FINDINGS of Coroner Simon Cooper following the holding of an inquest under the *Coroners Act* 1995 into the death of:

Gerard Ernest Stefaniw

Record of Investigation into Death (With Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Simon Cooper, Coroner, having investigated the death of Gerard Ernest Stefaniw with an inquest held at Hobart in Tasmania make the following findings.

Hearing Date

5 November 2018 at Hobart in Tasmania

Representation

Ms E Avery Counsel Assisting the Coroner

Ms G Chen for the Tasmanian Health Service

Mr C Mackie for Ms Sarah Campbell

Introduction

1. Mr Gerard Ernest Stefaniw was born in George Town, Tasmania on 24 March 1953. He was single man with no children at the time of his death. He is survived by three siblings. Mr Stefaniw died on 21 October 2016 at the Roy Fagan Centre in Lenah Valley. When he died he was an inpatient at the Centre.

2. His sister, Ms Rosemary O'Brien, gave evidence at the inquest.[1] She said that growing up she always knew that her brother 'was different to other people'. Although educated in 'mainstream' schools, it seems Mr Stefaniw struggled academically. Ms O'Brien said that her brother was

[1] Affidavit sworn 20 February 2017, exhibit C8, as well as *vive voce* evidence.

also ‘always very small in stature and skinny’ and that he was diagnosed with cerebral palsy.

3. The evidence was that, apart from a relatively brief period of employment shortly after leaving school, Mr Stefaniw was effectively unemployed for most of his life.

4. It is clear from Ms O’Brien’s evidence that Mr Stefaniw, although supported by his family, had a difficult life and struggled with both physical and mental illness. She painted a picture of a fiercely independent man becoming increasingly paranoid and incapable of looking after himself in the last decade or so of his life.

5. At the time of his death, Mr Stefaniw was the subject of an order made on 26 August 2016 under the provisions of the *Guardianship and Administration Act* 1995.[2] That order was made following a review of an earlier guardianship order made on 12 May 2015. Both orders were made after hearings before the Guardianship and Administration Board. After the hearing, the board expressed itself satisfied that Mr Stefaniw was a person with a disability, was unable by reason of the disability to make reasonable judgements in respect of his personal circumstances, and was in need of a “limited” guardian.

6. The board ordered that the Public Guardian continue as Mr Stefaniw’s guardian. The Guardianship and Administration Board further ordered that the powers and duties of the Public Guardian were limited to:

    a. Decisions concerning where [Mr Stefaniw] was to live whether permanently or temporarily.

    b. Consent to any healthcare that is in the best interests of [Mr Stefaniw] and to refuse or withdraw consent to any such treatment.

[2] Exhibit C21.

c. The provision of support services to [Mr Stefaniw].

7. The order was expressed to remain in effect until 25 August 2019. It was therefore operative at the time of Mr Stefaniw's death.

8. It is clear from the evidence at the inquest that Mr Stefaniw's medical and personal history was complex. Medical records from his time at Strathglen Nursing Home, the Roy Fagan Centre, as well as the digital medical record kept by the Tasmanian Health Service were all tendered at the inquest.[3] As already mentioned, he had cerebral palsy which significantly impinged upon his mobility. In addition, he was diagnosed as suffering from hip dysplasia and was deeply troubled by severe degenerative hip disease which caused him significant pain and also restricted his movement. Spinal issues necessitated surgery to attempt to correct vertebral bone slippage. The evidence was that Mr Stefaniw suffered chronic and complex pain from both his hip and cervical spine issues. In addition, in the lead up to his death, he suffered urinary and faecal incontinence.

9. Mr Stefaniw had a lengthy history of engagement with the various mental health services provided by the Tasmanian Health Service. The evidence makes clear that he suffered from significant cognitive impairment. In a helpful report tendered at the inquest, Dr Matthew Fasnacht, an Old Age Psychiatrist and the clinical director of the Older Persons Mental Health Service (which includes the Roy Fagan Centre), said that Mr Stefaniw's cognitive impairment extended to his judgement and planning.[4] It was characterised by rigidity, impulsivity, and impaired interpersonal skills.

10. Dr Fasnacht said that by early 2015 Mr Stefaniw's self-care had deteriorated so much that he was suffering from malnourishment and living in squalor. Mr Stefaniw's brother visited from interstate. He found his brother's living conditions to be very poor and it was apparent to him

[3] See exhibits C18, C19 and C20 respectively.
[4] Exhibit C25.

that Mr Stefaniw had been injured as a result of several falls. His brother found him covered in faeces.

11. This deterioration in his physical and mental health, and consequent inability to care for himself, resulted in the making of the first order by the Guardianship and Administration Board referred to above. Initially Mr Stefaniw was accommodated at Strathglen Nursing Home in Southern Tasmania. His medical conditions necessitated three admissions to the Roy Fagan Centre. The first was in February 2016, the second in May 2016 and his final admission in September of the same year.

12. It is apparent from the evidence, which included two affidavits made by his solicitor Ms Sarah Campbell, as well as his medical records and telephone records, that Mr Stefaniw was very unhappy about being home housed at the Roy Fagan Centre.

The Role of the Coroner

13. Before an analysis of the circumstances surrounding Mr Stefaniw's death is undertaken it is important to say something about the role of a coroner. A coroner in Tasmania has jurisdiction to investigate any death which appears to have been unexpected or unnatural.

14. When investigating any death, whether or not an inquest is held, a coroner performs a role very different to other judicial officers. The coroner's role is inquisitorial. She or he is required to thoroughly investigate a death and answer the questions (if possible) that section 28 of the *Coroners Act* 1995 (the *Act*) asks. These questions include who the deceased was, the circumstances in which he or she died, the cause of the person's death and where and when the person died. This process requires the making of various findings, but without apportioning legal or moral blame for the death.[5] A coroner is required to make findings of fact from which others may draw conclusions.[6] A coroner is

[5] See *R v Tennent; Ex parte Jaeger* [2000] TASSC 64, per Cox CJ at paragraph 7.
[6] See *Keown v Khan* [1998] VSC 297; [1999] 1 VR 69, Calloway JA at 75 – 76.

also able, if she or he thinks fit, to make comments about the death or, in appropriate circumstances, recommendations to prevent similar deaths in the future.

15. A coroner neither punishes nor awards compensation – that is for other proceedings in other courts, if appropriate. Nor does a coroner charge people with crimes or offences arising out of the death the subject of investigation. In fact, a coroner in Tasmania may not even say that he or she thinks someone is guilty of an offence.[7] I should make it very clear that in this case there is no reason to think, at all, that anyone has committed any crime or offence in relation to Mr Stefaniw's death.

16. As was noted above, one matter that the *Act* requires is a finding of how the death occurred.[8] It is well-settled that this phrase involves the application of the ordinary concepts of legal causation.[9] Any coronial inquiry necessarily involves a consideration of the particular circumstances surrounding the particular death so as to discharge the obligation imposed by section 28(1)(b) upon the coroner.

17. The standard of proof in coronial inquests is the civil standard. This means that where findings of fact are made a coroner needs to be satisfied on the balance of probabilities as to the existence of those facts. However, if an inquiry reaches a stage where findings being made may reflect adversely upon an individual, it is well-settled that the standard applicable is that articulated in *Briginshaw v Briginshaw.*[10] That case stands for the proposition that it is particularly important to bear in mind the seriousness of any allegation and that the task of deciding whether a serious allegation is proved should be approached with great caution.

18. The question of whether Mr Stefaniw was a person held in care, in terms of the *Act* is an important one. Unlike the situation where a person is

[7] Section 28 (4) of the Act.
[8] Section 28(1)(b) of the Act.
[9] See *March v E. & M.H. Stramare Pty. Limited and Another* [1990 – 1991] 171 CLR 506.
[10] (1938) 60 CLR 336 (see in particular Dixon J at page 362).

detained under the term of the *Mental Health Act* 2013 (which the evidence shows Mr Stefaniw was not), the fact that an order has been made under the terms of the *Guardianship and Administration Act* 1995 does not necessarily lead to the conclusion that a person is 'held in care' in terms of the *Act*.

19. In her findings and recommendations in relation to the death of Molly Jessie Smith,[11] Coroner McTaggart dealt with the issue of whether a person, subject to an order made under the terms of the *Guardianship and Administration Act* 1995 is, or could be, a person "held in care" in terms of section 3 of the *Act*.

20. That section defines a person "held in care" as:

> *"A person detained or liable to be detained in an approved hospital within the meaning of the Mental Health Act 2013 or in a secure mental health unit or another place while in the custody of the controlling authority of a secure mental health unit, within the meaning of that Act*".

21. The significance of whether Mr Stefaniw was a person held in care is twofold. First, if he was, the holding of an inquest in relation to his death was, in terms of the *Act* mandatory.[12] Second, if the inquest was mandatory then, in addition to making the findings mandated by section 28(1) of the *Act*, an obligation is cast on the coroner to "report on the care, supervision or treatment of that person while that person was held in custody or a person held in care."[13]

22. Coroner McTaggart stated that: "…it is therefore a question of fact as to whether the aspects of control or compulsion are present such that a person can be found to be detained, notwithstanding the absence of a formal order legitimising that detention".[14] I respectfully agree. It is

[11] [2017] TASCD 444.
[12] see section 24(1)(b).
[13] see section 28(5).
[14] In re Molly Smith, page 14.

necessary to analyse the circumstances of Mr Stefaniw's time at the Roy Fagan Centre to determine whether, as a matter of fact, he was a person detained in an approved hospital.

23. I turn to that evidence. First, it is clear that the Roy Fagan Centre was as at the time of Mr Stefaniw's death an approved hospital in terms of the *Mental Health Act* 2013.

24. Second, it is quite plain on the evidence that Mr Stefaniw was subject to the control of staff and detained within the Roy Fagan Centre against his will. For example, the day before his death several staff members describe what was termed "an escape attempt" by Mr Stefaniw. Second, he had retained a solicitor, Ms Campbell, with a view to challenging the Guardianship and Administration Board Order so as to enable him to leave the Roy Fagan Centre. Third, there is a plethora of evidence, particularly in the form of his mobile phone records, showing he was constantly in contact both with his solicitor and the Ombudsman complaining about his enforced stay at the Roy Fagan Centre. When the evidence is viewed as a whole it is clear that Mr Stefaniw was detained at the Roy Fagan Centre, that that detention was such that he was subject to the control of staff, was not free to leave and was resident there against his will. In all of the circumstances I am satisfied that Mr Stefaniw was a person held in care in terms of section 3 of the *Act*. As such, an inquest is mandatory and I am required to report on his "care, supervision or treatment… while [he] was a person held in… care" as required by section 28(5).

Circumstances of Death

25. As has already been mentioned, it is clear on the evidence at the inquest that Mr Stefaniw was deeply unhappy about being subject to the Guardianship and Administration Board Order and being accommodated at the Roy Fagan Centre. The evidence was that he sought advice from the Legal Aid Commission on 13 May 2016 with a view to challenging

the order. He was referred to Ms Sarah Campbell, a solicitor who specialised in mental health and disability law.

26. Mr Stefaniw instructed Ms Campbell to explore avenues for him to be discharged both from the Roy Fagan Centre and from the effect of the order. An application was lodged to review the order. That review was listed for hearing on 28 October 2016. At the same time Ms Campbell arranged for Mr Stefaniw's cognitive functioning to be assessed by Dr Grant Blake, a registered psychologist. Dr Blake duly provided an independent psychological assessment in relation to Mr Stefaniw's cognitive functioning and decision-making capacity. That report was tendered at the inquest.[15]

27. The substance of the report, and a summary of Dr Blake's opinion, was that Mr Stefaniw was in need of a guardian and, moreover, his decision-making was so impaired that the order was fully justified. He saw Mr Stefaniw on 11 October 2016 and authored a report the next day. He sent that report to Ms Campbell who, upon receipt of it, made an appointment to see Mr Stefaniw and discuss the content of it with him in person. Ms Campbell gave evidence that she met with Mr Stefaniw at the Roy Fagan Centre on 19 October 2016. She said she met with him in his room and spoke with him about the contents of the report for just over an hour or so. Ms Campbell's evidence was that Mr Stefaniw was in bed when she saw him and that no one else was present in the room. She said that she read the report to Mr Stefaniw and provided him with a copy. The evidence was that Mr Stefaniw instructed her to seek a second opinion.

28. Ms Campbell, in addition to making two affidavits, gave evidence at the inquest. During her evidence she stated that after she had finished speaking with Mr Stefaniw she spoke with the then Clinical Nurse Consultant, Mr Colin Brett. She said she told Mr Brett that she had taken

[15] Exhibit C18.

Mr Stefaniw through the contents of the report and indicated that although Mr Stefaniw was not obviously upset by the contents of the report those contents may warrant extra care or observation. She said that her conversation with Mr Brett was consistent with her usual practice of updating staff. Ms Campbell recorded the conversation with Mr Brett in a file note she made a few days after Mr Stefaniw's death. The file note was tendered at the inquest.[16]

29. Mr Brett made an affidavit[17] and also gave evidence at the inquest. In the affidavit he said:

> *"My staff were anxious about Sarah Campbell spending so much time with Mr Stefaniw that they asked me to speak with her. They were concerned as to why she was supporting his application when he couldn't even look after himself.*
>
> *I was present in the room with Sarah [Campbell] and Mr Stefaniw when they were discussing the finalised report. This was on the Thursday, the day before Mr Stefaniw committed suicide in October 2016".*

30. Contextually, the report referred to by Mr Brett in his affidavit can only be the report commissioned by Ms Campbell from Dr Blake.

31. The evidence in Mr Brett's affidavit as to when Ms Campbell attended upon Mr Stefaniw was, he conceded in his evidence at the inquest, wrong. Mr Stefaniw died on Friday 21 October 2016. The day before that, Thursday 20 October was, Mr Brett agreed, and I take judicial notice of, Show Day in Southern Tasmania, a public holiday which Mr Brett said he did not work. Nor did Ms Campbell. Her evidence was, as has already been mentioned, that she saw Mr Stefaniw on 19 October, two days before his death. I accept her evidence as to the date of her final attendance on Mr Stefaniw.

[16] Exhibit C27B (Annexure B) and Legal Aid Commission of Tasmania file C27.
[17] Exhibit C28.

32. I do not accept that Mr Brett was, as he said in his affidavit, present when Ms Campbell met with, and discussed Dr Blake's report, with Mr Stefaniw. Ms Campbell's evidence on the point is to be preferred. Unlike Mr Brett she impressed as a careful witness. Where there is any dispute between her and Mr Brett's evidence I prefer her evidence. His credibility was poor. He was wrong about the date and, doing the best I could, appeared to resile from a good deal of the material that he advanced in his affidavit. I accept Ms Campbell's evidence that she had alerted Mr Brett to the fact that Mr Stefaniw may not be happy with Mr Blake's report and that staff "should keep an eye on him". I am satisfied that Mr Brett did nothing about this information and passed it on to no one and recorded it nowhere.

33. I should also add, to the extent that it is necessary to say so, that I am completely satisfied that Ms Campbell's representation of Mr Stefaniw was entirely appropriate, that at all times she complied with her professional duties and that her conduct in no way contributed to his death.

20 and 21 October 2016

34. Mr Stefaniw was found naked and hanging by an electrical cord around his neck, tied to a cupboard in his room in the Rosewood Unit of the Roy Fagan Centre by Nurse Janelle Coleman, at about 6.00am on 21 October 2016.

35. Subsequent investigation determined, and I am satisfied, that the electrical cord belonged to an electronic PlayStation type device belonging to Mr Stefaniw and situated in his room.

36. Mr Stefaniw had last been seen alive by Ms Coleman who was working a night shift at around 3.30am.[18] She saw him sitting on his bed

[18] Exhibit C11.

watching television. The evidence from several staff members was that it was not unusual for Mr Stefaniw to be awake at that time of the morning. In her affidavit tendered at the inquest Ms Coleman said that Mr Stefaniw "looked fine" when she saw him at 3.30am.[19]

37. Nurse Makwe said in her evidence that at about 4.00am she heard Mr Stefaniw's television volume increase. Again the evidence was that it was far from unusual for Mr Stefaniw to raise the volume of his television. It would seem that he had little else in his life other than his television and a game console. From time to time requests were made of Mr Stefaniw to turn his television down although on this occasion no such request was made of him.

38. Although the evidence was that Mr Stefaniw was restricted somewhat physically in his movements and needed a walking frame to assist with mobility, there is nothing to suggest that he was incapable of tying the electrical cord around his neck nor placing himself in the position that he was found by staff. The circumstances in which he was living and the nature of the secure unit lead me to conclude that no other person had access to his room and therefore was involved in any way in his death.

39. Whether Mr Stefaniw intended to take his own life is less easy to be definitive about. There was a good deal of evidence that he had a history of refusing to eat or drink and take his medications - activities undertaken by him usually by way of protest against what he perceived to be some type of injustice he was subjected to. The fact that he was found naked is unremarkable – at least in the context of Mr Stefaniw - because there was a good deal of evidence that he spent much of his time naked. His being naked neither supports nor detracts from a conclusion that his death was suicide. In all of the circumstances, whilst satisfied that Mr Stefaniw placed the electrical cord around his neck, I cannot be satisfied to the requisite legal standard that he did so with the

[19] Exhibit C11.

express intention of ending his own life. This is because, as has already been said, he had a history of undertaking actions designed to protest against perceived injustices and also given his level of cognitive impairment he may not have perceived the finality of the consequences of his actions.

Formal Findings

40. On the basis of the evidence at the inquest, I find, pursuant to Section 28(1) of the *Act* that:

    a. The identity of the deceased is Gerard Ernest Stefaniw;

    b. Mr Stefaniw died in the circumstances set out in this finding;

    c. The cause of Mr Stefaniw's death was asphyxia caused by hanging; and

    d. Mr Stefaniw died on 21 October 2016 at the Roy Fagan Centre, Lenah Valley in Tasmania.

Report on Care, Supervision or Treatment

41. As a consequence of the conclusion I have reached that Mr Stefaniw was a person 'held in care' in terms of the *Act* at the time of his death, it is necessary for me to comment upon his care, supervision and treatment whilst in care.

42. Evidence was adduced at the inquest from Dr Alison Cleary, a geriatrician whose care Mr Stefaniw was under from 28 February 2015 to 24 August 2015. In addition, Dr Matthew Fasnacht gave evidence. Dr Fasnacht oversaw Mr Stefaniw's treatment and had him under his direct care in May 2016. Mr Stefaniw also received treatment from Dr Anisha Grover at the time of his death.

43. Dr Cleary conducted an assessment of Mr Stefaniw's cognitive capacity in care in 2016. She determined as a result of that assessment that he

was impaired and was suffering vascular dementia. His cognitive capacity was assessed to be well below normal. Dr Cleary did not identify Mr Stefaniw as being a particular suicide risk although she described him as “highly volatile, impulsive… and a risk taker opposed to restrictions”. Dr Cleary expressed surprise that Mr Stefaniw had committed suicide largely as a result of his limited mobility due to his cerebral palsy, his frailty and mobility impairments.

44. Dr Cleary’s evidence was helpful in determining the level of care and surveillance that Mr Stefaniw required. She said he needed care but would have been opposed to increased surveillance. She was very familiar with the Rosewood Unit at the Roy Fagan Centre where Mr Stefaniw was housed at the time of his death. The evidence was, and I accept, that increased surveillance of Mr Stefaniw would have been very difficult to carry out without agitating him further. Dr Cleary highlighted the ethical conundrum that increased surveillance in the aged care sector causes as it is an unquestioned intrusion on independence. Her opinion, which I accept, was that increased surveillance, generally speaking, would not have been of any value to Mr Stefaniw and was not justified.

45. Dr Fasnacht said in his evidence that Mr Stefaniw had exhibited chronic suicidal ideation and behaviour which included an overdose in August 2016, threats to overdose in February 2015 and a reported drug overdose in November 2010. Notwithstanding this, he was unaware of past attempts or expressed intentions to commit suicide by hanging. Dr Fasnacht’s evidence was, in many respects, similar to Dr Cleary’s, that is to say, Mr Stefaniw’s history of agitation was usually associated with a response to dissatisfaction such as medication or his perception (real or imagined) of restrictions upon his ability to act independently. The evidence was that this behaviour sometimes presented as verbal abuse, hostility and aggression.

46. Like Dr Cleary, Dr Fasnacht said in his evidence at the inquest that, in his view, Mr Stefaniw would have reacted adversely to any increase in surveillance.

47. While I accept that, in a general sense, it would have been impracticable and even counter-productive for staff to monitor Mr Stefaniw much more than they did in general, the situation would have been materially different had they been aware of the adverse report, about which Ms Campbell had made Mr Brett aware, but with which information Mr Brett did nothing. It is likely that an increased level of checking would have been undertaken.

48. The evidence satisfies me in a general sense that the care, supervision and treatment of Mr Stefaniw was subject to one qualification of an entirely appropriate standard. That qualification is that, as has already been alluded to, Mr Brett was apprised of reason to have concern by Ms Campbell and he did nothing to pass that information on. None of the staff rostered on in the Rosewood ward had any knowledge that Mr Stefaniw had received an adverse report. As a consequence they did nothing to depart from the ordinary regime for checking upon him as they had no reason to do so.

Conclusion

49. The circumstances of Mr Stefaniw's death do not require me to make any comments or recommendations. This is because I am satisfied by the evidence that was adduced at the inquest, and in particular the internal review carried out by the Roy Fagan Centre after Mr Stefaniw's death,[20] that a number of appropriate steps have been taken to address the issues that arose from Mr Stefaniw's death. In particular, the Centre has provided staff with increased training in relation to the assessment and management of risk of self-harm. In addition, steps have been taken

[20] Exhibit C16.

to remove, where appropriate, hanging points from various rooms on the wards. It is recognised, however, that it is impossible to eliminate every single hanging point from every room in each ward without compromising the quality of life of the patients at the facility.

50. I express my thanks to counsel at the inquest for their assistance.

51. In conclusion, I offer my sincere and respectful condolences to Mr Stefaniw's family on their loss.

Dated: 18 January 2019

Simon Cooper
Coroner