive way about exhumation, autopsy and inquest processes during the death investigation, as well as about access to the body of the deceased, and its release for burial or cremation. It is apparent from the expression of a variety of grievances in this regard that there is a strong perception among some family members that administrative reforms are needed, as well as the need to institute short-term counselling and support programs for the bereaved. .... In addition, for the integrity of the death investigation system, means of enabling family members to satisfy their need to participate meaningfully in inquests, without abusing the process or unduly elongating it, require further investigation. An aspect of this is recognition of the specialisation of legal practice in coroners' inquests and, more importantly, provision of legal aid funding (at a suitable level) for family members to be energetically and competently legally represented at inquests. Another crucial part of relatives' involvement is affording them the capacity to give voice to their distress and grievances in a sensitive and unthreatening way, not unduly constrained by evidentiary proprieties, in the course of inquests, whether in the form of oral evidence or provision of written material to the coroner.<sup>1</sup>

16. The guiding principle of a restorative coronial process is that the inquest process should aim to do no greater harm to families already traumatised by the death of a loved one.
17. In the ACT, the practices of the Coroner's Court have been reviewed by an independent facilitator with a view to making formal provision for restorative based processes. I address the findings of that review in the context of recommendations arising from the inquest.

#### *A Restorative Approach to the Inquest*

18. In the absence of established restorative processes, but consistent with broad restorative principles, the Court engaged with the family to more actively involve them in discussions about the scope of the investigation and how the hearing for the inquest might be conducted. This level of contact was made easier by virtue of the fact that the only represented interest in the inquest was a grieving family.
19. I met with the extended Booth family in August 2022. I apologised to the family for the lack of progress in the investigation and for the paucity of information that had been provided to them by the Court. Nathan's family said they wanted information about the circumstances of Nathan's disappearance and death to be drawn from as wide a source as possible. They were promised a thorough investigation, a hearing and better communication from the Court.

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<sup>1</sup> Dr Ian Freckleton; *Death Investigation, the coroner and therapeutic jurisprudence* Journal of Law and Medicine November 2007 pp 9-10.

20. Counsel Assisting was appointed and was instructed to give those commitments some practical focus. The AFP were asked by me to appoint a new case officer and to ensure his investigation was appropriately resourced. A brief of evidence was produced, the scope of which was significantly defined by Counsel Assisting. It included reports from a number of experts. The family was encouraged to meet with the experts on their own before the hearing so they could have the chance to meet them in an informal setting and ask questions of them. They took up that opportunity with Professor Olley.
21. A hearing was conducted from 29 to 31 May 2024. It was opened by me on the banks of the Murrumbidgee River a few kilometres upstream from where Nathan's body was found. The balance of the hearing was conducted in the Galambany Court. Galambany means 'we all, including you'. Its name and physical configuration encourage an inclusive environment. The extended family was encouraged to come to the Court, and they attended in large numbers. Parties to the inquest sat at the round bar table. Dialogue occurred (with the permission of their legal representatives) directly between the Court (Coroner and Counsel Assisting) and family members who were in the court room. Family members were permitted to use the remote witness room as a means of engaging in the Court process without the formalities associated with the court room.

### *The Hearing*

22. The hearing that followed focused on the experts who had been briefed to help explain how Nathan's body came to be in the position in which it was found.
23. At the conclusion of that phase of the inquest, I indicated to the family that the coronial brief would be supplemented by material that would address the missing persons investigation.
24. A fresh statement was prepared by the new case officer and given to the family by Counsel Assisting. The lengthy statement was drafted to address the various theories and rumours that had been brought to the family's attention as to how Nathan died and test them against the known evidence, particularly that given by the experts called in the first phase of the inquest.
25. Counsel Assisting wrote to the family after the first phase of the inquest. He indicated that his assessment of the fresh evidence was that whilst it put the various rumours and theories to rest, it could not provide an explanation of why Nathan went to such a remote area of the river and entered the water where his body was found. In his view, a further hearing would not assist me in arriving at the finding I was required to make. He indicated (consistent with an indication given by me at the end of the first phase of the hearing) that the Coroner was likely to make an open finding as to the 'manner' of Nathan's death.

The family agreed that no further hearing was required. Submissions prepared by Counsel Assisting were given to the family. At a directions hearing conducted on 5 December 2024, I received the fresh evidence and confirmed that I did not intend to hold a further hearing. Nathan's family and former partner were given the opportunity to make submissions which were later received by the Court.

## **Part 5 – Nathan Booth And His Family**

26. In understanding who Nathan was and what he meant to his family and friends, I was greatly assisted by a written reflection prepared by his family. What follows in this Part is substantially a recitation of aspects of that reflection.
27. Nathan was born on 15 July 1979. He grew up in their modest home in Red Hill, surrounded by the warmth of his family. Born as the third child, Nathan was the younger brother of Alex and Deanne and older brother to Melanie, Erica, Bill and Shona. His mother and father separated before he was born. His mother, Rayleen, worked tirelessly to give her children love and stability.
28. At age 11, Nathan and his family moved to Rockhampton where he lived with his aunt for a number of years.
29. After he returned to Canberra, and as he entered his teenage years, the weight of the disadvantage his family suffered became heavier.
30. Drugs flooded the streets of Canberra in the mid-1990s, and like many young people, Nathan was caught in its wake. What started as experimentation using marijuana developed into heroin and amphetamine use. His family described heroin as a substance Nathan and his friends didn't fully understand until it was too late.
31. Addiction became part of Nathan's life. With the support of those around him, he sought to address that addiction with placements in residential rehabilitation programs, without long term success. The reality of Nathan's use of illicit drugs brought him in contact with the criminal justice system. As his family conceded, he 'was no saint'. He spent significant periods of time in prison, usually for offences commonly associated with his opioid addiction. Nathan's last period of incarceration was when he was remanded in custody from 6 December 2018 to 6 April 2019.
32. Even when addiction took hold, he showed moments of incredible love and care. His family described to me an episode when at just 14, Nathan stepped in to help raise his sister's newborn son.
33. Nathan was the father of four daughters. He fought to remain a presence in the lives of his children after child welfare intervention.

34. Nathan was involved in a major accident in 2009 when he was hit by a train. He suffered head injuries. He suffered depression for many years of his life and took anti-depressant medication to address that issue.
35. At the time of his disappearance, Nathan was in a relationship with Sharelle Charles. They commenced their relationship in around 2006. Sharelle had three children from a previous relationship. She resided with Nathan and her children at a house in Kambah.
36. The relationship between Sharelle and the deceased was fraught, with periods of separation and ongoing arguments, often about Nathan's drug usage. He regularly absented himself from the family home.
37. His family described his life, particularly in relation to his struggles with drug addiction, as reflective of the challenges faced by the children of the Stolen Generation. The *Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families (Bringing them Home)*<sup>2</sup> found that members of the Stolen Generation and their children suffered a range of adverse personal and social consequences including greater exposure to violent behaviour, poorer mental health, higher rates of incarceration, poor educational, employment and housing outcomes and higher rates of drug use.
38. Nathan's family in their submissions explained this reality:

Nathan Booth's story is not just the story of one Aboriginal man. It is the story of his family, his people, and the nation we all exist within; a nation that has spent too long ignoring the painful truths it needs to confront.

Nathan's life provides an insight into what it means to grow up as an Aboriginal in Australia; a reality shaped by systemic racism, oppression, violence, loss, and the ongoing fight for justice. Nathan's story and his legacy deserve more than convenient conclusions or empty promises.

[It] shines a light on the harsh realities faced by Aboriginal families like ours, the Booth family. These harsh realities are a result of simply being born Black, realities too many Australians will never experience or understand.

Nathan's story carries grief and real truth-telling, but also the power of his legacy to our family; a family who refused to be broken, even when the system tried its hardest to break us.

39. His mother Rayleen is from the Stolen Generation and had been removed from her family as a three-year-old. She was accommodated in out of home 'care' and it was only as a

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<sup>2</sup> Part 3, Chapter 11, Human Rights and Equal Opportunity Commission Report *Bringing them Home* Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families April 1997.

12-year-old that she was placed with extended family. In the words of Nathan's family, Nathan was 'born into a society that claimed to be changing but remained deeply unjust'.

40. His family was touched with tragedy. His older cousin Patrick Booth was 17 when he died in custody in the 1988. An inquiry into his death was conducted as part of the Royal Commission into Aboriginal Deaths in Custody.
41. Another cousin, Ida Lyn Booth, was killed in a hit-and-run incident while crossing the street in Redfern, Sydney. No one was charged, and there was no inquest into her death.
42. Another cousin, Felicity Dalton, was found dead on a pathway in Canberra. The family told the Court that 'authorities blamed her death on her addiction, her life reduced to a statistic in a system that ignored the humanity of Aboriginal people'.
43. Another cousin, Danny Taylor, drowned in a channel in the Riverina district while in the care of foster parents. He had been taken from his mother's care with the promise of being returned to her.
44. David Doolan, another cousin, died of alcohol poisoning which caused liver failure.
45. Two more cousins, Owen and Bryan King, both died in the 2000s. One from a drug overdose and the other from suicide in Canberra.
46. Another cousin, Rayleen Booth, died in the 1990s at the hands of her ex-partner after he was released from prison, where he was charged with domestic violence against her. He killed her the day of his release.
47. The family described the effect of this family history in these terms:

For the Booth family, these losses weren't isolated tragedies. They were part of a pattern of neglect and abandonment by authorities; a constant reminder that the system was not built to protect them. It was built to control, contain, and dismiss them. These deaths were more than heartbreak; they were fuel for anger, a reason to resist. Nathan carried that anger with him, not as bitterness, but as a fierce love and protection for his family.

48. The family spoke to the Court of their profound dissatisfaction with the missing persons process and what they regarded as the neglect of the coronial system. They wanted to know how it was that Nathan's body ended up where it was found. They had to wait four years for that question to be seriously addressed:

This lack of transparency and the disregard for vital facts surrounding his death was a profoundly draining and painful experience for our family. The emotional toll of pushing for justice while being met with systemic indifference must not be ignored. We demand acknowledgment of the obstacles we faced and the failures that compounded our grief.

49. The family addressed these issues in the submissions that were made to the Court at the completion of the inquest [130]-[145].

## Part 6 – Nathan Booth – His Associates and Methadone Use

### *The Rumours Surrounding Nathan's Disappearance*

50. I have canvassed aspects of Nathan's connection to family and community and his struggles with addiction. His family justifiably resisted any attempt to define Nathan simply by reference to that issue. However, the reality of his life was that his addiction influenced his social context. When Nathan was reported missing, the investigation addressed all possibilities to explain his disappearance. Necessarily the missing persons investigation and then the coronial investigation addressed the possibility that he had been murdered by known associates.
51. Rumours began circulating after he went missing. Those rumours were reported to his distressed family. In the inquest, to address the family's concerns, a 'rumour matrix' was developed by the police for what was intended to be the second part of the inquest. It would be unfair to the named persons to refer to those rumours in detail, other than to say that the rumours included suggestions that:
- (a) Nathan had stolen drugs from 'Asians' or 'drug dealers' and that they were looking for him;
  - (b) Bikies were after Nathan (for reasons unknown);
  - (c) Nathan had been killed for doing 'something bad' and his body dumped on Mount Ainslie;
  - (d) Nathan had been dragged away in a car, either by 'a white woman' in a Mercedes Benz or by 'Asians';
  - (e) Two [named] men had killed Nathan with a machete and buried him at Kambah Pool/in 'the river';
  - (f) Nathan had been taken to Kambah Pool and that his ankle was broken when trying to run away;
  - (g) Nathan had been tortured (by 'Asians') which had been videoed;
  - (h) A named person (1) (known to be a drug dealer) had killed Nathan and may have been tasked by 'Asians' from Sydney to do that;
  - (i) A named person (2) had 'put a contract' out on Nathan and his body was dumped in the river after they shot him with heroin;
  - (j) A named person(s) (3) was/were s involved in Nathan's murder or was present when he was killed;

- (k) A named person (4) had committed gun offences and was known to be hanging around with Nathan;
- (l) Named person (5) was involved and had set 'Nathan up'. That person had stolen something and Nathan had been trying to return it;
- (m) Named persons (6) were involved in Nathan's murder;
- (n) Named person (7) with bikie associations had confessed to having murdered Nathan; and
- (o) Named person (8) with bikie associations was involved in Nathan's murder.

52. In all, 23 separate rumours were identified and assessed by the AFP. Where names were given to the rumoured wrong doers, people were interviewed (if they were willing to speak to the police).
53. Ultimately, the veracity of those rumours fell to be tested in light of the expert evidence tendered at the hearing (see Part 9 and Part 10, [82]-[112]).

#### *Methadone Use*

54. Nathan's use of methadone was circumstantially relevant to when he disappeared and when he came to be in the river where he was found. His pattern of usage can also assist in understanding those same issues.
55. Nathan was first prescribed methadone in a methadone dosing program in 1999. Daily dosing recommenced from 2005 and appears to have continued until 2019. By November 2016, his dosage had increased to 120 mg daily (where it appears to have remained). The deceased apparently felt better on a higher dose. He used other drugs including benzodiazepines and pregabalin to address withdrawal symptoms.
56. Nathan obtained his methadone at the methadone clinic at TCH. He presented each day. An iris scan allowed him the access his dose. On 1 May 2019 Nathan had a 'medical review' in which the registered nurse noted the daily methadone dose of 120 mg and recorded 'Comfortable. Has been on the same dose for a long time, intermittent cannabis use. No other substance use reported. No other regular medication. No other health issues'. The observations were that he looked well, not intoxicated and no objective signs of withdrawal.
57. On 16 May 2019 at 0930 hours Nathan presented for his methadone dose at TCH intoxicated with slurred speech. He was 'too intoxicated to be dosed'. He returned that afternoon after 1500 hours not intoxicated and received his 120 mg dose.

58. The records confirm that apart from these occasional problems, Nathan was very consistent in obtaining his methadone at the clinic and the routine (except during periods of custody) was uninterrupted for several years.
59. His last known dose of 120 mg methadone was dispensed at 1508 hours on 27 June 2019.

## **Part 7 - The Scene of Death**

### *Location*

60. A central consideration in my findings as to the manner and cause of Nathan's death was the isolated location in which his body was found. The Murrumbidgee River flows through the ACT in a northerly direction. Two boys who had found Nathan's body had trekked a considerable distance. On 1 December 2019, they left the Tuggeranong Dam early. The plan was to find their way to the Murrumbidgee River and follow it up to Kambah Pool where they would be picked up. The boys trekked along its banks following the northerly flow of the river, fishing as they went. There was no established walking trail. The level of the water was low. They smelt something on the breeze and tried to find where the smell came from. They found Nathan's body. The evidence establishes the body was within the eastern part of the Murrumbidgee River north of Pine Island and south of Red Rocks Gorge, about 300 metres off the Centenary Trail (that follows the River to the east) between the Bullen Range Reserve to the west and the Urambi Hills Nature Hill Reserve to the east. The GPS co-ordinates were latitude 35.411037 longitude 149.043158.
61. The path the boys took highlighted the challenges facing anyone minded to access that spot by following the river. Accessing the spot from the Centenary Trail that roughly followed the river required walking down to the river through steep and rocky terrain and sometimes through quite heavy vegetation. It would be a very considerable challenge to take either route to the spot where Nathan was found in limited light. The suburb of Bonython borders the Pine Island Reserve. Nathan was known to visit that suburb by walking through the Reserve.
62. Set out below are two images. The first is taken from an AFP Geospatial Report, with RP being the Reference Point where Nathan's body was found. The second is a photograph taken by investigating police. A broom appears at the place where Nathan's

body was found (an arrow has been added). The images show the challenges confronting anyone wanting to access the areas.





### Nathan's Body

63. Nathan's body was substantially decomposed. His feet and shoes were wedged under a rock, and his legs and torso draped over a number of other rocks. The bottom of his left leg was wedged between rocks, and his foot was turned up, unnaturally, against his leg. Part of his body was in the flowing water. His arms were extended above his head. His body was partially submerged. He was still fully clothed, including shoes and socks still on his feet.
64. Nathan's body was photographed and a forensic examination was conducted at the scene. No injury consistent with an assault could be seen. His clothing did not indicate he had been stabbed or shot. Whilst this examination revealed a cut in the buttock area of his tracksuit pants, the cut was not reproduced in the boxer pants that were worn beneath that area.

65. A phone had somehow remained in the pocket of Nathan's tracksuit pants (the pocket did not close with a zip, button, Velcro or similar). When examined, the phone yielded, in my view, no information of relevance [127].

### The Surrounding Area

66. A search of the riverbank near where Nathan's body was found was conducted. A mobile phone and a watch were found, neither of which could be linked to Nathan.
67. ACT Police Search and Rescue, including Maritime members, conducted a search of the riverbanks and the river body 350 metres upstream of where Nathan was located and 900 metres downstream. This included wading and snorkelling of the river.
68. The search located no items deemed to be related to the investigation. Items of clothing and rubbish located at several locations on the riverbank were examined and dismissed as not related to the deceased.

## **Part 8 – The Postmortem Process**

### *CT scans*

69. Prior to autopsy, Nathan's body was subject to a computed tomography ('CT') scan. On those parts of the body that could be fully visualised (which included the head, neck and abdomen/pelvis), no acute fractures were seen. Some of the limbs could not be fully visualised, although no fractures were identified.

### *Forensic Odontology – Identification*

70. For the purposes of identification, Nathan's dental records were obtained and compared against images obtained through postmortem dental imaging. Forensic odontologist Dr Griffith formed the opinion that sufficient points of concordance existed between Nathan's dental records and that imaging to confirm that the person found was indeed Nathan.

### *Autopsy - Observations & Testing*

71. At the direction of the allocated Coroner, Professor Johan Duflou, forensic pathologist, conducted a post-mortem examination. The extent of decomposition made the process of examination difficult.
72. Professor Duflou was able to identify (and exclude) some matters of relevance:
- (1) a fracture of the distal left fibula (a broken ankle) was diagnosed by direct visualisation of the bone. No other fractures of bones were identified.
  - (2) within the limits imposed by decompositional changes:

- (a) there was no indication of fatal neck compression.
- (b) no gunshot wounds were identified.
- (c) no sharp force injuries were identified.
- (d) there was no indication of blunt force head injury.
- (e) no blunt force injuries to the trunk were identified.
- (f) there was no indication of significant natural disease.

73. Samples of tissue and hair were taken for the purpose of DNA testing and toxicological analysis.

74. The following positive results were reported in a specimen of liver tissue:

Methadone	15 mg/kg (approx.)
Methamphetamine	2 mg/kg (approx.)
Amphetamine	Detected
Mirtazapine	Detected

75. A sample of head hair obtained from the nape of the neck region of the scalp was submitted to the Victorian Institute for Forensic Medicine for toxicological testing. The following positive results were reported:

Methadone	3	ng/mg (approx.)
EDDP (methadone metabolite)	0.7	ng/mg (approx.)
Methylamphetamine	0.09	ng/mg (approx.)
Delta-9-tetrahydrocannabinol <sup>3</sup>	0.2	ng/mg (approx.)
Diazepam <sup>4</sup>	0.02	ng/mg (approx.)
7-amino-clonazepam <sup>5</sup>	0.05	ng/mg (approx.)

### *Autopsy - Opinion*

76. The appearance of the body suggested to Professor Duflou the 'likelihood the deceased had been dead for a number of months prior to being found at the scene'.

77. In the opinion of Professor Duflou, the fracture to the ankle likely occurred at around the time of death. Professor Duflou noted:

... a fractured distal fibula is typically the result of twisting an ankle or similar event when landing on the foot often as a result of jumping or falling from a height. Less commonly, this fracture can be the result of direct impact to that part of the lower extremity, for example by

<sup>3</sup> A metabolite of cannabis.

<sup>4</sup> Diazepam is a benzodiazepine and, relevant to Nathan's circumstances, commonly used in the context of addressing anxiety associated with drug withdrawal.

<sup>5</sup> Clonazepam is benzodiazepine and, relevant to Nathan's circumstances, used to address panic and anxiety. .

a blow with a blunt object to that part of the body. Because the fibula is not a direct weight bearing bone, a person with such an injury is often still able to walk, albeit with difficulty and with a significant limp. The affected part of the leg is generally very painful and is usually swollen. It may appear deformed. If the fracture is compound, i.e. is associated with penetrating injury to the overlying skin, there may be blood loss from the injury.

Overall, it is very likely that the deceased's movement across terrain, and especially in the area where found, would have been significantly inhibited.

78. As to the drugs detected by testing:

... [the level of] both methadone and methamphetamine are such that they may individually or together have resulted in death from overdose, although it is also possible that the drugs at the levels detected were providing an effect desired by the deceased and did not cause or contribute to death.

79. He was not able to attribute death to a specific cause:

Possible causes which cannot be excluded in this case include a drug overdose (by methamphetamine and/or methadone, and other drugs), exposure to elements, drowning, injury which has not been identified at autopsy, and natural disease not identified at autopsy.

### *Specialist Toxicology*

80. Professor Drummer, one of Australia's leading toxicologists, was briefed to give more detailed opinions as to the possible significance of the drugs that were found in the toxicological analysis done of the tissue and hair taken from Nathan's body. He was briefed with a range of material including the results of Nathan's toxicological analysis, records relevant to Nathan's use of methadone and his medication prescription history.

81. Professor Drummer provided the following information and opinions:

- (a) The extent of decomposition in this case makes it difficult to determine what drugs Nathan had used in the period close to his death. Some drugs may have been present in his system as the time of his death but were no longer detectable because of the process of decomposition. The sample from Nathan's liver suggested he had used methadone and methamphetamine 'within a few days of his death'. It is not possible to say in what dose those drugs were taken.
- (b) The hair analysis provided confirmation that in the 6 months before he died, Nathan used methadone, methamphetamine, THC (cannabis), diazepam and clonazepam. It was not possible to say in what doses these medications/substances were taken. Neither diazepam nor clonazepam were in his prescription history.
- (c) No pregabalin was detected but may have been present in his body at the time of death.

- (d) Methamphetamine rarely causes death on its own. If the methadone had been used as prescribed, then absent the presence of another opioid, death from the combined effects of methadone and methamphetamine 'would be unlikely'.
- (e) Deaths involving methadone usually entail the use of additional methadone and misuse of other central nervous system drugs such as heroin, other opioids, alcohol or natural disease processes (such as heart disease) or injury.
- (f) The analgesic effects of methadone may have reduced pain of a broken ankle. However, it is not possible to say what level of pain Nathan experienced at the time of his death.

## **Part 9 – Determining When and How Nathan Died**

### **When Nathan Died**

- 82. Certain companies produce, for a commercial purpose, high resolution aerial images of urban (and adjoining) areas taken from over flying planes. Such images were available for 2019. AFP investigators had taken photographs, video, and drone footage of Nathan's body and where it was found on 1 December 2019. The images taken by the AFP were used to identify distinctive features of rocks and boulders that surrounded and supported Nathan's body. The river at this time was very low, allowing relevant rocks to be identified. Aerial images had been taken by different companies in 2019 on 17 May, 19 June, 25 July, 18 and 22 October.
- 83. Looking at those images, an object was identified within the river precisely where the body was later found in the images taken on 25 July and in the subsequent images. At the hearing, evidence was received from two eminently qualified geospatial specialists from the AFP. The effect of their evidence was that the object that was identified in the images first appeared on 25 July (and remained present in the October images). Significantly, the object was absent in the May and June images. It was, therefore, after 27 June 2019 (when Mr Booth left his home in Kambah and went to TCH to obtain his methadone dose), and before 25 July 2019 (when the object first appeared in the aerial imagery) that Nathan's body came to be at the place where it was found on 1 December 2019.
- 84. The missing persons investigation found no trace of Nathan's movements after he received his last dose of methadone at 1508 hours on 27 June 2019. He had been living at the home he shared with Sharelle before that date. No reason is known as to why he did not return home on that day and no evidence was found by the police that Nathan was staying at another person's house around this period.

85. Nathan required methadone and regularly attended to receive his dose. The dose was high. It is possible, as his family suggested, that the methadone found in his blood during the postmortem process had been derived from his contacts in the drug community. Whilst I cannot completely discount this possibility, it is difficult to understand why after 27 June 2019 he would choose to source methadone in the community when he would likely have been asked to pay for it. He had a free source of methadone available in the large dose that he physically required. The missing persons investigation did not produce evidence of Nathan sourcing methadone from other users in the community. It is likely that he would have reported this change of routine to Sharelle and his family.
86. I consider it is much more likely that Nathan died around the time he failed to return home on 27 June 2019 (rather than at a time near to 25 July 2019), However, I am, consistent with the submission made by the family, content to find that Nathan may have died on a date somewhere between those two dates.

### **How Nathan Died**

87. Central to the question as to how Nathan died, was the issue of where Nathan entered the river.
88. One hypothesis, and a possibility that haunted his family, was that Nathan had been the victim of foul play and had entered the water upstream (dead or unconscious) at or closer to Pine Island (a commonly used recreation area to the south sometimes associated with drug dealing) and had drifted to where he was found.
89. Expert opinion was obtained to address this possibility (what I will call the 'drift theory').
  - (a) Rain and River Data
90. Water flows were obviously relevant to the drift theory – the flow of water around the time of Nathan's disappearance would have had to be capable of transporting his body over a distance. Raw rain data was required to begin the analysis of water levels. Lobbs Hole Creek is the nearest rain and river data collection point used by the Bureau of Meteorology south of the Pine Island Reserve. This station is about 5 km upstream from where Nathan's body was found. The evidence suggested that it would take about 10 hours for the water to travel from Lobbs Hole Creek to the spot where Nathan's body was found. The data that was collected at Lobbs Hole Creek included readings of the river height and the water discharge rate *at that point*. That historic information has assisted the calculation of the water level, flow and restriction points (mostly rocks that were present in the flow of the river) in June and July 2019 that were nearer to where Nathan's body was found.

(b) Modelling of Water Flow

91. The raw rainfall data was then considered in the context of the characteristics of this stretch of the river. Advice was received from two fluvial geomorphologists, Professor Jonathan Olley and Dr Timothy Peitsch. They co-authored a report as to the behaviour of the Murrumbidgee River from Pine Island Reserve to the point where Nathan's body was found. Using 'LiDAR' imagery<sup>6</sup>, they constructed a digital model of the river to show its depth, width and other physical characteristics. The water discharge rates<sup>7</sup> (using the Lobbs Hole Creek data) were used to calculate the water depth as it flowed along the river<sup>8</sup>. The maximum flow that the river achieved between 27 June and 25 July 2019 was 2 cubic metres per second. If the river channel was 20 metres wide, the water would be about 15 cm deep.
92. Assuming that a body could not be carried by water less than 15 cm deep, Professor Olley identified eight points in the river between Pine Island and where Nathan's body was found, through which his body could not have been carried. The closest of these points was about 20 metres upstream from Nathan's body. This was also the part of the river that was referred to by kayakers as 'the chasm'.
93. Professor Olley went further. He concluded that it would have been impossible for water to have moved Nathan's body at all. Professor Olley produced a diagram of the river cross-section at the mark where Nathan's body was found. The elevation of the riverbed was traced out, with the boulders amongst which Nathan's body was found. The width of the River at that point is about 30 metres. With a flow rate of *2 cubic metres per second*, which was the maximum flow achieved between 27 June 2019 and 25 July 2019, at the position where Nathan's body was, the water level is just at, or marginally below, the *base* of boulders on the riverbed. For the water to have reached the top of the boulders at the point where his leg was wedged, a flow rate of *20 cubic metres per second* was required. Nathan's body could not have drifted, even from nearby shallow waters, into the position in which it was found *on and between* two boulders.

(c) The Kayaker's Experience

94. To give this evidence practical expression, Court investigators identified a kayaker who regularly paddled in this stretch of the river. Mr Geoffrey Perman had been an active kayaker for about 20 years. He would have paddled from Pine Island to Red Rocks Gorge somewhere between 100 and 150 times. He kept detailed notes in his diary of his

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<sup>6</sup> 'LiDAR', which stands for Light Detection And Ranging, is a remote sensing technique that uses light in the form of a pulsed laser to measure distance, in this case from an aircraft to the earth's surface.

<sup>7</sup> A 'discharge rate' is how much water passes through a point over a set period of time. In this instance it was expressed as cubic metres of water per second.

<sup>8</sup> Once the discharge rates for 27 June through 25 July 2019 were applied to the model of the river, shallow areas could be identified.

paddling journeys and produced videos that recorded those journeys on a *Go-Pro* camera attached to his helmet. Mr Perman gave evidence in the inquest at the same time as Professor Olley and the Court and the parties had the opportunity to cross check the scientific modelling against Mr Perman's experience and knowledge of the area.

95. Mr Perman had kept a video of when he went kayaking on 7 February 2019. The data from Lobbs Hole Creek that day was higher than the June-July 2019 period (a river height of 1.829 metres, and a discharge rate of 2.448 cubic metres per second). At 'the chasm', Mr Perman and the other kayakers 'portaged' – that is, they paddled to the riverbank, and then carried their kayaks around the chasm area, and once past it, re-entered the water and kept paddling. Mr Perman described the rocks at this point of the river as being quite high (i.e. the water level was low), and that at that level he wasn't going to get through in a kayak.
96. At the hearing, Mr Perman was also shown drone video of the river taken on 13 March 2024, when the river was closer to the June-July 2019 period<sup>9</sup> Mr Perman watched the video and said that he would have had 'zero chance' of paddling through the chasm in those conditions.

(d) The Survivalist

97. Dr Luckin is a survival expert. He too was part of the 'gathering of the experts' that occurred during the hearing. He told the inquest hearing that he has been involved in search and rescue as a paramedic since 1974, and as a medical doctor since 1982. He provides advice about survivability to police and search and rescue authorities on average 90 times a year. His evidence addressed a number of issues including whether it was likely that Nathan had suffered the injury to his distal left fibula (identified at autopsy) before it became wedged between the rocks where he was found. He noted the significant staining on the rocks underneath Nathan's body suggested his body had not moved during the period of decomposition. As to the timing of the injury to Nathan's left fibula, Dr Luckin was of the view that it would have been impossible to walk on that kind of fracture as the distal fibula was grossly displaced outwards and upwards involving a rupture of the entire ligamental structure holding the ankle in its normal position.
98. He concluded that the state of the ankle was not affected by the passage of time. He saw no evidence that it could have moved, particularly as it was wedged underneath the rock. In his view 'the position of the foot postmortem is absolutely consistent with falling

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<sup>9</sup> The height was 1.75 metres, and the discharge rate was 1.768 cubic metres per second. The river height on 25 July 2019, when the aerial imagery first showed an object in the river, was 1.736 metres.

and fracturing and remaining in that position'. As to how that fracture occurred his opinion was:

That fracture of the ankle requires considerable force and the likely mechanism that I see is that he stepped or jumped or fell from a higher rock on to – on to that rock and subsequently he slipped so that his foot went between the rock that he was lying on and the rock he was under - jammed under and fell forwards. Now, that fracture may have occurred when he hit the rock. It may have occurred as he twisted underneath the rock. I think it more likely occurred as he hit it, but either way, landing like that he would then have fallen forwards, face forwards on to – on to the rock.

99. It was put to Dr Luckin, on behalf of the family, that it may have been possible for Nathan to have been placed in the position he was found, by another person or persons. Dr Luckin replied from a commonsense perspective:

I think that that is so unlikely as to be something I would not consider a possibility. To do so you would have had to pick him up, take him, choose your position, lie him down, jam his foot and his leg underneath the rock, position his foot and then stand back and say, 'Am I happy with the position', and apart from the mechanical difficulty of doing that, I can see no conceivable reason that one would wish to do that. If you were going to dispose of a body, you would presumably dump the body in a convenient spot. You would – I cannot see any conceivable reason that one would – no, I cannot see any mechanism by which one would position the body in the position that Nathan was in to do that, so I think the possibility of his being staged in that position, I would discount that.

100. The above evidence (including Professor Duflou's findings on autopsy) suggests with a high degree of probability that Nathan walked to where he was found and that he became trapped when his leg became wedged between rocks. It is also likely that he broke his distal fibula in the process.

#### **Part 10 - Why was Nathan in the area where he was found?**

101. The second phase of the hearing (ultimately not conducted) was to be directed at the question as to why Nathan's body was found where it was and why Nathan was on the rock when his foot became wedged.
102. To anticipate the conclusion reached below, on the available evidence, it is impossible to say.
103. The area where Nathan's body was found was remote and difficult to access. It is difficult to conclude that he got there in any other way than walking (probably with some rock climbing/scrambling) involved.
104. It is not reasonably open to find that Nathan found his way to where he died in a significantly impaired state. The toxicological and hair analysis conducted in the postmortem process and commented upon by Professor Drummer suggested that

methadone and methamphetamine was present in his blood at the time of his death. Professor Drummer was not able to say:

- (a) when the methadone was consumed (from 2 days to a week);
- (b) what the concentration was at the time of Nathan's death; or
- (c) whether his cognition or motor control would have been compromised by methadone or methamphetamine intoxication.

105. Nathan was an experienced user of both substances. In respect of his methadone his daily dosage was high (120 mg) but he was able to live in the community between doses. Therefore, it is equally likely that he was or was not suffering impairment as he made his way to the point in the river where he was found. It was not easy to access the point in the river where his body was found, and it would have been much more difficult to get there if he was significantly impaired.

106. The various theories and rumours that were circulating in the community after his disappearance have been summarised above [51]. So far as they involved an assertion that he died as a result of being assaulted, shot or otherwise killed by another person or persons, they carry little weight given the evidence in the first phase of the hearing.

107. They do, however, have as a central theme that Nathan had wronged people in the drug community. It is possible, for example, that Nathan was seeking to 'lay low' for a period to escape from people who may have wished to do him harm. Why he would choose the spot where he was found to effect that purpose is less obvious. He may have been forced to go there by those who wished him harm. However, why this difficult to access area would be chosen is not clear. How he came to have his leg wedged in the rocks is also not obvious in this scenario.

108. It is equally difficult to provide a satisfactory and benign explanation for his presence in the area. Whilst he was familiar with the area in a general sense, and there were tracks nearby that he may have walked in the past, as the family have fairly asserted, the evidence does *not* suggest that:

- (a) he was a fisherman;
- (b) he was fond of finding his way to the River around that area;
- (c) he was a 'bush' person; or
- (d) he went 'bush' when he periodically absented himself from his family.

109. He was known to walk his dog towards Kambah Pool and the Murrumbidgee River, but this dog had been impounded by the time he went missing.

110. It is possible that he was walking to his home in Kambah from Tuggeranong where he accessed most of his services and deviated from the path. Why he would choose to do so on his own on this day in a Canberra winter is again obscure. It would involve making his way through very difficult terrain and through (sometimes) thick vegetation.
111. He was, as his family submitted, a very social person, usually driven to seek out the company of others rather than go for walks in isolated areas.

### *Conclusion*

112. I am not able to reach a standard of satisfaction as to the manner of Nathan's death. I will therefore not make findings as to that issue.

### **Part 11 – The Cause of Death**

113. Professor Duflou found no evidence of inflicted injury (gun shot or knife wounds or trauma causing bone fracture). Nathan was probably affected by drugs but possibly not intoxicated to a significant degree and certainly not to the point of causing death (for example, by respiratory depression following an overdose). Those possible causes of death excluded, the only other explanations are environmental - either drowning or hypothermia.

### *Drowning*

114. The evidence of Professor Olley is important in considering the possibility that Nathan drowned. His evidence was that the peak water level between 27 June and 25 July 2019 was below the level of the rock on which Nathan's body was found. Given his foot was wedged holding him in place, it would not have been possible for his face to have been submerged in water. I therefore discount drowning as a possible cause of death.

### *Hypothermia*

115. Hypothermia occurs when core body temperature drops below 35 degrees Celsius (Normal body temperature is around 37 degrees Celsius). When body temperature drops, the heart, nervous system and other organs can't work as well as they usually do. If not treated, hypothermia can cause the heart and respiratory system to fail and eventually can lead to death. Dr Luckin described it this way:

So as soon as the core temperature starts to drop, the function of the brain immediately starts to decrease. There is a progressive decrease in blood flow to the brain and oxygen consumption of the brain which reflects activity of the brain. So all of the functions of the brain progressively diminish and the first ones are the higher things, that is the awareness of what's going on; one's ability to make decisions; to remember one's training; understand the risks; understand the situation that you're in; and to make appropriate decisions to take protective measures. And that progresses to a feeling of fatigue and weakness; to a

progressive decreased level of consciousness; eventually to being extremely sleepy; and to loss of consciousness; and eventually to death.

116. The Bureau of Meteorology records indicate that between 27 June and 25 July 2015, the average minimum temperature was about -3 degrees, and the average maximum was 15 degrees. The average water temperature was 6.85 degrees. These figures reflect typical colder weather patterns for the Canberra area in the winter months. The place where Nathan was found is a natural wind tunnel. Nathan was lightly clothed, and his body was likely processing methadone and other substances. It is a possibility that after he entered the river, at least part of his clothing may have become wet. All of these features would have rapidly accelerated the development of hypothermia. Dr Luckin's evidence was that the maximum period that he would have expected for survival would have been a few hours after temperatures dropped to these low levels.
117. Consistent with the evidence before me and the submissions received on this issue, I find that Nathan died of hypothermia.

## **Part 12 – Answering The Questions the Family Have Asked**

118. Section 3BA(2)(a)(i) of the Act obliges me, as far as is practicable, to conduct my inquest in a way that recognises that Nathan's family and friends have an interest in having all reasonable questions about the circumstances of his death answered.
119. In their submissions, they raised concerns as to the lack of clear communication with the family during the missing persons investigation. I address those issues in my discussion of matters of public safety (Part 13).
120. The family raised specific concerns about things that were done or not done in the missing persons investigation and that various lines of inquiry were not sufficiently pursued, namely:
- (a) not speaking to people who may have been at the methadone clinic at the time Nathan attended on 27 June 2019;
  - (b) not making enquiries of, or delayed enquiries of, certain individuals who were named as contacts on the phone found in the pants Nathan was wearing.
121. The family also submitted that the process of identification had been unreasonably delayed. It is beyond the scope of the coronial process to conduct a detailed examination of the missing persons investigation given that ultimately that investigation became part of the coronial brief.
122. For what was to be Part 2 of the hearing, a lengthy statement was prepared by Senior Constable Cunningham that detailed every step taken in that investigation. The

statement ran to 74 pages. It is apparent that considerable effort was devoted to locating Nathan, including speaking to a vast array of witnesses and conducting covert surveillance (including telephone interception) of some of them and searching out relevant documentation. Unfortunately, what is also apparent is that the movement of the investigation into the coronial jurisdiction after Nathan's body was found, caused the investigation to effectively pause. The sophisticated investigations and analysis that were done after June 2022 might have been undertaken at an earlier time. That delay is symptomatic of the delays that were evident in the coronial processes at the time. I have commented in other cases that the effect of such delay is to cause trauma to already distressed families. I apologise for that delay and its impact on Nathan's family and friends.

123. I will address the specific questions or criticisms the family have made of the missing persons process below.

*Potential Witnesses at the Methadone Clinic*

124. What is called a 'dose report' was obtained from the TCH methadone clinic. It is unclear from the evidence when (and indeed how) this report was obtained. Senior Constable Cunningham was not able to say when asked during the hearing. The dose report lists those people who presented for dosing on a given day. A person 'A1' was in attendance 9 minutes before Nathan received his dose. Another person 'B2' was in attendance at the clinic for dosing 40 minutes after Nathan. There is no reference in the brief to A1 being spoken to by police. Person B2 was known to a family friend and they (and a third person) had a discussion about Nathan. They indicated they hadn't heard anything about his whereabouts.
125. Counsel Assisting has submitted that it would be reasonable to moderate expectations as to the forensic significance of both the dose report and speaking further to the attendees at the methadone clinic on 27 June 2019. No person is recorded as attending with Nathan. If A1 and B2 are spoken to, they may or may not recall details of Nathan's visit to the clinic on that day, remembering that person A1 attended 9 minutes before Nathan and B2 40 minutes after Nathan. It is also noted that CCTV footage from the clinic was overwritten by the time Nathan was reported missing.
126. At the conclusion of an inquest such as this, involving a death that may be suspicious, the evidence that has been obtained (including the evidence relevant to his attendance at the methadone clinic) will be reviewed by the AFP. My findings will be available to AFP members involved in that review. The 'methadone clinic evidence' can be reviewed in that context.

### *Telephone evidence*

127. The evidence in relation to the phone found on Nathan's person is complex and, to assist the family, was addressed at length by Counsel Assisting in his reply submissions. The device was last used on 24 February 2019 (4 months before Nathan's attendance at the methadone clinic) by a telephone number linked to another person (B3). On 27 January 2019, the device was used by a number associated with someone in NSW (B4) who is the mother of B3. Both people were spoken to by Senior Constable Cunningham in the coronial phase of the investigation. As to the SIM card for that device, it was associated with person B5 - a person who never lived in the ACT and who had no connection to Nathan. Evidence from relevant service providers was obtained within days of the phone being found so no evidence was 'lost'. There were no 'contacts' in the phone as the family suggested in their submissions. I am satisfied that the missing persons team and Senior Constable Cunningham exhausted the phone's evidential value. It was not, and could not, be useful in determining the manner and cause of Nathan's death.

### *Delay in Identification*

128. It is acknowledged that the time taken to formally identify Nathan was delayed. Police visited Nathan's family the day after his body was found and indicated that it was the belief of investigators that Nathan's body had been found. The autopsy was conducted on 3 December 2019. A request was made on that day for dental records to be obtained to enable a process of odontological comparison to be conducted for identification purposes. There was delay in facilitating an examination of Nathan's body by a forensic odontologist because at the time there was only one expert available in the ACT. An identification by DNA was considered. However, delays in processing DNA samples were anticipated. The examination by the forensic odontologist was conducted on 18 December 2019 and his positive identification was accepted by the Coroner the next day and communicated to the family.

129. Circumstantial identification of Nathan was available within 24 hours of the discovery of the body and was communicated to the family. The delays experienced in the formal identification were longer than is optimal. I apologise to the family for that delay and for the distress that it caused.

### **Part 13 – Matters of Public Safety**

130. As noted [8], section 52 of the Act obliges me to state whether a matter of public safety arises in connection with the inquest, and if it does, comment on it.

## *Family Submissions*

131. The family submitted that I should make a number of recommendations in respect of four issues arising from the missing persons investigation.

### (a) AFP Communication in Missing Persons Cases

132. In respect of communication issues arising in missing persons cases, the family submitted (in the following terms) that the AFP should develop culturally sensitive guidelines governing police interactions with Aboriginal families:

That, if one does not exist, a framework or set of guidelines should be established for the AFP to guide their communication with Aboriginal families of individuals who are reported missing. This should include an understanding that the Aboriginal concept of 'next of kin' does not necessarily correspond the western understanding of this concept.

That when a person is reported missing, the family of that person is provided with comprehensive information about the missing persons process, including the information that should be documented and provided to police, and what the family can do to assist in the locating of that person.

That police should be aware of cultural sensitivities during a missing persons investigation of an Aboriginal individual. The family reports that uniformed police attended home visits to interview Nathan's family members. Police should be cognisant of Aboriginal families' cultural sensitivities about police, and that uniformed police attendance upon a residence, for any purpose, is likely to raise angst and waryness (sic) amongst people within the residence.

### (b) Culturally specific advertising as to missing person reports

133. Nathan's family, noting their experience of uncertainty as to if and when a missing persons report should have been made, submitted:

The family advocates for a culturally specific information campaign for the Aboriginal community that encourages earlier reporting of people who they suspect may be missing or have not had contact with for an irregularly long period of time.

134. Both suggestions warrant consideration by the AFP. I note that these issues were not ventilated at the hearing and were not the subject of specific evidence. The AFP were not represented at the inquest. In those circumstances I do not find that a matter of public safety arises in respect of which it is appropriate for me to comment or make recommendations. However, I will forward my findings to the Chief Police Officer for consideration of these issues and, if appropriate, for direct response to the family.

### (c) Information about Coronial Processes

135. The family made the following submission about information being available to families in the coronial process:

Nathan's family suggests that the process for seeking further review of coronial findings should be made clearer to interested parties, and that more information about the coronial

process should be provided to families at the outset of investigations. To that end, the Coroner's Court may benefit from a dedicated Aboriginal Liaison [officer] or similar to assist families participating in the coronial process.

136. I have accepted [19] the family's criticisms as to how the Coroner's investigation into Nathan's death was progressed. Any decision of a Coroner to make findings without a hearing being conducted is appealable to the Chief Coroner (section 34A of the Act). However, it is acknowledged and accepted that it is difficult for families to navigate the complexities of the coronial process, particularly when unrepresented and when confronted with a lack of information as to how the investigation into a loved one's death is being progressed. Cultural or other considerations may also affect a particular family's interactions and engagement with the coronial process.
137. The general issue of communication with families has been a vexed one for the Coroner's Court. Historically, the Court was not separately resourced to employ what are now known as Family Liaison Officers. When Nathan's death came into the coronial system on 1 December 2019, there were no formal processes for communicating with families and no dedicated staff resources were in place to facilitate that contact. Since that time, the Court has recruited two Family Liaison Officers whose primary role is to communicate with families who are in the coronial process. The ability of the Court to keep families up to date with developments in their loved one's inquest remains challenging given the volume of cases at hand is very high (with over 400 active coronial cases at any given time). It is hoped that the Booth family would have experienced a different level of communication today.
138. No specific recommendation is made in this respect. However, a recommendation follows addressing making the processes of the Court more open and, where appropriate and practicable, more restorative.

(d) Alerts from the methadone clinic

139. The family suggested that there should be a mechanism by which the methadone clinic should raise alerts when someone doesn't attend for their regular dose:

There would be benefit in the implementation of a system that 'flags' when regular methadone (sic) program attendees fail to collect their dose at TCH after a prescribed period of time. Services such as the methadone program are a regular point of contact for individuals who otherwise live a transient lifestyle or have no fixed place of abode.

140. The proposal advanced by the family raises complex issues around patient confidentiality. Whilst Nathan was open as to the role his methadone dose played in addressing his opioid addiction, there would be others who would be alarmed by the suggestion that their dosing practices would be communicated to anyone.

141. I note that it would be open in all cases (as it was for Nathan) to consent to the disclosure of such information.
142. This issue was not considered at the hearing and was not the subject of any evidence nor submission from Canberra Health Services. In other coronial proceedings<sup>10</sup>, I made recommendations that this framework be reviewed. The Government has provided a response to that recommendation.
143. I will not make a recommendation as to this issue. I will forward my findings to the Chief Executive of Canberra Health Services inviting consideration of the family's proposal in light of any review of protocols surrounding the disclosure of patient information.

### *Submissions of Counsel Assisting*

#### Protocols for Coronial Engagement with Aboriginal Families

144. After outlining the attempts made by the Court in this inquest to make the coronial process a more welcoming space for the Booth family, Counsel Assisting observed:

There is no regulation, practice note or protocol in the Territory that concerns engagement with Aboriginal families in the coronial proceedings. Other jurisdictions make provisions for Aboriginal deaths in custody (see the State Coroner's Protocol in NSW issued on 9 March 2022 and the Practice Direction 6 of 2020 issued by the Victorian State Coroner on 22 September 2020) and more generally for the adoption of more accessible and inquisitorial measures (see for example in Queensland the practice notes that provide for pre-hearing conferences, concurrent evidence, and family statements). There is also considerable guidance to be found within coronial reform material from Western Australia that is concerned with Aboriginal families.

145. The submission is a reasonable one and one that the Booth family endorsed. However, there are practical and procedural considerations that arise in respect of this submission.

#### (a) Report after an Inquest

146. In the first instance there are some statutory constraints that impede me from making the recommendation sought by Counsel Assisting (or at least compelling the Attorney General to respond to any comment).
147. The recommendation urged upon me by Counsel Assisting and the family is a matter concerning "the administration of justice" for the purposes of section 52(4)(b) of the Act. The terms of section 52(4) of the Act require a Coroner to state whether matters involving public safety or the administration of justice arise and if they do, comment on them. If a comment or recommendation is made by a Coroner about a matter of *public safety* (section 52(4)(a)(i) of the Act), it invokes the process of a Governmental response set out in section 57(4) of the Act. However, according to their terms, sections 57(3) and (4)

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<sup>10</sup> See: *Inquest into the death of Joshua* [2023] ACTCD 2.

of the Act only require the Attorney-General or another Minister to respond in the prescribed way in relation to matters of *public safety*. Correspondence from the then Attorney-General, Mr Rattenbury, regarding a recommendation made by me in respect of a matter concerning the administration of justice<sup>11</sup>, suggested that he was acting on the advice that he was not required to respond in the manner contemplated by section 57 of the Act.

148. It appears there was an error in the drafting of section 57 of the Act<sup>12</sup>. There is nothing intrinsic to the operation of the Act or from the explanatory material relevant to the terms of section 57, that would justify a difference in approach as between matters of public safety arising from an inquest and matters concerning the administration of justice.

**I recommend that section 57(3) and section 57(4) of the Act be amended so as to require the Attorney-General or another Minister to respond in respect of comments made by coroners in respect of matters involving the administration of justice.**

(b) Role of the Dedicated Coroner and General Procedural Guidance

149. I fulfil the role of the dedicated coroner. No statutory recognition is given to the role and the Chief Coroner remains the head of the jurisdiction.
150. I have no authority to make regulations or procedures as to how the Court should generally operate in all inquests. That power is reserved to the Chief Coroner: section 51A of the Act. In the absence of a practice direction, I can, as I did in this inquest, give directions as to how an inquest conducted by me should be undertaken: section 51A(2)(b) of the Act. It is not appropriate for recommendations to be made in findings by a Coroner other than a Chief Coroner, that purport to persuade the head of jurisdiction to a particular point of view as to how the Coroner's Court should operate. Nor would it be appropriate for the Attorney-General in the context of a response to any recommendation I would make (section 57 of the Act) to suggest to the Chief Coroner that such an approach be adopted.
151. My findings will be referred to the Chief Coroner for her consideration in due course.

(c) Restorative Processes Generally

152. In 2015, the ACT Government committed to the idea of Canberra as a 'Restorative City' based on the principles of 'restorative practice'. In November 2021, the Attorney-General, Mr Shane Rattenbury, advised that a pilot restorative reform process would be trialled in the area of coronial reform. The outcomes of that process were published in

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<sup>11</sup> *Inquest into the Death of Herman Holz [2023] ACTCD 6*

<sup>12</sup> For example, contrast the terms of section 72 of the Coroners Act 2008 (Vic).

the *ACT Coronial Restorative Reform Process and Summary Report* ('the *Legge Report*') in 2024. Specific consideration was given in the *Legge Report* as to how the processes of the Court could be modified to better accommodate the needs of Aboriginal families involved in the coronial process.

153. The *Legge Report* contained detailed reference to the 2023 report of the University of Western Australia Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention entitled *Coronial Responses to Suicides of Aboriginal and Torres Strait Islander People*. The *Legge Report* found (omitting references):

This research has examined the current cultural capacity and safety of coroners, court staff and coronial processes, and explored ideas for improvement. It is based on a review of published academic literature and other documentation, the outcomes of a workshop discussion with Aboriginal and Torres Strait Islander people who have lost loved ones to suicide, and interviews with coroners, court staff and others with a professional or occupational interest in Indigenous people's experience of the coronial process.

The preliminary report outlines research findings and includes State/Territory and national directions for reform in these key areas:

- Improving coroners' and court staff's knowledge and understanding of Aboriginal and Torres Strait Islander cultures, especially kinship structures and protocols after a passing.
- Culturally responsive communication with Aboriginal and Torres Strait Islander family members, including maintaining contact through the coronial process and providing appropriate documentation and information resources.
- Accountability to ensure coronial findings and recommendations are applied in Aboriginal and Torres Strait Islander suicide prevention policy, programs and investment.
- Improved identification of Aboriginal and Torres Strait Islander people in the coronial system.
- Ensuring culturally appropriate support for Aboriginal and Torres Strait Islander families, including through the creation of identified roles in Aboriginal and Torres Strait Islander Engagement Units within coroners' courts.

The report notes that:

*The epidemiology, methods and preceding factors of suicide deaths among Indigenous people are distinct from those present in suicide deaths of non-Indigenous Australians, which may mislead coroners and their staff if they are not alert to these issues.*

This report [the *Legge Report*] aligns with issues identified in the restorative reform process. Its recommendations should form the basis of ongoing engagement with First Nations people in the ACT, in order to ensure the ACT Coroner's Court operates in culturally safe and responsive ways.

154. Neither the Government nor the Coroner's Court has responded to this recommendation or generally to the *Legge Report*. It would be inappropriate for a Coroner to urge the Chief Coroner or the Government to do so.

155. Despite their merit, I decline to make the recommendations advanced by Counsel Assisting and the family for the above reasons. I will however, forward my findings to the Attorney-General and the Chief Coroner for their consideration.

#### **Part 14 – Formal Findings Required by Section 52(1) Of the Act**

156. I find that between 26 June 2019 and 26 July 2019, Nathan Daniel Booth died at a place on the Murrumbidgee River north of Pine Island and south of Red Rocks Gorge about 300 metres off the Centenary Trail (GPS co-ordinates were latitude 35.411037 longitude 149.043158) of hypothermia. No make no further finding as to the manner of his death.

#### **Postscript**

157. During the inquest process I thanked the family for their courage and their level of engagement. I am heartened that the processes adopted in the inquest did something – even if done belatedly – to give them a level of comfort as to how Nathan’s death was investigated. It is not for me to say that my findings will give the family ‘closure’ or that they have been provided with definitive ‘answers’ as to the circumstances of his death. They will still grieve, and they will continue to speculate as to how he came to be at the place where he died.

158. I thank Counsel Assisting and those who instructed him for their hard work and innovative thinking. I thank Senior Constable Cunningham. Their collective effort resulted in an investigation of great quality. I thank the representatives of the Booth family and Sharelle Charles for their assistance and patience in a complex and uncertain coronial and court room environment.

159. I express my condolences to Nathan’s family. In so doing, I note with great shame that after the hearing was completed, a commemorative chair that had been placed near where the inquest was opened at Pine Island was desecrated with racist markings. The family responded to that confronting circumstance with demonstrable hurt but with great dignity.

I certify that the preceding one-hundred-and-fifty-nine [159] numbered paragraphs are a true copy of the Reasons for Findings of his Honour Coroner Archer.

Associate: Lucy James

Date: 30 April 2025