CORONER'S COURT OF THE AUSTRALIAN CAPITAL TERRITORY

Case Title:	**Inquest into the death of Felipe Esteban Alvarez (No 2)**
Citation:	**[2026] ACTCD 12**
Decision Date:	3 August 2026
Before:	Coroner Archer
Findings:	See [72-73], [188-193]
Catchwords:	**CORONIAL LAW –** MANNER AND CAUSE OF DEATH – death from drug toxicity – collapse after ingestion of drugs – delay in calling an ambulance – naloxone not available – responsibilities of workers from peer-based harm reduction service who were present – public safety issues – encouraging users present at collapse to call emergency services
Legislation Cited:	*Coroners Act 1997* ss 3BA, 13, 34A, 52, 55 & 58 *Criminal Code 2002* s 603 *Drugs of Dependence Act 1989*, s6 *Drugs of Dependence Regulation 2009*, s6 *Northern Territory Criminal Code 1883* (NT), s155
Cases Cited:	*Inquest into the death of Felipe Esteban Alvarez* (No. 1) [2025] ACTCD 11 *Doomadgee v Clements* [2005] QSC 357 *Thales Australia Limited v The Coroners Court & Ors* [2011] VSC 133 *Commissioner of the Australian Federal Police v Hills Greenery Pty Ltd* (No 2) [2024] NSWSC 448
Texts Cited:	ACT Drug Strategy Action Plan 2022-2026
Representations:	**Counsel Assisting** Mr K Lee (instructed by Ms S Richards) **Counsel for Canberra Alliance for Harm Minimisation & Advocacy** Mr S Onitiri (instructed by T Maling) **Counsel for Ms Emma Snazelle** Ms K Musgrove (instructed by Ms L Sutton) **Solicitor for Ms Gabrielle Alvarez** Aboriginal Legal Service **Mr PK and Ms KT self-represented**
File Number:	CD 94 of 2021

CORONER ARCHER:

INTRODUCTION

1. Felipe Esteban Alvarez ("Mr Alvarez") died on 30 March 2021. On that day at about 1300 hours, the Australian Federal Police ("AFP") were called to an address in Taylor in the ACT in response to a duress call from ACT Ambulance Service ("ACTAS"). On their arrival, the AFP found ACT Fire Brigade ("ACTFR") and ACTAS members administering medical treatment to an unconscious male, now known to be Mr Alvarez. He appeared to be suffering from a drug overdose. Despite their efforts, Mr Alvarez could not be revived. The evidence obtained during the inquest suggests that Mr Alvarez had collapsed much earlier than was indicated to ACTAS by those present. Two of the people present were employees of the Canberra Alliance for Harm Minimisation & Advocacy ("CAHMA") although not on duty that day.

2. Mr Alvarez's death was referred to the Coroner pursuant to section 13(1)(a) of the *Coroners Act 1997* (ACT) ("the Act"), as Mr Alvarez had died "in unknown circumstances".

3. The findings of the pathologist who conducted the post-mortem examination were that Mr Alvarez died of "toxicity caused by a combination of methylamphetamine and morphine". From the autopsy findings it is clear that Mr Alvarez suffered from (possibly undiagnosed) heart problems.

4. Mr Alvarez's death and inquest is one of a series of cases referred to the Coroner's Court in recent years where death by overdose has been accompanied by circumstances of onlookers either delaying or failing to call 000 to seek medical assistance. The circumstances of Mr Alvarez's death have unique characteristics but raises common themes concerning the demonstrated reluctance of bystanders to make calls to 000, apparently out of a fear of causing police attendance. The death also raises questions around how CAHMA ensures that the risks associated with the drug harm minimisation model on which it operates are appropriately managed.

FELIPE ALVAREZ

5. At the conclusion of the hearing for the inquest, a statement from his sister Ms Emma Snazelle, was read by her Counsel. Ms Snazelle spoke of a man who was funny and larger than life, kind and fiercely loyal. His childhood was described as one of loss, hardship, betrayal and abuse. Before Felipe was five the family unit had broken down and he had already witnessed horrific violence within the family. At nine years of age his father suicided.

6. She spoke of the violence in the family home that continued and escalated to include abuse. In spite of this and against the odds, Felipe completed his education. He attained his year 12 certificate in about 1990. Felipe gained qualifications as a construction rigger, crane operator and gained employment within the construction industry. Ms Snazelle described Felipe's love of his children .

7. Felipe's emotional and physical scars were always just under the surface. He turned to alcohol and the use of drugs. What followed this, Ms Snazelle described, was poor choices, poor judgment, inability to seek help and inability see where his life was headed. In his mid-20s, Felipe was sentenced to prison where he remained until he was 48 years of age. Whilst he studied during his prison term, on his release from prison, he was completely overwhelmed. The years of incarceration left him further scarred and broken and he was not prepared by the prison system to succeed or even to adjust to life after release. Because of his past, he had limited employment opportunities. He worked for himself repairing and selling cars.

8. Ms Sanazelle described Felipe as "not a perfect person, nor did he ever claim to be". She described Felipe turning to the organisation CAHMA for help. He was vulnerable and, in her view, CAHMA failed him.

9. Ms Gabrielle Alvarez also read a statement to the Court that reflected upon Felipe's life and her relationship with him. She described him as a "beautiful complex soul", "[a] proud Ngunnawal and Chilean man raised in both cultures and deeply proud of them". Having lost his father to suicide when he was very young, he never recovered and like "too many Aboriginal boys his pain was met with silence, judgment and incarceration - not care, not healing."

10. One of the consequences of his long incarceration was that he was deprived of the opportunity to be present for his family and particularly his children. Ms Alvarez had tried to maintain a relationship with Felipe over the years he spent in custody. She made no criticism of the justice system and the prison system in which Felipe had spent so many years. In her view, it kept him alive. He died too soon after being released. He was trying to rebuild his life and had come to the ACT for a fresh start. He was not a hard man, but a "gentle giant" willing to help and mentor others. His life mattered. He sought help because he was vulnerable and he needed holistic care. In her mind that is not what he received.

THE FINDINGS I AM REQUIRED TO MAKE

11. I am required to make manner and cause of death findings (section 52(1) of the Act) and, (if relevant), public safety findings (section 52(4) of the Act).

12. For ease of reference the relevant portions of those provisions are reproduced:

> **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.
>
> (2) A coroner holding an inquiry must find, if possible—
>
> (a) the cause and origin of the fire or disaster; and
>
> (b) the circumstances in which the fire or disaster happened.
>
> (3) At the conclusion of an inquest or inquiry, the coroner must record the coroner's findings in writing.
>
> (4) 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.
>
> (c) …

PROCEDURAL HISTORY

Background and Interlocutory rulings

13. Pursuant to section 34A of the Act, a coroner has a discretion as to whether to hold a hearing in an inquest. In the absence of any provision prescribing how a hearing should be conducted, a coroner may determine the procedure to be followed in a hearing: section 51A(2)(b). For the reasons separately published (*Inquest into the death of Felipe Esteban Alvarez (No. 1*) ("my previous decision"), I determined that I would call only one witness at the hearing and otherwise rely on the information already at hand in the inquest to make the findings required by section 52. The purpose of the hearing was to elaborate the evidence available to me in respect of the public safety issues that seemed to arise from the inquest into Mr Alvarez's death. That was most efficiently achieved by calling Mr Chris Gough, the Executive Director of CAHMA, as the single witness at the hearing. I acknowledge that the approach of not calling those people who were present during the death of Mr Alvarez was not supported by his family.

14. Following my interlocutory ruling a hearing was conducted on 4 and 5 August 2025.

15. At the hearing, apart from Counsel Assisting, appearances were announced separately on behalf of Ms Emma Snazelle and Ms Gabrielle Alvarez, sisters of Mr Alvarez. Mr PK and Ms KT were present during the hearing and could ask questions of the witness and make submissions if they chose to do so. The other people who were present at the scene of Mr Alvarez's death before the attendance of emergency services workers - Ms DK, Ms NB and Mr XD - were not present at the hearing. This was despite the extensive efforts of the Court to encourage their attendance and participation as people having a sufficient interest in the inquest.

PART 1 – MANNER AND CAUSE OF DEATH – SECTION 52(1) OF THE ACT

THE CIRCUMSTANCES SURROUNDING MR ALVAREZ'S DEATH

Mr Alvarez's Recent Past

16. Over his adult life, Mr Alvarez battled with issues concerning addiction to illicit drugs (including heroin and amphetamines). He had an extensive criminal history and his offending to some extent was influenced by those addiction issues.

17. He moved to the ACT in 2020 with the help of his family to have a "fresh start". He had recently been released from prison in NSW having served a lengthy prison term for robbery related offences. After moving to the ACT, he had secured accommodation through ACT Housing in a two-bedroom unit in Taylor in the ACT ("the unit").

18. In the time between his release from prison in 2019 and his death he had been using illicit drugs. He was known by others to be a user of illicit drugs. The extent and frequency of that use is difficult to determine. That issue is important as the expert evidence available to me suggested that the regularity or otherwise of his recent heroin use could be an important matter in determining his potential vulnerability to overdose.

Involvement of CAHMA Employees

19. The role played by CAHMA in drug harm minimisation in the ACT is developed below. As at the day of Mr Alvarez's death Mr PK and Ms KT were employed as paid peer workers with CAHMA but were not on duty on the day of his death. Mr PK commenced as a casual employee on 23 March 2020. He was employed in the position of "Peer Worker" and typically worked one five-and-a-half hour shift a week each Tuesday and occasionally worked additional shifts. He had volunteered with CAHMA for about a decade prior to his employment.

20. Mr PK was rostered on to work on 30 March 2021 but texted David Baxter, CAHMA's Naloxone Manager, at around 0930 hours to say that he was sick and would not be coming into work. Consistent with Mr PK not having worked his shift that week, there is no payslip for him in the subpoenaed material produced by CAHMA for the pay period covering 30 March 2021, and he is not recorded on the CAHMA Staff Movements Record Sheet as signing in for work on that day.

21. Ms KT had commenced as a casual employee on 2 July 2020 but was not rostered to work on 30 March 2021.

22. It is also an important part of the narrative of events to note that one of Mr Alvarez's sisters, Ms Gabrielle Alvarez, was also employed by CAHMA.

Obtaining and consumption of the drugs that were relevant to Mr Alvarez's death

23. In my previous decision, I indicated there were findings of fact that were open to me as to:

    (a) how the drugs relevant to Mr Alvarez's death were obtained and consumed; and

    (b) how those present reacted to Mr Alvarez's apparent overdose.

24. I am satisfied on the basis of the evidence before me that those findings, with only slight modification, should be made. Some of the parties suggested that they didn't agree with the foreshadowed findings of fact. Those affected by these findings were given the opportunity to provide relevant evidence from the witness box. None of them chose to.

25. In very broad terms, the coronial investigation suggested that a number of people (including the affected people) were present in the unit before Mr Alvarez's death:

    (a) Ms NB

    (b) Mr XD

    (c) Mr PK

    (d) Ms DK

    (e) Mr NE

    (f) Ms KT

26. All of them were known to Mr Alvarez to a greater or lesser extent.

27. Two days before his death, Mr Alvarez went to Sydney with Ms NB, Mr XD and Mr PK to purchase drugs. Mr Alvarez asked Mr NE, a neighbour, to look after the residence and his dog.

28. During the morning of 30 March 2021, Mr Alvarez, Mr PK and Ms DK all injected heroin from a bag of heroin Mr Alvarez had obtained in Sydney the day before.

29. Soon after injecting the heroin, Mr Alvarez got “jelly legs” and started to fall to the ground. Mr PK and Ms DK recognised that as a sign of an overdose.

30. Ms DK called for Mr PK and he caught the deceased and lowered him to the ground on the floor in or near the kitchen.

31. Mr Alvarez was turning purple and not breathing and Ms DK started chest compressions. It is likely that by this stage, Mr Alvarez was “overdosing”.

32. Mr XD and Ms NB who had temporarily left the unit before Mr Alvarez injected himself, returned to the residence.

33. As they were walking up the stairs, they heard Ms DK and Mr PK yelling, “He’s overdosed, Phil’s overdosed”. They walked into the unit and saw the deceased on the ground.

34. Either Mr PK or Ms DK were doing chest compressions. Mr XD may have taken over chest compressions at some point.

35. At the time, Mr Alvarez was not his normal colour, and he was not breathing or not breathing properly.

36. After the CPR was administered, the people present determined that Mr Alvarez was breathing, and they left him on the floor but put him on his side, possibly in the recovery position.

37. He was left in that position for a period of time (possibly some hours).

38. No one called an ambulance and naloxone was not administered. Calling an ambulance would have been consistent with the training that Mr PK and Ms KT had received through CAHMA. Mr PK did not have naloxone with him, even though he attended the residence with the intention of using heroin and had been supplied with “2 naloxone packs [four doses] on request two weeks beforehand on 16th March [2021]”. It was open to Ms KT to obtain naloxone and bring it with her.

39. Ms KT came to the unit during the morning and probably consumed some heroin. She was aware, or was made, aware by others present that Mr Alvarez had overdosed.

40. Later (and perhaps hours later) one or more of those present checked to see if the deceased was breathing. He was not. Mr XD checked for a pulse but could not find one. Ms NB also noticed around this time that Mr Alvarez was no longer breathing.

41. Mr PK and Mr XD rolled Mr Alvarez over. His face was blue. They started chest compressions and Ms NB called an ambulance. The call was made at 1233 hours.

42. A transcript of the call was before me at the hearing. Ms NB told the 000 operator that Mr Alvarez was "unresponsive. He's not breathing. He's blue". She was not frank about the circumstances of his collapse. When asked what the cause "could have been", she said she was "not quite sure". She did not mention anything about the use of drugs or a possible overdose. She told the operator that her partner was "working on him".

43. The 000 operator gave instructions about how to perform CPR and advised that two ambulance crews and a fire brigade unit were on the way. An unidentified male shouted in the background, "He's still unresponsive" and asked whether he should continue to do compressions. The operator told him that he should.

44. The operator asked, "When was the last time that you saw him alive – awake?", Ms NB responded to say they had been with him most of the day and that "we came into his room, and he was on the floor" so her partner checked on him. She said her partner (Mr XD) was "very well trained".

45. The operator asked if the patient had any health problems. Ms NB said "no" but added that he was very overweight and that she thought he might have low blood pressure. She also said he had been awake for a couple of days and "they could be contributing factors". She said "there was nothing that was significantly outstanding. It was almost like he had a fit…".

46. Ms NB told the operator that she would wait out the front to meet the ambulance crew.

47. An ACTFR crew arrived at the unit first. When they went up the stairs to the unit (at about 1241 hours), they saw Mr XD and Ms DK with Mr Alvarez performing chest compressions. The ACTFR crew took over the chest compression, attached an Automated External Defibrillator ("AED") and provided oxygen through an airway tool that had been inserted. ACTAS arrived at 1246 hours. They took over resuscitation efforts. Mr Alvarez was in cardiac arrest. He had no pulse and was not breathing. His pupils were fixed and dilated, he was unresponsive and had track marks on his arms. Despite prolonged resuscitation efforts over about an hour, Mr Alvarez could not be revived. At 1348 hours, ACTAS told attending police that Mr Alvarez had died.

48. Below is an extract from ACTAS records of their attendance upon Mr Alvarez:

> Per bystanders on scene, pt (sic) injected heroin at approximately 1200 hours and fell unconscious. They performed cardiac compressions on him for approximately 5 to 10 minutes. He resumed spontaneous breathing, and they

> place him in the recovery position and went to the units' balcony to have a smoke. They returned approximately 15 minutes later and found the pt (sic) prone, unresponsive and not breathing. They called 000. CPR commenced ...
>
> Several bystanders close by with one combative and agitated. Yelling at ACTAS and ACTF&R personnel on scene to administer naloxone.

Police Arrival and Scene Investigation

49. The AFP attended at 1303 hours. That afternoon a Forensic Medical Officer ("FMO") and AFP Forensic Examiners examined Mr Alvarez's body in situ at the unit. Nothing suspicious (that is, evidence of active 3rd party involvement causing the death) was found. The unit was searched. It was generally in a clean and tidy state. There were indicia of drug use in the unit. At least some of the drugs referred to above were found in two freezer bags on the balcony. It is not clear whether the drugs that were found were the total of the drugs obtained in Sydney.

50. The drugs were subsequently analysed. The methylamphetamine was approximately 26.53 grams in weight with a purity of 75%. The heroin was approximately 27.8 grams in weight and was 35% in purity. The possession of drugs of that trafficable quantity exposes a person to possible criminal penalty. Both drugs are controlled drugs. A person commits an offence if the person traffics in a controlled drug other than cannabis. The maximum penalty that applies is 1000 penalty units, and imprisonment for 10 years or both.[1]

Post-mortem examination

51. On 31 March 2021, Coroner Lawton directed that there be a postmortem examination of the deceased. Dr Sajiv Jain, a pathologist, performed the autopsy at the ACT Forensic Medicine Centre, Phillip, ACT on the same date. Relevantly, post-mortem toxicology showed the presence of:

    (a) Amphetamine at 0.05 milligrams per litre;

    (b) Methylamphetamine at 0.47 milligrams per litre.

    (c) Morphine at 0.10 milligrams per litre; and

    (d) Tetrahydrocannabinol (cannabis) 6 nanograms per millilitre.

52. Trace amounts of diazepam, nordiazepam and codeine were also detected.

[1] See section 603 of the Criminal Code 2002(ACT)

53. The presence of morphine in blood can be an indicator of heroin use, as can small amounts of codeine. The level of drugs found were the subject of commentary by ACTGAL in their report to Dr Jain. The levels of morphine, amphetamine and methylamphetamine span concentrations that have been observed in cases where:

    (a) no ill side effects have been observed;

    (b) where the effects were described as "toxic"; and

    (c) in cases where death has been occasioned.

54. As noted below, the blood concentrations of morphine and amphetamines are difficult to interpret especially as the toxic effects of those drugs will depend to a significant degree on the prior pattern of usage and the degree of tolerance that has been acquired.

55. The post-mortem examination also revealed biventricular hypertrophy with an enlarged heart. Biventricular hypertrophy involves the thickening of both the left and right heart ventricles. If left untreated, severe biventricular hypertrophy can lead to heart arrhythmia, heart failure, and sudden cardiac death. This heart pathology can be associated with extended amphetamine use. There was no coronary artery disease. There was bilateral pulmonary oedema.

56. Dr Jain's opinion was that Mr Alvarez died from "toxicity caused by a combination of methylamphetamine[2] and morphine". His opinion was that the biventricular hypertrophy may have contributed to death but did not cause it.

57. Expert evidence was sought as to the effects of the drugs that were detected at post-mortem. Professor Drummer, one of Australia's leading toxicologists, was approached to provide an opinion as to the significance of the toxicological findings. Relevantly, his opinions were:[3]

> The presence of bilateral pulmonary oedema of the lungs is commonly observed in deaths associated with cardio-respiratory deaths associated with heroin or when lung function is impaired for a period of time.
>
> The toxicology analyses on peripheral blood confirmed the presence of morphine and methylamphetamine. Morphine may have derived from the use of heroin, since it is readily metabolised to morphine and accords with the circumstances of a likely purchase of a heroin-like substance. Given the circumstances, it is assumed that the

[2] The terms "methylamphetamine" and "methamphetamine" are used interchangeably according to the preference of the person quoted. These reasons have otherwise used the term "methylamphetamine".

[3] Paragraph numbers and references have been deleted and emphasis added.

morphine has derived from use of heroin. Ideally, the presence of 6-acetylmorphine in blood, or most often urine, confirms prior use of heroin.

Given the relatively rapid metabolism and elimination of heroin (largely through morphine and morphine conjugates) it is probable that the blood concentration of morphine will have been much higher soon after the injection. It is also probable that the often-detected immediate heroin metabolite, 6-acetylmorphine, will have been completely metabolised to morphine and morphine conjugates, and partly eliminated.

While heroin (and morphine) is a drug of a high risk of causing a fatal response there is no obvious fatal dose or fatal blood concentration given the large variability in response by users, particularly in that tolerance to the effects will occur with regular use. This leads to a lower risk of an overdose; however, it is not known to what degree the deceased was tolerant to heroin (or other opioids) and what dose was injected.

The use of the term 'regular drug user' may not imply regular use of one drug, e.g. heroin. Less than regular, that is daily or almost daily use of heroin is unlikely to cause significant tolerance.

Importantly, the presence of methylamphetamine, either because it was present in the injection with heroin, or was used separately, can increase the risk of a fatal reaction (overdose). In the USA the combined use of opioids with methamphetamine (often termed a 'speedball') have led to a large increase in deaths. However, the effects of the combined use of these two drugs are not necessarily certain since it depends on the relative doses of the two drugs and what tolerance, if any, has been developed to these drugs.

The use of both drugs together, or other opioids with methylamphetamine, depending on the doses and relative doses, can enhance the sense of euphoria and well-being, however since both drugs can at least affect cardiovascular function the use in a person with a potentially compromised cardiovascular function may further increase the risk of acute cardiac arrythmias.

While cannabis use is often not considered as a cause of death when other causes are identified, there is evidence that cannabis can trigger occasional serious medical emergencies and sudden death. A positive blood concentration of THC in a situation of significant heart disease, which has been found in the deceased, may contribute to sudden or unexpected death. This risk may be higher again, when drugs such as heroin and methylamphetamine are also affecting cardiovascular function.

58. Based on Professor Drummer's evidence, I find that the drugs consumed by Mr Alvarez were individually and collectively dangerous to consume and individually and collectively capable of causing death. I am not able to say whether his usage on the day of his death was consistent with an established pattern of usage. His heart condition made him vulnerable to cardiac arrythmia when using illicit substances. Cardiac arrythmia may have been associated with his death.

AN APPROPRIATE RESPONSE TO MR ALVAREZ'S COLLAPSE

Medical Issues

59. The Court sought expert advice as to what an appropriate medical response to an overdose would be. Mr Howard Wren was the Chief Officer of ACTAS from 2017 to March 2025. He holds a number of qualifications including nursing and paramedic certificates and a bachelor's degree in clinical practice. ACTAS responds frequently to calls where overdose to drugs and medications is suspected.

60. In a statement dated 25 June 2025, Mr Wren expressed these opinions (emphasis has been added):

> The term "collapse" is assumed to mean a sudden deterioration in conscious state and subsequent falling.
>
> In the context of using illicit opioids, some degree of sedation is common and expected, and the distinction here is the sudden nature of the onset of action.
>
> Overdose would generally be the most likely cause of collapse if observed soon after taking illicit drugs.
>
> Anaphylaxis is a possible alternative cause, but this would be unusual.
>
> Immediate action should be to check the level of consciousness. If that is found to be significantly depressing, the person should be monitored closely, and steps taken to protect the airway. This is most easily achieved by rolling the person onto their side. The rate and depth of breathing should be checked and carefully monitored.
>
> Safe practice would suggest that an ambulance be called at this time. If naloxone is available, it should also be administered in this situation.
>
> …….
>
> As a generalisation, collapse with unconsciousness represents a potential medical emergency and an ambulance should be called immediately.

> If CPR was applied, the most significant sign of recovery is improvement in the level of consciousness. The appearance of breathing that is not accompanied by an improvement in level of consciousness is still an indication of concern. The strong recommendation in this situation would be that an ambulance is called.
>
> …….
>
> The situation of collapse does suggest a greater effect than what might usually be expected. As such, it is a possible indicator of significant overdose.
>
> Snoring indicates some obstruction of the upper airway. In the setting of ingestion of an opioid, this would indicate a significant degree of depression of consciousness, with consequent higher risk of hypoxia[4].

61. It is not suggested that those present at the scene when Mr Alvarez collapsed were medically trained.

The Use of Naloxone

62. Naloxone is a drug that can temporarily reverse the effects of an opioid overdose. Naloxone can be taken by injection or by administration as nasal spray. It operates by blocking opioid drugs (such as heroin) from attaching to opioid receptors in the brain that are causing respiratory depression. Its effects may be temporary (it lasts between 30 and 90 minutes) and a person can overdose once it wears off.

63. Naloxone is listed on the Pharmaceutical Benefits Schedule ("PBS"). Pharmacies, doctors and hospital pharmacies in all states and territories can supply naloxone to individuals as well as alcohol or other drug treatment services.

64. Naloxone and its use by CAHMA is a subject that is developed below. It is noted that given that they went to Mr Alvarez's unit in anticipation of using opioids, Ms KT and Mr PK should (according to the training that had been given to them by CAHMA) have had naloxone with them.

Reasons for not calling an ambulance

65. It is difficult to establish with precision why those present acted in the way they did in not calling 000 promptly. Not all of those present were later prepared to speak to the AFP. Of the bystanders who were interviewed by the police, little by way of explanation was given. Ms DK, for example, acknowledged "we should have maybe called the ambulance straight away, just to be on the safe side". Mr PK was not expansive in his response to

[4] Relevantly to overdose, brain damage caused by reduced supply of oxygen to the brain as a result of depressed breathing.

questions asked by the police. He was not asked directly why he didn't call an ambulance and did not offer an explanation of why that did not occur. Ms NB said she had "triple-O ready on dial, waiting for [Mr XD] to call it". After recounting the efforts to resuscitate that lasted in her mind over an hour and half, she felt that "Bull" (Mr Alvarez's nickname) "needed a sleep" because "he had been partying a bit lately" and "he might get the shits if we wake him up now".

Consequences of the failure to promptly call an ambulance

66. The calling of an ambulance after Mr Alvarez's initial collapse was at the very least a "safe practice". The severity of his initial reaction, the period of a loss of consciousness and the cessation of breathing suggested a medical emergency.

67. It is difficult to determine what the consequence of the delay in calling 000 was. Mr Alvarez's breathing stopped when he collapsed. His heart conditions may have made him more vulnerable to cardiac arrythmia and a heart irregularity may have formed part of the condition requiring medical attention.

68. Whilst his breathing was restored after CPR was first performed, it is impossible to determine the period of depressed breathing and unconsciousness and whether the cessation of breathing caused hypoxic damage to Mr Alvarez's brain, such as to render him unconscious but to not immediately cause death. Medical intervention administered at that stage may not have been able to restore Mr Alvarez to consciousness without ongoing impairment arising from brain damage. On the other hand, it may be that Mr Alvarez did not suffer life threatening injury after he initially collapsed and that medical intervention after the first episode of unconsciousness may have saved his life. A third possibility is that he was suffering depressed breathing in the period after the first use of CPR (evidenced perhaps by the snoring that was heard) and that he suffered hypoxic brain injury at that time. The autopsy findings do not allow these scenarios to be differentiated as the least or most likely. I also observe that the time taken to call an ambulance after his second collapse is difficult to determine and it is similarly difficult to determine what the consequence of that further delay (if significant) might have been.

69. All that can be said is that if, when his breathing was first restored, Mr Alvarez had a chance of survival, that chance was potentially taken from him by a delay in administering appropriate care through:

    (a) (in the first instance) calling an ambulance; and

    (b) allowing his medical condition (including heart irregularities) to be holistically and expertly assessed.

70. The significance of the absence of naloxone in the context of Mr Alvarez's treatment by bystanders is impossible to quantify. Administration of naloxone when he initially collapsed may have restored him to consciousness more quickly or it may not have. Its use when he was later observed to be not breathing may or may not have improved his condition. If he had already suffered hypoxic brain injury the effects of the administration of naloxone are likely to have been significantly diminished. The fact that Mr Alvarez may have had compromised heart function also makes it difficult to assess the impact of naloxone had it been administered.

Referral to DPP

71. My previous decision noted that the circumstances of Mr Alvarez's death had been referred to the Director of Public Prosecutions ("DPP") pursuant to section 58 of the Act and that the DPP had advised that no charges would be preferred in respect of Mr Alvarez's death. I indicated that the position would be re-considered in light of the evidence called at the hearing. There was no fresh evidence arising from the hearing that suggested to me that it was appropriate to refer the matter to the DPP again.

FINDINGS - SECTION 52(1) OF THE ACT

Cause of Death

72. Based on the information before me, I find that Felipe Esteban Alvarez died at approximately 1348 hours on 30 March 2021 at a unit in Taylor, in the Australian Capital Territory. I find that the disease or condition directly leading to death was toxicity caused by a combination of methylamphetamine and morphine (ingested as heroin). Biventricular hypertrophy and an enlarged heart contributed to death but did not cause it.

Manner of Death

73. I make the following findings as to the manner of Mr Alvarez's death:

    (a) At the time of his death Mr Alvarez was a user of heroin and other drugs although his pattern of use is not known.

    (b) With others he purchased the drugs that caused his death in Sydney on or about 29 March 2021. Those drugs were purchased in quantities that are considered trafficable under the Criminal Code 2002 (ACT).

    (c) He voluntarily ingested the drugs that caused his death. It is inferred that his experience in the use of such drugs alerted him to the dangers associated with their use.

(d) He took those drugs by injection (self-administered) in the company of others.

(e) He collapsed in a state of unconsciousness soon after taking the drugs and stopped breathing.

(f) Naloxone was not administered.

(g) It was apparent that his condition was a medical emergency and that an ambulance should have been called.

(h) Although his breathing was restored after resuscitation, he had not been breathing for some time. It should have been obvious that any medical repercussions of that reality should have been urgently explored.

(i) He was left to "sleep it off" probably for some hours. The fact that he was breathing was assumed by those present to be an indication that the cause of the overdose had receded. The fact that Mr Alvarez was snoring was possibly an indication of respiratory suppression that may have reflected, or exposed him to, hypoxic brain injury.

(j) Those present in the room when Mr Alvarez collapsed also consumed heroin and/or methylamphetamine from the quantity of drugs obtained in Sydney.

(k) After a considerable period of time, Mr Alvarez again stopped breathing. It is unknown how long he had stopped before that was recognised. Attempts to resuscitate him by those present were unsuccessful.

(l) It is unclear how long the period was between the recognition that he had again stopped breathing and the 000 call made at 1233 hours.

(m) Ms NB misled the 000 operator by giving a false account of how and when Mr Alvarez became unconscious.

(n) The account given by one or more of the group to attending paramedics similarly involved misrepresentations as to the circumstances of Mr Alvarez's collapse.

(o) The conduct of the group in not calling for medical help immediately upon Mr Alvarez's initial collapse and providing misleading information to ACTAS was morally blameworthy and showed a chilling indifference to the possibility of a loss of a life. Their conduct deprived Mr Alvarez of any chance of survival he may have had after his initial collapse.

(p) I am not able to say with certainty why an ambulance was not called. Self-interest, including concern as to the possible involvement of the police, is likely to have been one of the motivating factors.

(q) Mr PK and Ms KT may (this is addressed further below) have acted contrary to the training that they had received through CAHMA by:

i. not bringing naloxone with them to the unit when it was reasonably anticipated that heroin would be consumed; and

ii. by not calling an ambulance when present or being made aware of Mr Alvarez's initial collapse.

(r) I am not able to be satisfied on the balance of probabilities that the actions or inaction of those who were present caused or contributed to the cause of Mr Alvarez's death.

(s) Mr Alvarez's death is appropriately described as an accidental drug overdose.

PART 2 - PUBLIC SAFETY ISSUES – SECTION 52(4) OF THE ACT

SECTION 1- THE ROLE OF CAHMA – RESPONSE AND GOVERNANCE

Introduction – The Scope of the Inquest

74. The jurisdiction granted to me under section 52 of the Act constrains my examination of matters of public safety to those that "arise" in "connection with" the inquest.

75. Given an inquest is primarily focused on determining the manner and cause of a death, it is not open to me or any other coroner to investigate matters that might be referred to in evidence as if acting as a Royal Commission. It is important to state clearly what was not within the scope of the inquest:

(a) The inquest did not canvass harm minimisation strategies generally.

(b) The inquest did not focus on whether in general terms the harm minimisation approaches of CAHMA were effective or whether generally its management processes were, or presently are, fit for purpose. In that respect, the material before the inquest disclosed that CAHMA, before and after Mr Alvarez's death, had been the subject of more than one independent evaluation suggesting there were measurable public health benefits arising from its work.

(c) CAHMA represents a unique (as far as the Territory is concerned) attempt to progress harm minimisation strategies from within the drug taking community rather than trying to impose outcomes from above.

(d) Whilst drug laws in the ACT have been modified in recent years to place greater emphasis on de-criminalisation of certain forms of drug possession, the inquest did not seek to evaluate the effectiveness of those changes,

although they do represent a significant background circumstance relevant to how drug users might respond to an episode of overdose.

76. The following points should also be made so that the findings made in the inquest are placed in appropriate context:

    (a) CAHMA does not represent the totality of how the ACT responds to illicit drug use or the dangers that can arise from that use. Canberra Health Service, medical practitioners, ACTAS, the AFP (and other front line responding agencies) and various other NGOs all have a role to play at the front line of dealing with that issue and providing appropriate health messaging in the area of harm minimisation.

    (b) Although CAHMA does receive monies from the Government, its budget is relatively modest and the effectiveness of its operation is heavily reliant on a small number of full-time staff, part time workers and volunteers.

77. I received submissions from CAHMA as to the findings I should make including submissions as to the public safety issues I was entitled to consider. The submissions advanced the general proposition (which I seek to paraphrase) that a coroner was not able to make public safety findings or comments unless there was causal link between a safety failure or shortfall and the manner and cause of the deceased's death. Put as starkly as that, the submission is rejected. Whilst I have conceded there are limitations on my power to investigate and make comment, there is ample authority that the power of a coroner to make public safety recommendations in respect of safety issues that arise from an inquest is not predicated on there being a directive causative association between the identified safety issue and the relevant death: see *Doomadgee v Clements [2005] QSC 357*, at 360; *Thales Australia Limited v The Coroners Court & Ors [2011] VSC 133*. Otherwise, CAHMA's submissions focused centrally on submitting that I should not make findings or recommendations that might compel peer workers to refrain from illicit drug use when interacting with "service users". That proposition is addressed below.

The Role of CAHMA in Harm Minimisation

78. The National Drug Strategy[5] is made up of three parts:

    (a) Demand reduction;

[5] The *National Drug Strategy 2017–2026* is Australia's overarching policy framework (negotiated between Commonwealth, State and Territory Governments) aimed at preventing and minimizing the harmful effects of alcohol, tobacco, and other drugs.

(b) Supply reduction; and

(c) Harm reduction.

79. A reduction in demand is achieved by education and drug treatment programs aimed at discouraging drug use. Supply reduction involves restricting the supply of drugs largely through law enforcement activity. Harm reduction (minimisation) aims at reducing the harm done by drugs through community-based programs and initiatives often funded by governments. Some of those initiatives - HIV education campaigns, needle exchange programs, drug or pill testing and safe injecting rooms - are strategies that have been implemented in different parts of Australia.

80. In a statement provided to the Court and in his evidence, Mr Gough provided a comprehensive outline of the history of CAHMA and the role played by CAHMA in the ACT's harm minimisation strategy. Part of that outline included the following description of CAHMA's role:

> CAHMA is a peer-based harm reduction service, run by and for people who use or have used drugs and/or drug treatment services. The harm reduction strategies and programs developed by CAHMA are not premised on advocating for abstinence from drug use. Instead emphasis is placed on education and the provision of supports, material aid, and services to reduce the harms of drug use.

81. Mr Gough emphasised that CAHMA values the lived or living experience of its workers and volunteers and, as part of its philosophy, anticipates that its workers or volunteers may be actively engaged in the use of illegal drugs.

82. Mr Gough outlined the leading role that CAHMA has played in Australia in developing and trialling programs for the wider distribution of naloxone within the drug taking community. The Take Home Naloxone Program ("THN") is now a national scheme. Under license CAHMA obtains naloxone from the Commonwealth under the THN and distributes it (in an accountable way) for use by opioid users through its peer support and peer treatment support workers. Volunteers and employees are offered take-home naloxone kits.

83. CAHMA has a Board of Directors, comprised of seven elected positions with two-year terms, and two seconded or appointed positions. Mr Gough is the Executive Director of CAHMA and has held that role since March 2016. It is apparent that he has played a critical role in the development of CAHMA and that the organisation has been heavily reliant on his work and endeavour.

84. CAHMA is funded through both the ACT and federal governments as well as other grants and contracts. For the financial year 2025-2026, the total budget for CAHMA was around $2.1 million. Approximately just under $1 million came from the ACT Health Directorate, with approximately $600,000-$700,000 coming from the federal government through the Primary Health Network for the ACT (the Capital Health Network), and the remainder was from other grants and subcontracts.

85. CAHMA presently employs 12.9 full-time equivalents: four full-time, eleven part-time and ten casual workers. This includes a naloxone co-ordinator. As at March 2021, CAHMA employed eight full-time equivalent: two full-time, seven part-time and eleven casual workers.

86. CAHMA provides a number of services and programs, including:

    (a) Peer Treatment Support and Case management;

    (b) Naloxone Program;

    (c) The Connection;

    (d) The Drop-in Centre;

    (e) Community Development Program; and

    (f) Community barbecues.

87. As part of the naloxone program, CAHMA also provides naloxone brief intervention training and supplies naloxone to peer workers to be given to opioid users. This program aims to mitigate risks associated with potential overdose.

88. CAHMA also works with CanTEST Health & Drug Checking to develop systems for testing illicit drugs that are available within the drug using community.

89. For the 2020-2021 financial year, the total budget for CAHMA was around $1.3 million. As at March 2021, CAHMA had around 50 to 75 people coming through the drop-in centre each week, several hundred people attending outreach barbecues, and around 60 people engaging in the peer treatment support service. Mr Gough gave evidence that at the time of the hearing, there were between 75 to 100 people coming through the drop-in centre each week, several hundred people attending outreach barbecues, around 80 to 90 people engaged in peer treatment support at any one time, and around 500 people complete naloxone training over the course of the year. I accept Mr Gough's evidence that CAHMA was and is uniquely placed to play an educative role amongst drug users to improve their safety.

Integrity Processes

90. The CAHMA harm minimisation model carries with it inherent risks which are, in general terms, acknowledged by the organisation itself. Staff who may have criminal records and who may be active drug users are employed to engage with drug taking peers and by encouragement, counselling, support and education try to influence users to use illicit drugs in the safest way possible. By the use and distribution of naloxone CAHMA can and does play a role in mitigating the consequences of overdose.

91. One of the risks associated with this model is that public monies can become an indirect support for the drug taking practices of peer workers and their clients. The integrity of peer and peer support workers and appropriate governance structures within CAHMA are critical to ensuring this does not occur. Criminal record checks, Working with Vulnerable People processes, good training and the development and enforcement of Codes of Conduct are central tools in ensuring that the selection process for peer workers has rigor and that there is an ongoing reminder of a peer worker's ethical obligations.

92. Mr Alvarez's death highlights how a lack of integrity amongst peer workers and poor governance in respect of the recruitment of appropriate staff can expose others to the potential for health-related harm.

Mr Alvarez as a Client

93. An issue arose during the inquest as to whether it was appropriate to regard Mr Alvarez as a client of CAHMA. As is developed below, the categorisation was important as CAHMA's Codes of Practice and directions otherwise given to staff[6] make clear that staff are to refrain from taking drugs in the presence of clients. Appropriate boundary setting would require nothing less. The categorisation also coloured how CAHMA responded to Mr Alvarez's death.

94. There is no dispute that Mr. Alvarez had historically been a client of CAHMA. The view taken by Mr Gough at the time of Mr Alvarez's death and at the hearing was that he was not a client of CAHMA at the time of his death. Mr Gough relied on CAMHA's digital document management system as evidencing that fact. Those records indicate that Mr Alvarez commenced a "treatment episode" as a client of CAHMA on 3 March 2020 and that he ceased being a client on 26 June 2020, when he was transferred to another service provider. Mr Gough referred to this as the "treatment episode" being closed.

[6] There was some ambiguity in the evidence associated with the use of the terms "peer worker and "peer support worker". The Code of Conduct is expressed to apply to "the Board" , "staff" and "volunteers". The expression "staff" is adopted here.

95. Mr Gough agreed, however, that the fact that the treatment episode was closed did not mean that Mr Alvarez was no longer a CAHMA "service user" or "client". In the records of the organisation, including email exchanges, there was evidence of "service contact" occurring after that day and acknowledgement that Mr Alvarez remained a client of the organisation. Ultimately, Mr Gough conceded the possibility that the case management relationship between Ms Gabrielle Alvarez and Mr Alvarez had persisted after 26 June 2020 and that it was possible that Mr Alvarez was a client of CAHMA's at the time of his death.

96. On this evidence and Mr Gough's concession I find that Mr Alvarez remained a client of CAHMA's at the time of his death.

CAHMA's Frontline Workers - Peer and Peer Support Workers

General

97. All CAHMA workers are "peer workers". Peer workers have various roles including engaging in outreach, providing broad services, and interacting with CAHMA service users or CAHMA clients. In relation to this terminology, Mr Gough explained that 'service user' was a more 'universal' descriptor of someone who is using a service of CAHMA, whereas 'client' tended to connote a person who was using a service of CAHMA in a more engaged way, for example, as part of the peer treatment support program.

98. In a supplementary statement and in his evidence, Mr Gough explained that "peer treatment support workers" are a particular type of "peer worker" that "work individually, [to provide] one-on-one support with a service user or client on that client's health and wellbeing as part of the peer treatment support service".

99. The requirements attaching to appointment as a peer treatment support worker are more exacting than to be a general peer worker. However, both streams are subject to CAHMA's workplace policies and procedures and the Code of Conduct as they are "staff" of CAHMA.

Drug Taking

100. When peer workers engage in outreach services, they are considered to be at work. As has been noted, peer workers may themselves be active drug users. Mr Gough explains the rationale for this as follows:

> As a harm reduction service we understand that abstinence from drug use is only 1 goal for people seeking ATOD[7] treatment and that this is not everyone's goal, or

[7] Alcohol, Tobacco and Other Drugs

even most people's goal. Harm reduction seeks to engage with people where they are at in their health and wellbeing and for this reason they may be currently using drugs. We also recognise that many people in society use drugs in a non-problematic way and that for the majority of people who use drugs abstinence is not their goal and they want to continue to use drugs in a way that causes as little harm as possible.

CAHMA workers are peers and therefore reflect this diversity – with some being abstinent from drug use and others identifying as someone who still uses drugs. CAHMA manages this diversity by having a strong code of conduct and drug and alcohol procedure which focus on people's behaviour at work. Just like any other organisation we require people to attend work not under the influence of drugs or alcohol. CAHMA respects people's privacy and doesn't insist on people being abstinent as a pre-requisite of employment.

101. Mr Gough agreed that CAHMA's approach – which is consistent with other organisations that use a peer support model – potentially puts into contact active users who are peer workers with other active users who could be clients of CAHMA.

102. Indeed, Mr Gough noted that "unlike a registered nurse or a doctor, there is some expectation that people who are on staff will have relationships with … other community members who may become service users or clients".

103. This is an issue that arose in this case, with Mr PK and Ms KT both being peer workers and Mr Alvarez who was a CAHMA client at the time of his death.

Criminal Records and Working with Vulnerable People Checks

104. As noted above, the peer worker model and the assumptions on which it is based exposes CAHMA to some risk as CAHMA employees might encourage others (including clients) to engage in illicit drug use or other criminal activity.

105. Mr Gough explained that it is not unusual for peer treatment or peer support workers to have a criminal record as a history of drug use carries a greater risk of interactions with the criminal justice system. That was the case in respect of Ms KT and Mr PK. Both Ms KT and Mr PK have extensive criminal histories. Ms KT has been convicted for drug offences, dishonesty offences (including burglary in 2005), and offences of violence (including assault occasioning actual bodily harm in 2002 and common assault in 2011). For the offence of burglary, she had been sentenced to 20 months' imprisonment. Mr PK has been convicted for drug offences, dishonesty offences (including aggravated break and enter in 2002) and offences of violence (including armed robbery with an offensive weapon in 2003 and common assault).

106. It is not possible to say whether in light of their history Ms KT and Mr PK should have been employed as peer workers. However, their fitness to be recruited and retained as employed peer workers should have been determined on the basis of a rigorous application of established screening and eligibility tools used by CAHMA.

107. There are (and were at the time) two CAHMA policies or procedure documents relevant this issue:

    (a) Criminal Checks, Working with Vulnerable People & Child Protection Policy (approved by the Board of Directors in February 2019); and

    (b) *Criminal Checks Procedure* (approved by the Executive Director in February 2019).

108. Both policies apply to employees, volunteers, contractors and any other person who undertakes duties for, or otherwise represent, CAHMA, which includes peer workers. The Criminal Checks, Working with Vulnerable People & Child Protection Policy states that CAHMA is "committed to meeting its compliance requirements, which for some contracts includes undertaking criminal record checks". It further notes that "CAHMA has obligations to funding agencies to undertake criminal records checks for all current and prospective workers. These checks will be subject to supporting procedures attached to this policy". These policies applied to Mr PK and Ms KT both when they were volunteers and as employees.

Working with Vulnerable People

109. In the ACT by virtue of the operation of the *Working with Vulnerable People (Background Checking) Act 2011* ("WWVP Act") those working with "vulnerable people"[8] in a "regulated activity"[9] are required to undergo background checks to reduce the risk of harm to those vulnerable people. Those who are struggling with drug and addiction issues with attendant health and medical health issues may fall into the definition of a "vulnerable person". A decision was made in 2018 to apply this process to CAHMA workers and Mr Gough indicated in evidence that CAHMA had asked for an exemption, but it was not granted. Therefore, consistent with general WWVP Act processes,

[8] S7 of the WWVP Act defines a vulnerable person includes an adult who is—
    (i) disadvantaged; and
    (ii) accessing a regulated activity in relation to the disadvantage.

[9] S9 of the WWVP Act provides a person is engaged in a regulated activity if the person has contact with the vulnerable person as part of engaging in the activity.

CAHMA employees are subject to background checking. CAHMA undertakes a process of risk assessment itself in respect of an employee's background.

110. According to Mr Gough, the 2018 decision which required engagement with WWVP processes was implemented gradually, but in 2021 that process of change was not complete[10]. The evidence did not make clear what this meant for the profile of the peer and peer support cohort that was employed by CAHMA in 2021. However, what was clear was that neither Mr PK nor Ms KT held a Working with Vulnerable People card as required under CAHMA's Criminal Checks, Working with Vulnerable People & Child Protection Policy. Whilst this is now a pre-condition to employment with CAHMA, Mr Gough said it did not apply to Mr PK nor Ms KT at the time of the commencement of their employment. Why CAHMA had not applied this pre-condition to existing employees was not made clear but may have been explainable by resource constraints within the organisation at the time. It is also not known what conditions if any apply to CAHMA workers registered under the WWVP scheme. It is also not known how the Commissioner for Fair Trading (who oversees the WWVP scheme) considers evidence or information of ongoing drug use:

    (a) as a matter going to whether registration should be granted; and

    (b) as relevant to whether a CAHMA worker poses an unacceptable risk of harm to a vulnerable person (particularly when that drug use is undertaken with a vulnerable person).

Criminal Records Check

111. The Criminal Checks Procedure states that "CAHMA aims to reduce exposure to criminal activity by", amongst other things:

> Undertaking criminal record checks prior to the employment of staff and engagement of volunteers to ensure that engagement with the criminal justice system has been assessed and any risk to the organisation, or vulnerable people is mitigated and/or removed.

112. Certain offences, including "crimes of violence" and "crimes involving dishonesty" will trigger an assessment. In relation to an assessment, the policy states:

[10] In its response pursuant to the section 55 process CAHMA sought to emphasise that the gradual implementation of WWVP was done in co-operation with Access Canberra and the process was not obstructed or resisted by CAHMA.

> If an employee's criminal records check is assessed as low risk due to no relevant convictions, a record that a criminal record check has been conducted will be placed on an individual's personnel file and the original returned to the individual.
>
> If the assessment includes the identification of a serious offence, it will be referred for a risk assessment. This will be undertaken by the Management Team.

113. A "serious offence" includes an offence that involves violence or dishonesty or is a sex-related offence or serious drug offence. Where a lengthy custodial sentence has been imposed, the offence may also be assessed as serious. Convictions for drug offences do not of themselves disqualify a person from becoming a CAMHA employee. As the Criminal Checks Procedure put it:

> There is a balance to be reached in relation to protection of the organisation, service users and reflecting lived experience.

114. When issued a subpoena by the Court, CAHMA did not produce the criminal records of Mr PK or Ms KT from their own records, nor any documents suggesting it had undertaken any sort of assessment of that kind in their cases. Mr Gough acknowledged in his statement that whilst criminal history checks were standard practice, CAHMA could not "locate evidence of this for" Mr PK and Ms KT. He contended, however, in relation to both Mr PK and Ms KT that "[g]iven [they were] employed", CAHMA "would have been satisfied that" neither "pose[d] a risk to CAHMA or its service users". He did not have a recollection of conducting a check with respect to Mr PK and Ms KT but believed it was done as part of the standard practice.

115. The conducting of criminal records checks conducted by the AFP is subject to audit. The evidence before the Court was that no criminal records checks had been undertaken with respect to Mr PK or Ms KT by CAHMA or by the individuals themselves in 2020.

116. I am satisfied that they were employed by CAHMA without criminal records check being undertaken.

117. Mr Gough agreed that both criminal histories should have triggered a risk assessment, yet there is no evidence that one was done. Mr Gough accepted that "clients, back in 2020 and 2021, could have been put at risk because of [CAHMA's] lack of effective record keeping and diligence in relation to background checking".

Code of Conduct

General

118. In addition to screening processes Mr Gough explained that CAHMA employees and volunteers were subject to a Code of Conduct and various workplace policies. However, he admitted that "a lot of our staff will struggle to navigate these policies and procedures". The Code of Conduct on its face did not reference other provisions within CAHMA's governance structure relevant to any disciplinary processes to enforce defined workplace standards.

119. Mr Gough claimed that CAHMA has:

> a suite of policies and procedures backed up by a code of conduct that ensures that our expectations of … [workers'] behaviour at CAHMA are clear to them, that they can understand clearly what's involved and where our expectations are, and to make clear boundaries for the workers so that we can work safely to the best of our ability and ensure that every service user that comes through CAHMA, regardless of their journey, is treated respectfully and safely.

120. Relevantly, for present purposes, the Code of Conduct states that (with emphasis added) :

> Remember that you are responsible for your own actions and are held accountable for them by the organisation … During our peer work we must maintain professional boundaries in order to keep CAHMA a professional organisation and to protect its clients, volunteers and staff.
>
> [W]hile working and volunteering at CAHMA it is inappropriate to: use drugs on/around CAHMA premises or *engage in any activities around drug use/purchase*"
>
> …..
>
> Please ensure you have read and fully understand the CAHMA Drug and Alcohol Policy and Procedure
>
> ….
>
> <u>Lawful behaviour whilst off duty is not of concern, unless it brings the organisation of CAHMA into disrepute.</u>
>
> …….
>
> [Whilst it] "is not the intention of CAHMA to interfere with [the] personal lives of its employees or volunteers…..

…….

Your other activities should not interfere with, or have impact on your work commitments to CAHMA, nor compromise your position or the position of CAHMA within the community or public at large.

……..

CAHMA, like any organisation, expects its volunteers and employees to be committed to our clients

……

[Y]ou are required to demonstrate an understanding of necessary boundaries between yourself as a service provided and your clients

……

[W]e expect you to maintain appropriate boundaries when dealing with clients

Many of our clients seek our services during particularly vulnerable periods in their lives. So long as a person remains your client, it is inappropriate for you to create a personal relationship (e.g. Sexual relationship) with that client. This includes participation in any behaviour with a client that might contradict your role at CAHMA.

121. Specifically, as to drug use, Mr Gough agreed that the statement that "it is inappropriate to … engage in activities around drug use/purchase" contained in the Code of Conduct (extracted above) was not limited to CAHMA premises but applied generally if working for CAHMA.

122. The position he enunciated was highly nuanced with respect to drug use by CAHMA volunteers or workers with CAHMA service users outside of work. Mr Gough said that such use was "discourage[d]" and referred to the statement that "it is inappropriate to … ask CAHMA staff, volunteers or clients to get drugs for you".

123. Mr Gough accepted, however, there was no reference in the Code of Conduct to any expectation that CAHMA workers or volunteers would not use illicit substances with service users. He explained:

> … So, no, we don't have any expectation that's written like that to say, 'You cannot use substances in your own time with a service user.' … because it will happen. That's the nature of a peer-based organisation … We instead managed the nuance involved by having quite detailed, immersive, if you will, training provided by our operations and community development manager, which utilises the code of conduct

and the policies and procedures but also spends, depending on the person's skill basis, a considerable … amount of time, up to as long as it takes, six months, discussing these boundaries and discussing situations as they occur and trying to enforce these nuances in a way that the person understands them, and then at the end of that process of training, they have to do a written report which answers questions such as boundary issues.

124. Mr Gough said that, as part of this type of training, there could be a discussion to the effect that a peer worker should not be using drugs with a service user, but as a peer-based harm reduction service:

> We do expect that people will use drugs with other community members……..…we have ongoing relationships with our community that lasts for decades so it simply wouldn't be appropriate for us to say, 'You cannot use with service users outside of work'.

125. Notwithstanding this, Mr Gough said that with respect to a peer worker using with a service user, whilst not being a directive, CAHMA would give advice or recommend that the peer worker should not be using drugs with a service user. Whether Mr Gough was consistently differentiating "service users" from "clients" in this context was not clear. CAHMA policy in relation to peer workers using drugs with "service users" and "clients" was in the end somewhat ambiguous as demonstrated by the following exchange:

> *MR LEE: If it's your position that it shouldn't be happening, that is, a client or a peer worker using with a client or a service user, shouldn't that be made abundantly clear in the code of conduct?---I said it shouldn't in an - but I said it does, you know? So, again, we're not a doctor or a nurse. We're not an accredited health care worker. One of our functions is to provide harm reduction within the community and yet we have to balance being an employer as well and making sure that we're respecting people's privacy, so, no. We do expect that people will use drugs with other community members. That is part of our core function as a peer-based harm reduction organisation. … But - but we have ongoing relationships with our community that lasts for decades so it simply wouldn't be appropriate for us to say, 'You cannot use with service users outside of work.' We are dealing here with what happens within - within our remit, which is at work, and then we are providing guidelines while trying to protect the person's right to privacy.*
>
> *THE CORONER: So going back to the bottom line, as it were, do you say, 'No, you should not use drugs with a client.'?---Yes. Yes, we do. We say - think - think - well, we say - if it comes to our attention, we - we talk to the client. We might talk to the client.*

126. However, the Code of Conduct on its face did make clear that even in their private life employees of CAHMA could not engage in lawful conduct (including, it is assumed, drug

related conduct) that compromised the position of CAHMA in the community. I am satisfied that both Mr PK and Ms KT had signed the Code of Conduct and its prohibitions and admonitions applied to them and were known to them. The serious criminal conduct they were possibly involved with – trafficking in and possession of a trafficable quantity of prohibited drugs – was clearly conduct proscribed by the Code of Conduct in its own right and as an example of conduct, for example, that would tend to "compromise the position of CAHMA in the community". It may also have been that the failure to call 000 in the circumstances of this overdose, and the failure to have naloxone with them when opioid drug use was anticipated also involved conduct that compromised "the position of CAHMA in the community".

Re-enforcing integrity processes – how CAHMA responded to Mr Alvarez's death

127. The circumstances of Mr Alvarez's death involved the possible commission of serious criminal offences by employees of CAHMA and a failure to follow the protocols of CAHMA as they applied to overdose cases. The Code of Conduct of CAHMA contemplated that breach of it could lead to "warnings, suspension or dismissal" although no processes were prescribed in the Code for such sanctions to be imposed.

128. The inquest explored why in the circumstances of Mr Alvarez's death there were no Code of Conduct proceedings or other investigative processes in respect of the conduct of Ms KT and Mr PK to ensure that other people's safety was not prejudiced[11].

When did the management of CAHMA learn about the death

129. In a statement provided to the Court, Mr Gough stated that Mr Alvarez's death was brought to his attention "about 1-2 weeks after the death occurred". He was "made aware of this when a staff member told [him] that he had talked to [Ms KT] and/or [Mr PK]". He said in evidence that he did not remember which staff member had told him that.

130. In a file note made within 24 hours of Mr Alvarez's death, Mr David Baxter, CAHMA's Naloxone Manager wrote:

> [Mr PK] texted me at around 9:30AM on Tuesday 30th March to inform me that he was sick and would not be coming into work. I learned that day that [Mr PK] had been present at a fatal overdose. The following day I was told that the overdose victim was Felipe Alvarez, whose sister, Gabrielle, was at that time a member of the management team at CAHMA. All CAHMA staff are trained to recognise

[11] In its response to the provisional findings, CAHMA drew attention to the fact that in 2021 its "suite of policies and procedures" had been adapted from templates from the NSW Alcohol and Drug Association. They were updated as part of the internal review process associated with the "accreditation process" that was completed in November 2022.

opioid overdose and to respond via the administration of naloxone. Similarly, all CAHMA staff are offered take-home naloxone which they are strongly urged to carry with them at all times".

131. He highlighted his "chief concerns" as:

> Why, despite having attended several training programs around overdose management, did it not occur to [Mr PK] to carry naloxone when he must surely have known that he was going into a situation where people were likely to be using opioids and, therefore, at risk of overdose?
>
> Why did so much time elapse between Mr Alvarez becoming unresponsive and an ambulance being called? And what were those present doing during this time?

132. Mr Gough was Mr Baxter's line manager. In March 2021, they both had rooms at the premises out of which CAHMA operated and Mr Gough would have day-to-day contact with him and speak to him regularly. Further, the fact of Mr Alvarez's death must have been significant to Mr Baxter given Mr Alvarez's connection to CAHMA through his sister and the fact that a CAHMA peer worker had been present. Mr Gough would have expected Mr Baxter to bring an issue like this to his attention.

133. Mr Gough agreed that when he referred to being made aware of the death through a staff member, that staff member could have been Mr Baxter. Although Mr Gough's memory of the event was "very hazy", he was not prepared to accept that it was possible that he found out about the death on the day or the day after. He said, "I've thought hard about this and I can say nothing more specific than what is in my statement".

134. It is unlikely that Mr Baxter would not have brought this matter to Mr Gough's attention as soon as he found out that a CAHMA peer worker had been present, or when he found out that the death involved Ms Alvarez's brother. The tragedy of Mr Alvarez's death would have immediately been a matter of great significance within CAHMA given:

    (a) Ms Alvarez's presence on staff; and

    (b) the presence at the death of two CAHMA employees.

135. I find that CAHMA, through Mr Baxter, became aware of the presence of a peer worker when Mr Alvarez died within approximately 24 hours of the death. I also find that the behaviour of Ms KT and Mr PK described to Mr Baxter may have been contrary to the training given by CAHMA as to the carrying and use of naloxone and the calling of an ambulance.

136. I also find that the fact of the presence of CAHMA workers at the scene of Mr Alvarez's death was brought to Mr Gough's attention soon after it occurred.

Investigating the Conduct of Ms KT and Mr PK

137. Mr Gough's evidence in relation to the absence of an investigation into the conduct of Ms KT and Mr PK was inconsistent.

138. Mr Gough thought the Board made a decision not to conduct any review or investigation into Mr Alvarez's death. If that was so, it is not reflected in the Board Minutes and there appears to be no record of that decision.

139. The general tenor of Mr Gough's briefing to the Board at the time was that since Ms KT and Mr PK were not working at the time Mr Alvarez's death, CAHMA had no obligation to investigate their behaviour (notwithstanding those provisions extracted above that suggest the opposite was true). Mr Gough even proposed to the Board in the period after Mr Alvarez's death that the Code of Conduct be amended to make this explicit.

140. Mr Gough said that he did not seek any report from Mr PK or Ms KT about what happened. However, this is contradicted by an email dated 13 May 2021 in which Mr Gough wrote that he "did get an account from one of them", though he now no longer recalls who gave him that account and he made no notes of it. This assertion made by Mr Gough is also contradicted in his supplementary statement in which he described having "a very hazy recollection of speaking to [Mr PK] at some stage", However, Mr Gough said in evidence that he had no clear recollection of what was said.

141. It is clear that Mr Gough contemplated opening a "critical incident investigation" into the incident, using an investigator that CAHMA already had access to. The Board asked Mr Gough to look at this possibility. This, however, did not occur. Mr Gough explained this by saying that a professional investigator (who was known to Mr Gough and who was spoken to) said it was not possible to investigate, that the police would not provide any information and it would be difficult to establish any factual account of what happened. Mr Gough contended that he would have sought reports from Mr PK or Ms KT "If I thought it was possible". He said the relationship with "our" workers was "breaking down" and they were not at work every day. Speaking to them "would have been challenging" and "I decided not to do it".

142. Mr Gough ultimately agreed that CAHMA should have investigated and that he should have spoken to Mr PK and Ms KT, noting down formally what their version of events was.

143. Despite the lack of Code of Conduct proceedings, Ms KT and Mr PK remained as CAHMA employees only for a relatively short period after Mr Alvarez's death. Their positions at CAHMA were terminated on 27 April 2021 and the reason for termination was "Poor Performance". This was further explained in the letter of termination directed at Ms KT as follows:

> "The reason for the cessation of your casual employment at CAHMA is that your performance has been unsatisfactory including missing scheduled meetings, not following reasonable direction and repeated tardiness."

144. In neither case was their dismissal associated with Mr Alvarez's death.

Why Wasn't There an Investigation?

145. A particular concern of the family was why CAHMA had not conducted its own review of the circumstances of Mr Alvarez's death given the presence of CAHMA employees when he died and given (in their minds) that CAHMA had publicly undertaken to conduct such a review.

146. On 10 October 2021 the Canberra Times had published an article about Mr Alvarez's death. The article was tendered at the hearing. It is headed "Family of deceased call for Canberra drug harm minimisation group to face tough scrutiny" and refers to a complaint lodged by Mr Alvarez's niece to CAHMA's governing board. In the article, Mr Gough is quoted as saying that CAHMA was "actively investigating internally with a view to ensuring our policies and procedures are best practice". Contrary to the impression that the article created, Mr Gough explained at the hearing that the "internal investigation" was not an investigation into the circumstances of the death or the presence of Mr PK or Ms KT, but rather the ongoing review of policies and procedures as part of an accreditation process required by the Commonwealth Government that was due to be completed by "November 2022"[12]. This explanation may have been what Mr Gough intended to convey in his response to the journalist from the Canberra Times. However, the family might have reasonably assumed that what Mr Gough was offering was a review by CAHMA into the circumstances of Mr Alvarez's death.

147. There was evidence to suggest that Mr Gough and the Board took advice as to the reputational risks associated with Mr Alvarez's death. For example, the Board minutes for 25 June 2021 refer to Mr Gough discussing advice received from a public relations expert "that reputational risk was a problem". This included discussion about the fact that a CAHMA employee had been present when someone died. In an email sent by Mr

[12] T 102

Gough to the CAHMA board and others on 9 October 2021 about Facebook posts and the possibility of an upcoming Canberra Times article about Mr Alvarez's death. The email read:

> … we are aware of this issue and assure you that CAHMA's reputation is strong and if there are any lies or falsehoods printed in the media that we will hold those people to account in a way which ensures CAHMA can continue its good work and that its reputation is not sullied. …
>
> Be assured that the CAHMA Board is aware of this issue and we have professionals working on ensuring that CAHMA's reputation is maintained as a professional and cutting edge peer based organisation.

148. A follow up email was sent by Mr Gough on 10 October 2021 after the foreshadowed article appeared in the Canberra Times. It requested that "no one respond publicly to this article" and stated:

> I've talked to our PR expert. She has advised not to give the issue any oxygen by responding publicly. Why? Because although the article is not balanced it states everything that we can actually say and know now. There was no one there in a paid working capacity. That we train all our workers and volunteers in naloxone provision. The rest is just innuendo and rumour and you don't fight rumour with rumour because it just gives it oxygen. So what we will do is reach out to our funders (I have already talked this all through with them BTW) see if there really was a complaint and reassure them.

149. In an exchange at the hearing, he denied that CAHMA approach to the death was dictated by public relations considerations:

> Can I suggest to you that it's not emotion, that you were concerned, for whatever reason, to not ask the hard questions. You simply avoided asking the questions that you should have asked and that was a conscious PR - if I can put it as a PR response to what had occurred, that you decided, because there might be a coronial inquiry or for whatever reason, that the best approach was not to ask questions?---I don't think that's a fair characterisation, your Honour.
>
> Why? Why do you say that's not a fair characterisation because it's a finding that's open to me?---Because of - - -
>
> It's a finding that's open to me. I'm not saying that I'll make it but now is your opportunity to put to me your point of view in relation to why I shouldn't make that finding?---I don't have - because I believe that CAHMA's work and that the workforce

that's at CAHMA would never put the reputation of an organisation above the life of a person, and the overriding situation at CAHMA was one of extreme emotion and stress. And this was not a cold, calculated logical decision. This was CAHMA being involved in a very difficult situation and trying to navigate it to the best of our ability and we could have done a lot better. But we did not decide that someone's life is worth less than the reputation of our organisation.

150. Several other factors seemed to have provided at least a background circumstance that impacted decision making to not conduct an investigation.

Staff Distress

151. As noted, Mr Gough was clearly concerned about not creating further distress in the workplace by calling upon employees to account for what they knew. The presence of Mr Alvarez's sister on staff added to the complexity of the situation particularly after the relationship between Mr Gough and Ms Gabrielle Alvarez deteriorated after and because of Mr Alvarez's death.

External Accreditation Review

152. As part of the section 55 process, CAHMA was requested to provide further information about the accreditation process that may have been on foot at the time of the comments made by Mr Gough in October 2021. Mr Gough in his first statement noted that since November 2022, CAHMA has been accredited under the Australian Excellence Standard (ASES). No further detail was provided as to what was involved in that process or accreditation, other than the assessor and not CAHMA determine which documents are subject to review.

153. The Court was provided with information reporting the positive outcomes of an accreditation review undertaken in 2025 by ASES, suggesting CAHMA achieved accreditation at "certificate level".

154. Extracted in CAHMA's response to the section 55 process was the following passage from Mr Gough's evidence:

> What was this ongoing internal review?---So, as part of the federal government's requirements, CAHMA was required - and we had known that we were required to accredit at a deadline of November 2022. And so we were preparing for that accreditation, reviewing our documentation and so this, I guess, dovetailed into that ongoing process.
>
> So this was really though a ongoing review that had to occur as part of the accreditation process?---Yes.

It wasn't a review into the circumstances of what happened on the day of Mr Alvarez's death?---No, but it's obvious from these minutes that we are using the opportunity to - and the learnings from this experience in informing that accreditation process.

But there is no separate report or review prepared by CAHMA in relation to Mr Alvarez's death?---That's correct.

155. Whilst Mr Gough therefore asserted that “learnings” from the death informed that accreditation process so far as CAHMA was concerned there was no evidence to suggest that the fact of Mr Alvarez’s death or the circumstances surrounding it was information provided to those responsible for the accreditation process.

Public Safety Issues - Findings

156. I find that in respect of this aspect of the public safety issues arising from the inquest:

(a) There was a failure by CAHMA to apply its own safety and integrity processes in respect of the recruitment and/or continued employment of Ms KT and Mr PK.

(b) The justifications advanced at the time for not conducting an investigation was that as Ms KT and Mr PK were not at work in the events that led to Mr Alvarez’s death CAHMA could not examine their conduct under its Code of Conduct. As Mr Gough conceded at the hearing, this was not so.

(c) The decision not to conduct an investigation was influenced to some degree by extraneous and irrelevant considerations, including a concern to ensure CAHMA’s reputation was not damaged.

(d) This failure to conduct an investigation into the role played by Ms KT and Mr PK in the events that led to Mr Alvarez’s death exposed clients of CAHMA and users of CAHMA who interacted with those peer workers to potential risk.

(e) In respect of the issue as to whether CAHMA should direct staff not to use drugs with “clients” or “service users”, I recommend that clear published guidance (including in the Code of Conduct) should be developed and published, that while acknowledging CAHMA’s role as a peer support organization, makes clear:

iii. that use of illicit drugs when at work as a CAHMA employee is an unacceptable practice[13]; and

iv. any use of drugs with clients outside of work hours must

i. be consistent with the Code of Conduct; and

ii. be consistent with the responsibilities that apply to employees and employers under the *Working with Vulnerable People (Background Checking) Act 2011*[14]

v. I recommend that the Code of Conduct should be reviewed[15] in light of the evidence in this inquest to:

i. ensure that it provides appropriate guidance to CAHMA staff generally;

ii. specifically, as to their responsibility to ensure that the conduct of peer workers is consistent with the requirements and objects of the *Working with Vulnerable People (Background Checking) Act 2011*; and

iii. provide a mechanism by which breaches of the conduct should be actioned[16].

157. I shall cause this decision, the transcript of proceedings and submissions to be forward to the Commissioner for Fair Trading for consideration of whether the terms and objects of the WWVP Act are reflected in CAHMA's guidance as to drug usage by staff when working with vulnerable people who may be clients of the organisation.

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[13] CAHMA stated in its section 55 response: "CAHMA acknowledges the finding at "a" and says its current practices ensures this could not be repeated.

[14] CAHMA stated in its section 55 response to "b","c" and "d" that it acknowledged that CAHMA now had a better appreciation of its potential powers as an employer recognising that outside hours conduct may be relevant to ongoing employment.

[15] CAHMA stated in its section 55 response that its code of conduct was being reviewed, "informed by the Courts' findings".

[16] Anticipating that such a finding might be made CAHMA submitted:

> CAHMA does not oppose a recommendation that it update its code of conduct. However, if the Coroner considers it is within his power to make a comment, we submit that his Honour should find that any code of conduct amendment may have limited utility.

In its section 55 response CAHMA asked that this footnote to be deleted and the following be substituted:

> Anticipating that such a finding be made CAHMA originally submitted any amendment may have limited utility due to its concerns about its interpretation of the scope of its powers [under the] Fair *Work Act 2009* or *Social Community, Home Care and Disability Services Industry Award 2010* to regulate outside of hours drug use".

SECTION 2 - THE ROLE OF CAHMA – RESPONDING TO OVERDOSE

Background

158. As noted above, Mr Alvarez's death is one of a number of cases in the ACT where a death has occurred as result of an overdose where those present at the time of collapse have chosen not to call 000, meaning that the administration of medical assistance has been effectively prevented or deferred in a way that compromises the opportunity for potentially lifesaving treatment. There is no suggestion that any of these deaths were associated with the conduct of CAHMA peer workers. Given the role that CAHMA can play in educating drug users about an appropriate response to an overdose, the inquest explored the messaging it provided to its own employees about how to respond if they were present.

159. The motives of those who when at the scene of an overdose choose not to call 000 may differ from case to case. In respect of Mr Alvarez's death, those present had reason to fear the presence of police given the quantities of heroin and methamphetamine that were at the unit.

160. However, it was clear from the evidence that the general reluctance to call 000 commonly stems from suspicions that drugs users may have about police generally and concerns they may have as to what consequences will flow to them if the police attend with an emergency services agency (including ACTAS).[17]

Police Responses

161. The role of the AFP at the scene of an overdose has several aspects. The attending police may become involved in the administration of care. As was the case here, the police would have a responsibility to ensure those at the scene (including first responders) are safe. Naloxone in the form of a nasal spray, has been added to the first aid kit in the AFP vehicle fleet.

162. If the overdose has resulted in death, attending police would be obliged to investigate the death on behalf of the coroner to assist in determining the manner and cause of death. That would involve amongst other things, asking those in attendance to detail the circumstances in which the overdose occurred.

[17] Noting that the AFP might be the first at the scene and attending officers may assume the immediate responsibility of administering medical care including resuscitation.

163. Importantly and consistent with the AFP's law enforcement responsibilities, the circumstances of the overdose would have to be assessed to determine whether they suggest the possible commission of criminal offences. In that respect the following matters are noted:

(a) Failure to provide Assistance

A failure to provide assistance to someone who has overdosed is not of itself suggestive of the commission of a criminal offence. This reflects the position of the common law and is not modified by statute in the ACT as it is in the Northern Territory.[18]

(b) Involvement in Administration or Supply of a Drug

The actual physical administration of an illicit substance to a person that causes death can attract criminal liability for manslaughter in the ACT. The supply of the drug may attract criminal liability for drug supply but generally not for any health consequence that follows if voluntarily consumed.

(c) Possession Offences

As the overdose may have occurred in the context of a number of people using the drug associated with the overdose, attending police may choose to investigate the fact of possible illicit drug possession.

164. The law that applies to the possession of drugs has been significantly modified in the ACT after Mr Alvarez's death. On 28 October 2023, amendments to the Drugs of Dependence Act 1989 (ACT) and Drugs of Dependence Regulation 2009 (ACT) ('the Regulations') came into effect. The purpose of the amendments was "to enact a policy of the decriminalisation of drugs in the ACT".

165. Central to achieving this policy was the introduction of 'simple drug offences'. Simple drug offences reduce the maximum penalty for the possession of a small quantity of certain illicit substances to 1 penalty unit. Section 6 of the Regulations sets out the exhaustive list of the seven illicit drugs and their corresponding 'small quantity' to which the reduced penalty applies. This includes:

[18] Section 155 Northern Territory Criminal Code 1983 provides:

> Any person who, being able to provide rescue, resuscitation, medical treatment, first aid or succour of any kind to a person urgently in need of it and whose life may be endangered if it is not provided, callously fails to do so is guilty of an offence and is liable to imprisonment for 7 years.

(a) heroin with a small quantity limit of 1 g;

(b) methylamphetamine with a small quantity limit of 1.5 g; and

(c) amphetamine with a small quantity limit of 1.5 g.

166. Prior to the introduction of the simple drug offences, the possession of any quantity of illicit drugs, excluding cannabis, was 50 penalty units, imprisonment for 2 years or both.

167. Where a person is found to be in possession of more than one of the seven illicit drugs listed in Section 6 of the Regulations, they will still be found to have committed a simple drug offence if the total quantity of the combined substances does not exceed double the small quantity limit.

168. Where a police officer believes on reasonable grounds that a person has committed a simple drug offence, the officer may serve the person with an offence notice. The offence notice must state that no further action will be taken if the alleged offender either pays the prescribed penalty or attends the first session of an approved drug diversion program within 60 days of service of the offence notice.

169. The relevant explanatory statement to these amendments explained that the amendments form part of the ACT Government's acknowledgement that drug use is primarily a health and social issue. CAHMA submitted to a committee considering the new drug regime that with the "appropriate preparation, planning and development of this bill we will see significant reduction in stigma, discrimination and harms associated with drug use".

170. Pursuant to section 205B of the Drugs of Dependence Act 1989 (ACT), the amendments must be independently reviewed, as soon as practicable after 2 years of operation. The review must involve consultation with members of the community that are "likely to be affected by the operation of the amendments". The Health Minister must "present a report of the review to the Legislative Assembly within the 6 months after the review is started".

171. According to the Social Policy Research Centre at the University of New South Wales ('UNSW'), the ACT Government has contracted the UNSW Drug Policy Modelling Program ('DPMP') to conduct an evaluation of the amendments in collaboration with representatives from the Australia National University (ANU) and CAHMA.

172. The evaluation is to include quantitative analysis of routinely collected administrative data to assess program reach and implementation and qualitative data collected through an array of stakeholder interviews and focus groups, inclusive of people who use drugs. This will form part of the final evaluation report for the ACT Government.

173. It is not clear when the final evaluation report will be available.

174. Although not forming part of the evidence in the proceedings, public comments made by the AFP suggest that in principle ACT Policing is supportive of the ACT Government's harm minimisation and diversionary approach to personal illicit drug use in the ACT. How that commitment operates "on the ground" to inform how the police investigate possible offences and how discretions are exercised in respect of decisions not to charge or to employ diversionary options is more difficult to determine. Empirical data in respect of this issue may become available in the context of the review of the operation of the amendments to the *Drugs of Dependence Act 1989 (ACT)*.

Health Messaging Around Overdose

175. It is worthy of repetition that messaging to drug users about how to react to overdose can and does come from a multiplicity of sources not just CAHMA. It is also important to reiterate that there are other aspects to CAHMA messaging about overdoses including other first aid measures and the use of naloxone. New workers or volunteers at CAHMA undergo naloxone training consisting of at least one on one training with a CAHMA employee responsible for that training. The inductee would be instructed on how naloxone works and the signs of overdose justifying its use. In responding to overdose the PowerPoint training presentation received in evidence at the hearing instructed the CAHMA worker to:

    (a) Try and get a response from the person;

    (b) No response call "000" straight away and stay on the line with them;

    (c) Administer naloxone (If available); and

    (d) Place person in recovery position.

176. It is further suggested in that presentation that "you can attempt to clear the airway and provide rescue breathing" or chest compressions if the person goes into cardiac arrest or if rescue breathing is impractical.

177. That training package says that it is "prudent" for the patient to be taken to the hospital after recovering from an opioid overdose although added in bold letters is the admonition "DO NOT LET THE PATIENT SLEEP IT OFF".

178. The information sheet that accompanies the nasal version of naloxone (Nyxoid) directs the user of the product to call an ambulance immediately and give emergency services "as much information as you can" including "what substances you think the person may have taken".

179. In contrast, the Training Package entitled “Opioid Overdose Management training with Intranasal Naloxone” which is also used by CAHMA in its training suggests that when 000 is called “you don’t mention drugs or overdose but simply tell the operator that you have patient who is not breathing and non-responsive and that you need an ambulance urgently”.

180. In contrast again, the training program provided as part of CAHMA’s Train the Trainer program does include that “it is helpful if the first responder can tell the 000 operator that the victim is suspected to have overdosed on opioids”.

181. The training packages were silent as to the general issue of how interactions with the police should be approached. The training packages are also silent as to whether the life and health of the person who has overdosed is to be prioritised above all else.

182. Mr Gough’s evidence on this point was nuanced. Whilst acknowledging the content of the CAHMA training just referred to, he said a balance had to be struck so that people were encouraged to call 000 rather than fearing the consequences of doing so:

> So the balance becomes ensuring that the person rings 000 and that that occurs without setting up a training program that will actually do the opposite. So we have ongoing - we have ongoing discussions with the National Naloxone Reference Group to ensure that whatever we are discussing is best practice and I'm not sure of those details.
>
> ……
>
> So in some cases where someone is criminalised or has spent a long time in prison, they are concerned that the ambulance officer will call the police and that they will get in trouble and so it's - it's common within our community that people are too afraid of the consequences to ring 000.
>
> So what are those consequences?---The consequences are that the police arrives and - and - and then the person is in trouble with the police.
>
> For what?---For whatever - the police are the most feared institution to people who use drugs. They're often - there's - often have very negative experiences with police. There's often a lot of trauma involved with police because of past experiences and there's often bad relationships between our community and the police. All of these things factor into whether a person will or will not call 000.
>
> So what are they told?---My understanding is that they're told to call 000 and to tell the person that there's an - that - that they have identified an overdose and that they have naloxone and to follow the instructions of the person on the phone.

MR LEE: You say that they are told to tell the 000 operator that there has been an overdose?---That's my understanding, yes. But it's - but it's a continually updated area and I'm not sitting in those National Naloxone Reference Group meetings, so I don't - I don't know. It's not my role to provide this training.

183. Speaking of realities that applied at the time of giving evidence in late 2025, Mr Gough reported that police were attending overdoses more regularly and that as a result "the community" were becoming "concerned":

> Then on this document in front of you at 939 there's the reference to the same concern you've referred to about illicit drug users being reluctant to call 000 because of concerns they may end up in trouble with police?---Yes. Yes, that's right.
>
> Do you understand that to be the case?---I understand that and I've discussed this with the - the chief police officer that, in the last several years, there has been an increasing number of police attendances at ambulance attendances, and so the police should not show up in response to a 000 call unless either the caller or the ambulance officers request their assistance. It's still correct, however, it's happening more and more often that the police are attending and that's causing considerable concern within our community.
>
> THE CORONER: Did the police officer say why that might be?---The police officer suggested that it was in relation to ambulance officers feeling unsafe, for example, and the - and the - and the example was given of attending a large housing development, ACT Housing development, then in those cases the ambulance officers would fairly regularly call police. So around safety of the ambulance officers but also around mental health.
>
> …….
>
> What I can say is that the police are actively changing their response around being asked to attend more ambulance visits and it was discussed with me in relation to reports from our community that police were attending more ambulance callouts when our community member was calling the 000 line.
>
> …..
>
> So, in your mind, what is the trouble relevant to the circumstances surrounding the use of the drug that may have caused the overdose or is it to do with circumstances that otherwise might prevail?---Each member of our community has had different experiences with police so it's - it's a range of factors. It could be that they possess drugs. It could be that they have been assaulted by the police in the past and have

had bad traumatic experiences with the police. There are a range of reasons why our community is scared of ringing 000. CAHMA positions itself to support and train our community, and so it's important that we understand their concerns and address their concerns in order for them to provide the health intervention that will ultimately save someone's life.

184. In respect of the decriminalisation changes to drug possession laws Mr Gough was not convinced that they necessarily created an environment in which the drug taking community would always feel comfortable in calling 000 in the case of an overdose. Noting (despite the de-criminalisation changes) it still was an offence to possess heroin and other drugs "the community overall hasn't felt a significant reduction in stigma and discrimination, which would let them do things like ring 000 without fear". As to how many people were being charged with possession offences in the context of opioid use Mr Gough was not able to say, but as a matter of impression "the diversion processes were not being used in cases involving heroin and methamphetamine".

185. Mr Gough was questioned as to what level of engagement of CAHMA had with the AFP and what could be done to break down the feeling of suspicion and unease the drug using community might feel about police involvement in, amongst other things, responding to drug overdoses.[19] He indicated that it was difficult to objectively quantify what if any attitudinal changes had been caused by the decriminalisation process and the changing law enforcement patterns of ACT policing towards placing greater emphasis on harm minimisation. Although he stated that the lines of communication were open with the Chief Police Officer, he was not able to point to any formal policies, procedures or Memoranda of Understandings that had been developed to assist each organisation in sharing information or in agreeing how operationally each organisation could assist the other in reducing drug related harm. From "the community's" point of view he described the process of changing attitudes as being slow:

> Now, in relation to those who share the space with you, one of the big players, obviously, is the Australian Federal Police as they are policing issues concerning

[19] In its section 55 response CAHMA pointed to the complexities of this issue:

> "To the proposition that CAHMA could be doing more, which Mr Gough conceded, we submit that what CAHMA could be doing must be viewed in the context of its funded purpose. CAHMA's representation of people who use drugs and drug treatment services is within a health and human rights framework. It advocates for a marginalised sector of the ACT community, some of whom have experienced great trauma associated with the justice system. As the Court acknowledges at paragraph 182 [now 191], there is great complexity in this area. At every opportunity, CAHMA will continue to engage with other stakeholders".

not so much drug usage but drug trafficking in the ACT. That's where the emphasis these days lie?---That is correct.

Culturally, notwithstanding there may have been this significant shift in their focus, I hear from you that culturally not much has changed. Is that right, or? The on-ground police officers are to drug users the enemy?---The - I wouldn't say I've said that. I would characterise my comments as being that the - that the community has feared police for decades and it's going to take more than two years of police changing their behaviour to build trust in our community.

So what is the dynamic of change, therefore? What's going to influence that?---Law reform influences it strongly and the work that the ACT has done in cannabis law reform in particular has been excellent. Same with the Drugs of Dependent - Dependence Amendment Acts. CAHMA has been involved in those law reforms to a considerable degree, playing a - what we consider a leadership role. And - and we are also involved in - as a subcontractor, in the evaluation of the drugs of dependence amendment legal reforms that's being conducted by the Drug Policy Modelling Program.

I'm just wondering to what extent your organisation has a role to play in changing attitudes?---CAHMA has a large role to play in communicating with our community. One of the big problems that we face when drug users engage with police is that our behaviour, people who use drugs behaviour, is often aggressive, it's often a - a trauma response and it's unhelpful in it escalates the situation instead of de-escalating the situation. So CAHMA has been - CAHMA is - is proud of its relationship building with the Australian Federal Police in the form of ACT Policing over the last couple of years and we hope that we can continue to build that relationship and effect further change.

So, for example, the documents that Mr Lee took you that reflect the advice given and the context of various forms of training about it not being unreasonable that people are reluctant to speaker - to involve the police in respect of a response to an overdose?---Yes.

Is that good enough? It seems if I may put it bluntly and perhaps slightly unfairly to be a fairly old hat response to a situation that may be more fluid and dynamic on the ground?---It's - we can certainly do a lot better. We are dealing with generational change though.

But if you are an agent of change - and I'm not sure that the scripts, as I've put them,

or the outlines of the training that you have been taking to reflect present-day reality or not, but they don't seem on their face to be particularly informative, I could put it that way, about some of the things you've just spoken about, about what has changed, and that perhaps attitude - one would hope, the attitude of police in attending drug overdoses don't involve punitive action on their part. And if it does, I'm just wondering to what extent you are taking that up with the AFP in relation to perhaps trying to develop some cultural change around the way they are attending overdoses and the messages that are being given by them when they do attend an overdose?---We are two years into a small legal change.

Big legal change. Isn't it? It's a - - - ?---No, it's quite a small legal change. The AFP acknowledged themselves that they were already doing this prior to the legislation.

186. The point is made again, that in the ACT, CAHMA plays a role in informing policy and practice in respect of applying harm minimisation principles to illicit drug usage. It is not the only organisation with a responsibility in that domain. The Court acknowledges that funding of harm reduction programs is a small proportion of the monies devoted to law enforcement activities involving the use of illicit drugs.

187. The ACT Drug Strategy Action Plan 2022-2026 (the Drug Strategy") envisages that that partnerships and collaboration are central to improving health outcomes for alcohol and drug users:

> <u>Partnerships</u>
>
> In recognition of the social determinants of ATOD issues, and that age and stage of life issues associated with substance use can result in different risks and harms, integrated, holistic and systems-based partnerships between both government and non-government stakeholders are required to achieve the aims of the action plan. This includes partnerships with researchers, families and communities, peer educators, drug user organisations, Aboriginal and Torres Strait Islander communities, and other key demographic groups.
>
> <u>Co-ordination and collaboration</u>
>
> Co-ordination and collaboration at the international level, nationally and within jurisdictions leads to improved outcomes, innovative responses, and better use of resources. It supports jurisdictions to develop better responses and innovations within the national strategy that can inform and benefit all jurisdictions by sharing practices and learning.

PUBLIC SAFETY ISSUES - DRUG OVERDOSE – RECOMMENDATIONS

188. In respect of the issue of drug overdose, it is appropriate that training and messaging across all agencies be in terms that give primacy to the saving of life and the preservation of health. I recommend that CAHMA training dealing with responding to overdose be reviewed with a view to ensuring that the goal of saving life is identified as the primary goal of that response.

189. For CAHMA specifically, the challenge it confronts is to pursue that goal in a context where the lived experience of its worker and clients involves less positive interactions with police. This I acknowledge can produce hesitation in taking action to involve emergency services when someone may be in need of health care.

190. The responsibility to change attitudes in this space is not one that falls upon CAHMA alone. Further there is complexity in the area. The AFP has a continuing obligation within the harm minimisation paradigm to address supply reduction issues. There will be challenges to be confronted as to how charging discretions will be exercised where potentially more serious drug offending surrounds the circumstances of an overdose. In that regard, Mr Alvarez's death has just those issues.

191. The Drug Strategy requires co-operation between a range of agencies and, in respect of the response to drug overdose issues, the involvement of CAHMA, Canberra Health Services, ACTAS and other emergency service responders and the AFP. A level of formal discussion might potentially advance a shared position as to how that medical emergency is be dealt with in a way that encourages users who are present to act in a way that maximises health outcomes.

192. I recommend that CAHMA, subject to budgetary restrictions, participate in advancing this dialogue and publish a report on its progress within 6 months of the presentation of the report of the review into the operation of the amendments to the Drugs Of Dependence Act 1989. Government funding of this endeavour should be considered.

193. I do not recommend that the ACT follow the Northern Territory in criminalising any failure to provide assistance in the context of drug overdose. There is no evidence that this punitive approach encourages those present at an overdose to provide assistance. No other jurisdiction has followed the Northern Territory model.

MR GOUGH

194. The findings that have been made involves criticism of Mr Gough. That criticism must be placed in an appropriate context. At the time of Mr Alvarez's death and in the years before and since, the operation of CAHMA relied heavily on his endeavours. I

acknowledge that the conduct of Ms KT and Mr PK was contrary to the training they had been given by CAHMA. I also acknowledge that Mr Gough made apology to the family of Mr Alvarez for CAHMA not doing better in respect of some aspects of its response to Mr Alvarez's death.

195. I make no general criticism of Mr Gough. CAHMA's achievements reflect positively on him. I also acknowledge that the process of giving evidence was obviously confronting for him. The complexities associated with the harm minimisation model on which CAHMA is based requires a carefully constructed governance model with the resources to ensure it is consistently and effectively implemented. The increase in staffing and financial resources that are available to CAHMA is a healthy development and will spread the burden of appropriate governance.

196. The inquest heard evidence of the enhancement of CAHMA's governance structures since Mr Alvarez's death. It was not within the scope of this inquest to determine their adequacy in the present day.

197. At the very least the requirements to justify the expenditure of public monies will mandate the efficacy of the work that CAHMA undertakes is subject to audit and scrutiny.

SECTION 55 PROCESS

198. Section 55 of the Act requires that if a coroner intends to include in a findings a comment adverse to an identifiable person that person must be given an opportunity to make a submission or provide a statement to the coroner in relation to the proposed comment. On 27 May 2026 a notice was sent to CAHMA pursuant to section 55 of the Act together with a copy of my provisional findings. Submissions dated 23 June 2026 were received in response to that notice.

199. In some instances, those submissions caused me to modify my findings, including by the insertion of footnotes acknowledging the content of those submissions.

200. A copy of the provisional findings and a section 55 notice was sent to the individuals present at the unit. No responses to those notices were received.

DE-IDENTIFICATION OF WITNESSES NAMES

201. After the hearing the Court wrote to the parties inviting submissions as to whether the names of the those present at the unit when Mr Alvarez died should be named. During the proceedings an order had been made that prevented publication of those people's names.

202. Section 40 of the Act gives a coroner the power to give directions prohibiting or restricting the publication or disclosure of evidence whether or not a hearing has been held. Such an order can be made if "it is desirable in the public interest" or "in the interests of justice" to do so. No submissions were received from those people who were at the unit. Helpful submissions were received on behalf of Ms Emma Snazelle. Brief submissions were also received on behalf of Ms Gabrielle Alvarez. Those submissions advocated for the removal of existing non-publication orders as the naming of those present at the time of Mr Alvarez's death would ensure they are held accountable for their actions. Also, it was submitted, the messaging from the publication of their names would encourage others, in a like situation, to act more responsibly particularly those trained in the use of Naloxone.

203. I accept that "open justice" is an important feature of the coronial process notwithstanding the express limitation of that principle contained in section 40 of the Act. However, I am persuaded that a departure from that principle in the circumstances of the present case is justified in the public interest only to the extent of the names of those present at the unit are ordered not to be published.

204. I make that order for the following reasons:

    (a) It is well established that in determining the meaning and effect of the expression "public interest" the term must be construed according to the "usual principles of statutory construction, that is, having regard to the subject matter, scope and purpose of the enactment": per Lerace J in *Commissioner of the Australian Federal Police v Hills Greenery Pty Ltd (No 2)* [2024] NSWSC 448 at [39].

    (b) Where the "public interest" lies in any given case "imports a value judgement that takes into account "competing arguments about, or features or 'facets' of, the public interest", and is made not within a normative vacuum". In that case the relevant statute was "sufficiently broad to include, as factors requiring consideration, any relevant prejudice or hardship": *ibid.*

    (c) The Act requires the making of findings required by section 52. In this case the making of the manner and cause findings required by section 52(1) of the Act were capable of being made without a hearing and in the usual course of events would not have been published. The naming of individuals present at the time of Mr Alvarez's death was not essential to the making of those findings.

(d) Section 3BA of the Act states the Act's main objects. The objects amongst other things emphasise the importance of the coronial function in promoting public safety and the prevention of deaths and increasing awareness about serious risks to public health and safety: respectively section 3BA(1)(d) and section 3BA(2)(d) of the Act.

(e) In this case the inquest proceeded to hearing to enable the public exploration of public safety issues arising from the inquest into Mr Alvarez's death, particularly in the context of CAHMA's role and encouraging those present at overdoses to act protectively towards the person who has overdose to administer naloxone if available and to call emergency services. It is not clear that naming individuals who provide the context for a consideration of those public safety issues is necessary for findings to be made.

(f) As noted in the findings, the behaviour of bystanders exhibited in relation to Mr Alvarez's death is not a "one-off" event. There is no evidence before the Court that a coronial process that "names and shames" would encourage drugs users to act protectively towards others who are in their company and who may be suffering the potentially life-threatening effects of overdose.

(g) There are issues of psychosocial vulnerability that arises in relation to those who were present at the time of Mr Alvarez's death. They are people:

(i) with a long history of drug use;

(ii) who were, with a limited exception, self-represented;

(iii) who presented as people with an unsophisticated approach to the proceedings with a limited capacity to advocate on their own behalf; and

(iv) some of whom presented with mental health vulnerabilities.

205. I reject the suggestion made in submission that the particular individuals generally presented an ongoing risk to the public and that naming them will address that risk. The events in question occurred five years ago. Whilst their conduct may have been morally blameworthy, the DPP has determined that there was insufficient evidence to prove they had acted criminally.

206. For these reasons I have made a non-publication order in respect of the names of the people who were at the unit on the day Mr Alvarez died. I have provided the parties and the family of Mr Alvarez a copy of that order.

CONDOLENCES

207. In her statement to the court, Ms Snazelle described the challenges and delays of the coronial system and felt let down by this court:

> I did not come here seeking anything untoward for anyone. I came here to try and get some answers to those questions about what occurred in those four hours so that I can begin to grieve and heal. After this court process, I still have no answers.
>
> The loss of Felipe's life and the manner in which it occurred will haunt me to the end of my time. I miss my brother deeply. He mattered to me. I hope that lessons can be learnt from his passing and through this inquest.

208. I extend my condolences to Mr Alvarez's family and acknowledge their active and constructive engagement in the coronial process. I apologise for the delay in finalising my investigation and in doing so recognise that the delay in completing the inquest process has added to the trauma they have suffered in respect of their loss.

I certify that the preceding two hundred and eight [208] numbered paragraphs are a true copy of the Reasons for Decision of his Honour Coroner Archer.

Associate: Ella Mansfield

Date: 3 August 2026