IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2015 6083

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)

Section 67 of the Coroners Act 2008

(Amended pursuant to section 76A of the Coroners Act 2008 as at 19 February 2020)[1]*

Deceased:	**WARD HARKER**
Findings of:	**CORONER DARREN J BRACKEN**
Delivered on:	30 January 2020
Delivered at:	Coroners Court of Victoria, Kavanagh Street, Southbank
Hearing date:	4 – 6 December 2019
Appearances:	Mr P. Chadwick of Her Majesty's Counsel for Mr A. Tye Mr D. Oldfield of Counsel for Alfred Health
Counsel assisting the Coroner:	Senior Constable J. Allen Police Coronial Support Unit

[1] Refer to Schedule of Correction of Errors at pages 33-34.

Catchwords	Suspected homicide. No person charged with an indictable offence in respect of a reportable death, mandatory inquest

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HIS HONOUR:

BACKGROUND

1 Mr Ward Harker was 93 years old when he died in the Alfred Hospital on 1 December 2015. Mr Harker was a much-loved husband and father of Geoffrey Harker, Bruce Harker and Elizabeth Tye and grandfather to Ms Tye's son Angus.

2 Early in 2015, Mr Harker's wife moved from the home they shared in Sunbury, Victoria to an aged care facility also in Sunbury. Some two months later Mr Harker, suffering from dementia and unable to properly care for himself, moved from their home to the *'Noel Miller Centre'*, an aged care facility in Glen Iris.

3 On Monday 23 November 2015 and after complaining to staff at the Noel Miller Centre of abdominal pain, Mr Harker was taken to the Emergency Department of the Alfred Hospital where treating doctors diagnosed an inoperable perforated bowel and admitted Mr Harker to the hospital accommodating him in Ward 2 East.

4 During the morning of the following day, Mr Harker's family, including his daughter Ms Tye, discussed Mr Harker's condition, prognosis and care with doctors and hospital staff. All agreed that Mr Harker was to receive palliative care. Later that morning Ms Tye telephoned Mr Angus Tye, then living in Canberra and left him a message telling him of Mr Harker's admission to Hospital and a little about his condition. Later still that day Mr Tye flew to Melbourne and at about 11.00pm met his mother at the hospital.[2]

5 In the days following Ms Tye and other family members visited Mr Harker. Mr Tye regularly visited his grandfather staying at the hospital throughout most days.

6 On Saturday 28 November 2015, Mr Harker lost consciousness and remained unconscious until his death on 1 December 2015.

7 On 1 December 2015 and shortly after Mr Harker's death, Registered Nurse (**RN**) Nicholas Saunders, who was then working on Ward 2 East saw Mr Tye in the corridor near Mr Harker's room and noticed that he looked upset. RN Saunders took Mr Tye to a

[2] Inquest Brief, Statement of Elizabeth Tye dated 3 December 2015, p.78.

nearby *'family counselling room'* and later told police that there Mr Tye, said to him words to the effect of:

> *"I put him to sleep...I smothered him ....I grabbed the pillow. I put it over his face"*[3]

8 Mr Harker's death was investigated by the Victoria Police Homicide Squad. No charges were filed.

THE PURPOSE OF A CORONIAL INVESTIGATION

9 Mr Harker's death constituted a '*reportable death*' pursuant to section 4 *Coroners Act 2008* (Vic) (**the Act**); his death occurred in Victoria, and appeared to be one or more of unexpected, unnatural, violent or to have resulted directly or indirectly from an injury.[4]

10 The jurisdiction of the Coroners Court of Victoria is inquisitorial.[5] The purpose of a coronial investigation is to independently investigate a reportable death and to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[6] It is not the role of the coroner to lay or apportion blame, but rather to establish facts.[7] Neither is it the coroner's role to determine criminal or civil liability.

11 For coronial purposes, '*circumstances in which death occurred'*, refers to the context and background surrounding circumstances of the death. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the death, it is confined to those circumstances which are sufficiently proximate and may be causally relevant to the death.[8]

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[3] Inquest Brief, Statement of Nicolas Saunders dated 1 December 2015, p.63.
[4] Section 4, *Coroners Act 2008.*
[5] Section 89(4) *Coroners Act 2008.*
[6] Preamble and section 67, *Coroners Act 2008.*
[7] *Keown v Khan* (1999) 1 VR 69.
[8] Finding into death of Michael Atakelt with inquest, COR 2011 2479; Harmsworth v The State Coroner [1989] VR 989.

12 The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths by the Coroner making comments and recommendations. This is generally referred to as the '*prevention*' role of the Court.[9]

13 Coroners are also empowered to:

(a) Comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and

(b) Make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice. These powers are the vehicles by which the prevention role may be advanced.[10]

14 Coronial findings must be underpinned by proof of relevant facts on the balance of probabilities, giving effect to the principles explained by the Chief Justice in *Briginshaw* v *Briginshaw*.[11] Those principles explain that the 'strength of evidence' required to so prove facts varies according to the nature of the facts and the circumstances in which they are sought to be proved.[12] The principles enunciated by the Chief Justice in *Briginshaw* do not create a new standard of proof; there is no such thing as a "*Briginshaw Standard*" or "*Briginshaw Test*" and use of such terms may mislead.[13] Facts should not be considered to have been proved on the balance of probabilities by inexact proofs, indefinite testimony, or indirect inferences,[14] rather such proof should be the result of clear, cogent or strict proof in the context of a presumption of innocence.[15] Proof of facts underpinning a finding that would, or may, have an extremely deleterious effect on a party's character, reputation or employment prospects demands a weight of

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[9] Preamble and section 1(c), Coroners Act 2008; Victoria, Parliamentary Debates, Legislative Assembly, 9 October 2008, 4030 (Rob Hulls).
[10] Sections 67(3) and 72(2), Coroners Act 2008.
[11] (1938) 60 CLR 336, 362-363. See *Domaszewicz v State Coroner* (2004) 11 VR 237, *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152 [21]; *Anderson v Blashki* [1993] 2 VR 89, 95.
[12] *Qantas Airways Limited v Gama* (2008) 167 FCR 537 at [139] per Branson J but bear in mind His Honour was referring to the correct approach to the standard of proof in a civil proceeding in a federal court with reference to section 140 of the *Evidence Act 1995* (Cth); *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* (1992) 67 ALJR 170 at pp170-171 per Mason CJ, Brennan, Deane and Gaudron JJ.
[13] *Qantas Airways Ltd v Gama* (2008) 167 FCR 537, [123]-[132].
[14] *Briginshaw v Briginshaw* (1938) 60 CLR 336, at pp. 362-3 per Dixon J.
[15] *Briginshaw v Briginshaw* (1938) 60 CLR 336, at pp. 362-3 per Dixon J.; *Cuming Smith & CO Ltd v Western Farmers Co-operative Ltd* [1979] VR 129, at p. 147; *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* (1992) 67 ALJR 170 at pp170-171 per Mason CJ, Brennan, Deane and Gaudron JJ.

evidence commensurate with the gravity of the facts sought to be proved and the content of the finding based on those facts.[16]

15 Section 49 of the Act requires the court's principle registrar to notify the Director of Public Prosecutions if the corner investigating a death believes that an indictable offence may have been committed in connection with the death.

THE INVESTIGATION & INQUEST

16 I conducted an inquest into Mr Harker's death between 4 and 6 December 2018 during which ten witness gave evidence and 17 exhibits together with the balance of the Inquest Brief were tendered.

Mr Tye's objection to giving evidence.

17 I issued a subpoena to Mr Tye requiring him to give evidence at the inquest. Mr Tye answered the subpoena and at the commencement of the inquest, through his counsel Mr Chadwick QC, objected to giving evidence on the ground that giving evidence may tend to prove that he had committed an offence. Mr Chadwick made detailed submissions and after considering their content, basis and the circumstances I did not require Mr Tye to give evidence.

18 My decision not to require Mr Tye to give evidence and the reasons are subject of a separate written decision.

19 Subsequent to my announcing that I would not require Mr Tye to give evidence, Mr Chadwick informed me that Mr Tye would take no further part in the inquest directly or by counsel. Indeed Mr Chadwick explained that Mr Tye would not be present during the inquest. I briefly canvassed some of the evidence contained in the inquest brief with Mr Chadwick including that expected to be given by Registered Nurse Saunders[17] alleging that Mr Tye said to him words to the effect:

(a) "I put him to sleep.

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[16] *Anderson v Blashki* [1993] 2 VR 89, following *Briginshaw v Briginshaw* (1938) 60 CLR 336, referring to *Barten v Williams* (1978) 20 ACTR 10; *Cuming Smith & Co Ltd v Western Farmers' Co-operative Ltd* [1979] VR 129; *Mahon v Air New Zealand Ltd* [1984] AC 808 and *Annetts v McCann* (1990) 170 CLR 596.
[17] Inquest Brief, Statement of Nicolas Saunders dated 1 December 2015, pp.64-65.

(b) I smothered him.

(c) He was gasping for air, so I grabbed a pillow. I put it over his face.

(d) If you want to put me in prison or lock me up that's fine. I didn't want to see him like that anymore."[18]

20 Mr Chadwick told me that he understood the evidence that may be given and that he had explained to Mr Tye the effects of witnesses giving *'unchallenged'* evidence including such witnesses not being cross-examined.[19]

21 Thereafter Mr Tye and his lawyers left the court and took no part in the inquest.

The Investigation

22 On 1 December 2015 at 5.29pm, Senior Constable Ferguson and Constable Kennedy attended the Alfred Hospital and spoke to Mr Tye. Senior Constable Kennedy arrested Mr Tye and *'cautioned'* him telling him of his rights.[20]

23 Mr Tye was taken to the City West Police station where he was examined by a Forensic Medical Officer Dr Romey Giles and at 7.15pm a preliminary breath test was conducted yielding a breath alcohol reading of 0.205. Given the reading police did not then interview Mr Tye about Mr Harker's death.[21]

24 On the same day, police examined Mr Harker's hospital room and found a bag belonging to Mr Tye containing a 700ml bottle of Caribbean Rum with an estimated 40 ml remaining in it.[22] Police seized four pillowcases, although they were not subject to any forensic analysis.

25 Police established that there is no recorded CCTV footage of the hallway adjacent to Mr Harker's room.

26 On 2 December 2015, Mr Tye was interviewed by the Homicide Squad in relation to the death of Mr Harker, made a 'no-comment' interview and was released without charge.

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[18] Inquest Brief, Statement of Nicolas Saunders dated 1 December 2015, p.65.
[19] T.74, 94-95.
[20] Inquest Brief Statement of Fionnuala Kennedy dated 1 December 2015 pp.99 – 102.
[21] Inquest Brief, Statement of Dr Romey Giles dated 15 December 2015, p.104
[22] Inquest Brief, Statement of Riley Scott dated 17 May 2016, p.120.

27 Mr Tye has not since been charged with any offences in relation to Mr Harker's death.

Evidence at the Inquest

28 The evidence set out in this section is extracted from the Inquest Brief and viva voce evidence of witnesses.

29 On Monday 30 November 2015, Ms Tye stayed by her father's bedside believing that he would die that day. At approximately 11.30am, while RN Kristine Ermitano was changing the syringe driver administering medication to Mr Harker when Ms Tye asked her, a number of times, why Mr Harker was still being provided with medication. RN Ermitano's statement records Ms Tye being agitated, speaking loudly and telling her that the family had thought that Mr Harker would have died over the preceding weekend. RN Ermitano records her impression that Ms Tye wanted something to happen so that her father's life would end although makes it clear that she did not think that Ms Tye wanted to do something herself to end his life. RN Ermitano's statement reveals that she was somewhat concerned about what Ms Tye said and her manner. RN Ermitano told Ms Tye to speak to the doctor. [23] During her evidence, Ms Tye said she did not remember this discussion with RN Ermitano, however she did not deny having had that discussion. Ms Tye explained that the conversation as she recalled it dealt with family concerns about Mr Harker's condition and the expectation that Mr Harker would have died the preceding weekend given her discussion about his condition and treatment with the *'palliative care doctor'*. Ms Tye made very clear that at no time would she have spoken about *'getting rid of her father'*.[24]

30 In his written statement provided to police RN Ryan Simpson said that sometime on 27 November one of Mr Harker's sons asked him if he could give Mr Harker a little extra morphine. RN Simpson said he could not recall the name of the person to whom he spoke but remembered that he had grey hair and glasses and he thought it may have been Mr Geoff Harker.[25] RN Simpson told this person that his request was in fact illegal. RN Simpson also refers to the same person asking him on—he thinks—Monday 29 November 2015, how much longer Mr Harker would remain as he was.[26]

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[23] Inquest Brief, Statement of Kristine Ermitano dated 5 December 2015, p.32.
[24] T.224 – 225.
[25] Inquest Brief Statement of Ryan Simpson dated 5 December 2015 p.40.
[26] Inquest Brief Statement of Ryan Simpson dated 5 December 2015 p.41.

On the morning of Tuesday 1 December 2015, at approximately 8.30am, RN Simpson took a telephone call at the nurses' station from a man who RN Simpson thought was one of Mr Harker's sons, indeed in his statement he refers to thinking that it was the same son that he had spoken to twice before, who again asked how much longer it would be before Mr Harker died. RN Simpson told this person that he could not give a definite time frame.[27] Mr Bruce Harker's evidence at the inquest was consistent with it being him that spoke to RN Simpson on 27 November, not his brother Geoff.[28] Further, Mr Bruce Harker gave evidence that his brother Geoff is bald and does not wear glasses *"so it was obviously me"* [that RN Simpson described in his statement]. Mr Bruce Harker gave evidence about having had the conversations with RN Simpson but did not agree that they were in the terms set-out in RN Simpson's statement. When asked about the discussions he had with RN Simpson he gave evidence that he was concerned about and referred to his father being in ongoing pain.[29]

31 RN Nicholas Saunders told the court that on 28 November he was rostered to work the morning shift on Ward 2 East; Mr Harker was one of his assigned patients. At about 10.00am RN Saunders was with Mr Harker when Mr Tye arrived on the ward and, at approximately 11.45am, Ms Tye arrived. Mr Tye and Ms Tye spoke to RN Saunders about the 'comfort' that the palliative care was providing to Mr Harker. Ms Tye asked RN Saunders how long her father was going to be like he was, unconscious and unresponsive. RN Saunders told Ms Tye that it depended on how fit and healthy Mr Harker was but that the medication being used to keep Mr Harker comfortable would most likely end his life at some point. RN Saunders reported that a short time later Ms Tye said:

> *"...if an animal was in this state they would be put out of their misery at this stage."*.[30]

RN Saunders statement refers to Ms Tye telling him that it was cruel to keep Mr Harker as he was and that euthanasia should be legal.[31] Ms Tye acknowledged this conversation and said that at no time did she discuss acting to end her father's life with Mr Tye.[32]

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[27] Inquest Brief, Statement of Ryan Simpson dated 5 December 2015, p.41.
[28] T.202.
[29] T.202-204.
[30] T.126-127.

32 It is clear that Mr Harker's family were anxious about Mr Harker's suffering and condition. The evidence reveals that they spoke to hospital staff about how long he was expected to live while receiving palliative care. What, if any, discussion the family had amongst themselves about Mr Harker's condition and prognosis is unclear. What is clear however is that there is no evidence that the discussions with hospital staff or intra-family discussions were informed, far less driven by anything other than concern for Mr Harker's comfort.

Events of 1 December 2015

33 RN Saunders made a written statement to police dated 1 December 2015, gave viva voce evidence in chief and was cross examined.[33]

34 On 1 December 2015 Ms Tye was in and out of Mr Harker's room throughout the morning and went home after lunch while Mr Tye stayed at the hospital with Mr Harker.

35 At approximately 2.30pm, RN Simpson returned from his lunch break and assisted colleagues RN Tabios and RN Dunster, to turn Mr Harker onto his left side. Pillows were placed under Mr Harker's head, behind his back and between his legs to prevent pressure injuries. A fourth pillow was left on a bench near the sink in the room.[34]

36 At approximately 3.00pm, RN Alan Buchan went to Mr Harker's room answering the call buzzer and found Mr Tye there. In his written statement RN Buchan describes Mr Tye telling him that he thought his grandfather had died. [35] RN Buchan reported that Mr Tye was visibly upset but apparently not effected by alcohol or drugs and asked where he could charge his phone so that he could call his mother. RN Katherine Hesketh came into Mr Tye's room and in her statement said that she did not notice that Mr Tye was then affected by drugs or alcohol. [36] Mr Tye left the room to charge his phone and, at least according to RN Hesketh, seemed more interested in getting his phone charged than waiting for confirmation of his grandfather's death.[37]

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[31] Inquest Brief Statement of Nicholas Saunders dated 1 December 2015, p.63
[32] T.213.
[33] T.124 – 151.
[34] Inquest Brief, Statement of Ryan Simpson dated 5 December 2015, 41.
[35] Inquest Brief, Statement of Alan Buchan dated 9 December 2015, p.50.
[36] Inquest Brief p.89 – 91.
[37] Inquest Brief, Statement of Katherine Hesketh dated 2 December 2015, p.88.

37 At approximately 3.15pm, RN Hesketh and RN Tooth[38] went to Mr Harker's room and saw Mr Harker was positioned on his left side facing the room's door. RN Hesketh removed two pillows from Mr Harker's bed, one of which was on Mr Harker's left side, and according to RN Hesketh, was out of place and not placed the way a nurse would place it - it served no pressure relieving or comfort purpose. RN Hesketh later told police that she placed this pillow on a chair which was located to Mr Harker's left-hand side and that she then removed a second pillow from behind Mr Harker's back and placed it on the chair on top of the first pillow. Mr Harker was then positioned so that he was lying on his back with a pillow under his head and a pillow under his legs. His arms were crossed across his abdomen.[39]

38 At 3.20pm, RN Tooth sent a pager message to the Upper Gastrointestinal System Medical Team (the primary team in charge of Mr Harker's care) which stated,

> *"Ward 2E bed 29 pt HARKER has passed away at approx. 1515. Grandson present and is calling the NOK to inform. Thanks 63744."*[40]

39 At 3.29pm, RN Tooth telephoned Ms Tye from the nurses' station and passed the telephone to Mr Tye who spoke to his mother. Ms Tye later told police that she recalled speaking to Mr Tye who told her of her father's death and that she told him that she did not think that he was drunk when he spoke to her.[41]

40 RN Tooth remained at the nurses' station to complete her nursing notes. Her statement records that Mr Tye asked her for a pen and some paper and that she saw Mr Tye come and go from the ward and go into and leave Mr Harker's room. In her statement RN Tooth refers to seeing Mr Harker going into the toilet on the ward and then leave the ward.[42]

41 At approximately 4.00pm, Mr Tye approached RN Tooth at the nurses' station. Mr Tye spoke to her and she telephoned Ms Tye to see if she wanted to come to the hospital and say goodbye to her father. Ms Tye told RN Tooth that she did not. RN Tooth formed the opinion that Mr Tye was '*off his face*', intoxicated, and informed him that his mother

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[38] Inquest Brief Statement of Catherine Tooth dated 2 December 2015, p.35.
[39] Inquest Brief, Statement of Katherine Hesketh dated 2 December 2015, p.53.
[40] Inquest Brief, Exhibit 6, 168.
[41] Inquest Brief, Statement of Elizabeth Tye dated 3 December 2015, p.80.
[42] Inquest Brief, Statement of Catherine Tooth dated 2 December 2015, p.38.

was not going to come to the hospital.[43] Mr Tye asked if he could accompany his grandfather to the morgue. RN Tooth, nearing the completion of her shift, asked afternoon nursing staff members RN Dunster and RN Tabios to assist and left the hospital a short time later.[44]

42 At 4.15pm, Andrew Coutts, an administrative officer, saw Mr Tye in a hallway on the lower ground floor of the hospital.[45] Mr Coutts reported that Mr Tye appeared out of place, this area not usually being used by those visiting the hospital. In his statement to police Mr Coutts described talking to Mr Tye who, he said smelled strongly of alcohol and appeared intoxicated and possibly distressed; he recalled Mr Tye saying something about his grandfather dying.[46] Mr Coutts reported that Mr Tye was rambling and at one stage mentioned something about his grandfather's last breath and something about having been lucky to be in the room when his grandfather died. Mr Coutts realised that Mr Tye was saying that his grandfather was dead not that he was dying, although when he made his statement Mr Coutts said that he could not remember exactly what Mr Tye had said.[47]

43 At approximately 4.30pm, Mr Morris, a security guard, saw Mr Coutts and Mr Tye on the ground floor near the main reception. Mr Coutts left Mr Tye with Mr Morris. In his statement Mr Morris said that he thought that Mr Tye either had a severe mental health problem or was alcohol or drug affected.[48] After establishing why Mr Tye was at the hospital, Mr Morris spoke to the nurse in charge of Ward 2 East who told him that Mr Tye could say a last goodbye to Mr Harker if escorted by security.[49]

Registered Nurse Saunders

44 Mr Morris and another security officer, Mr Antilano escorted Mr Tye to Ward 2 East where they met RN Saunders. While RN Saunders was not assigned to look after Mr Harker that day, he recognised Mr Tye from previous visits. RN Saunders asked Mr Tye, if he was okay and Mr Tye said that he was.[50] RN Saunders noted that Mr Tye was

[43] Inquest Brief, Statement of Catherine Tooth dated 2 December 2015, p.38.
[44] Inquest Brief, Statement of RN Catherine Tooth dated 2 December 2015, p.38.
[45] Inquest Brief, Statement of Andrew Coutts dated 4 December 2015, p.56.
[46] Inquest Brief, Statement of Andrew Coutts dated 4 December 2015, p.56.
[47] Inquest Brief, Statement of Andrew Coutts dated 4 December 2015, p.57.
[48] Inquest Brief, Statement of Paul Morris dated 1 December 2015, 60.
[49] Inquest Brief, Statement of Paul Morris dated 1 December 2015, 60.
[50] T.128 -129

slurring his words and thought that he 'did not look quite right'.[51] In evidence RN Saunders said he thought that Mr Tye was inebriated and guided him to a nearby 'family room' and asked the security officers to wait outside. RN Saunders again asked Mr Tye if he was alright.[52] RN Saunders gave evidence that Mr Tye said:

"Can I tell you what I did?"[53]

45 RN Saunders told Mr Tye that he could, expecting that perhaps Mr Tye was going to tell him that after his grandfather's death that he had used illicit drugs[54] but RN Saunders gave evidence that Mr Tye said something to the effect of,

"I did it I put him to sleep."[55]

46 RN Saunders gave evidence that Mr Ty was upset and started to cry and said that he hadn't told anyone else and asked him, RN Saunders, if he was going to tell anyone.[56] RN Saunders said,

"He'd said that he'd smothered him after he said he'd put him to sleep"[57]

47 RN Saunders told Mr Tye that he just wanted to make sure he, Mr Tye, was okay and then left Mr Tye alone in the room.

48 RN Saunders went and told Mr Morris and his supervisor RN Hesketh what Mr Tye had told him[58] and RN Hesketh 'contacted management'.

49 RN Saunders then returned to the 'family room' and found Mr Tye slumped over his chair.[59]

50 Concerned, RN Saunders again asked Mr Tye if he was 'okay'. Mr Tye responded by raising his head smiling and telling him that he was.[60]

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[51] Inquest Brief, Statement of Nicolas Saunders dated 1 December 2015, 64 T.130.
[52] Inquest Brief, Statement of Nicolas Saunders dated 1 December 2015, p.64
[53] T.132 -133.
[54] Inquest Brief, Statement of Nicolas Saunders dated 1 December 2015, p.64
[55] T.133.
[56] T.134.
[57] T. 134.
[58] Inquest Brief, Statement of Nicolas Saunders dated 1 December 2015, p.65.
[59] Inquest Brief, Statement of Nicolas Saunders dated 1 December 2015, p.65.
[60] T.139.

51 RN Saunders sat with MR Tye and asked him to go over what he had previously told him. RN Saunders gave evidence that Mr Tye,

"*...sort of denied that he had said anything had happened – that he'd told me anything, initially. I then said to him. "Yeah, we just had a conversation. You said you smothered your – your grandad." Something along those lines. And then he agreed. He said, "I couldn't do it anymore." Something along the lines of, "I put the pillow over his face and that was it", and he sort of gestured to say the end.....He got a little agitated and said "If you want to - if you want to go and tell the police, that's fine."*[61]

52 RN Saunders gave evidence that he asked Mr Tye,

"*...when he decided to do it, he* [Mr Tye] *said something along the lines of three months ago. In looking back on it now that was an odd thing for him to say and I asked him what made you decide to do it today, and he said that "He was gasping for air so I grabbed a pillow and put it over his face".*"

Registered Nurse Katherine Hesketh

53 RN Hesketh gave evidence in chief by reading and adopting the content of her statement dated 2 December 2015.[62]

54 RN Hesketh gave evidence that at about 3.00pm on 1 December 2015 she saw Mr Tye leave his grandfather's room and speak to RN Buchan saying words to the effect 'I think he's died can you have a look'.[63] RN Hesketh went into Mr Harker's room with RN Tooth to find Mr Harker dead. RN Hesketh turned off loud music that was playing and reports seeing a pillow that she thought was out of place, not as she had left it when she had re-arranged the pillows on Mr Harker's bed earlier in the day.[64] RN Hesketh gave evidence of having then positioned Mr Harker in accordance with usual practice for a patient who has died.[65] She gave evidence that shortly after 5.15pm RN Saunders told her that Mr Tye had told him that he, Mr Tye, had smothered his grandfather.[66] RN Hesketh gave evidence that even though she thought that a crime may have been

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[61] T.140.
[62] T.98.
[63] T.104.
[64] Inquest Brief, Statement of Katy Hesketh dated 2 December 2015, p53 and T. 104, 110, 120, 121.
[65] T.106.
[66] T.108.

committed she did not think about securing Mr Tye's room by closing the door and stationing a security guard outside to prevent entry although she said that she could have. RN Hesketh gave evidence that she looked into Mr Harker's room sometime after 5.00pm and saw Mr Harker positioned in the bed differently from how she had positioned him after she had found him dead.[67]

Gahnn Squires

55 Ms Gahnn (Jeanne) Squires, Mr Tye's girlfriend in December 2015, gave evidence by video link. Ms Squires read and adopted a written statement drawn by Detective Senior Constable Saulle dated 25 May 2015 in Canberra.[68]

56 In her statement Ms Squires described having then been in a relationship with Mr Tye for two and a half years, of knowing that Mr Tye and his grandfather were very close and of Mr Tye going to Melbourne on 20 November 2015 because his grandfather was expected to die within the next 24 hours. Ms Squires refers to being in 'daily text or Facebook contact' with Mr Tye while he was in Melbourne and explicitly refers to one message in which Mr Tye told her that his grandfather was gasping for air and then stopped breathing for a period then gasping for air again. Ms Squires referred to having received a text message from Mr Tye that she said, said something like '*I wish I could make it stop but I wouldn't be able to live with myself if I did*'.[69]

57 Ms Squires also gave evidence of having received a message from Mr Tye on 1 December 2015 stating;

> "*I just had the most gruesome thought, if I used a pillow to put him out of his misery, nobody would know the difference, however, I would and that's the only thing that stops me...*"[70]

58 Ms Squires gave evidence that she responded, and Mr Tye wrote a message back to her at 2.17pm:

> "*He's so skinny and wasted away, no food or drink since last Monday. Touch your index finger and thumb together and that's the size of his upper arm, forearm and*

[67] T.101.
[68] Inquest Brief, Statement of Jeanne Squires dated 25 May 2017, pp. 68-71.
[69] Inquest Brief, Statement of Jeanne Squires dated 25 May 2017, p.69.
[70] Inquest Brief, Exhibit 4, 158.

lower leg. How a man of 93 years old can survive with a perforated bowel, no food and no water whilst being pumped full of morphine and other sedatives for over a week is a clear as day example of my grandpa's dog-headedness. He still has a dashing crop of silver curls and they say you get your hair from your mother's father...too many difficult conversations about the future and current situations..."[71]

59 Ms Squires gave evidence of both she and Mr Tye having been alcoholics and Mr Tye having sought treatment from the Melbourne Clinic after his grandfather's death.[72]

60 Whilst Ms Squires confirmed having received the text messages from Mr Tye as set out in paragraphs 57 and 58 above. When asked about why she didn't include in her statement a reference to the text message in which Mr Tye refers to putting a pillow over Mr Harker's head said that she hadn't remembered it when she was making her statement.[73]

61 Ms Squires said that Mr Tye told her that he was holding his grandfather's hand when he took his last breath.[74] Ms Squires gave evidence that Mr Tye told her that after his grandfather died he called his mother to let her know what happened and the next thing he knew someone was taking his fingerprints and someone giving him a document and at the top of the sheet the charge was murder.

62 Leading Senior Constable Allen assisting me then asked Ms Squires:

"Leading Senior Constable Allen

So that is really all you say you've talked about?

Ms Squire

Yep, exactly what he told me."[75]

63 I asked Ms Squires some questions about to whom she had spoken about coming to court and giving evidence.[76] Initially she said nobody and specifically said that she had not

[71] Inquest Brief, Exhibit 4, 159-160.
[72] T.255.
[73] T.259.
[74] T.261.
[75] T.263.

spoken to Mr Tye about 'all this'. Subsequently she said that she had spoken to Mr Tye about it, the night before she gave evidence and the day before that. Further she said that she had spoken to Mr Tye on the telephone every day since the Thursday prior to the day on which she gave evidence.[77]

64 I asked Ms Squires some questions about her text messages and Facebook communication with Mr Tye on 1 December 2015 and in the days immediately following.[78] Ms Squires gave evidence that she didn't hear from Mr Tye between late on 1 December and 3 December when she received a message via Facebook. She was unable to recall the detail of that message other than to say that Mr Tye told her that his grandfather had died and he was coming back to Canberra to collect his things and he was thinking about giving up alcohol.[79]

65 I asked Ms Squires some questions about her communication with Mr Tye before he returned to Canberra and afterward. In particular, I asked Ms Squires about what she and Mr Tye discussed when Mr Tye first returned to Canberra[80] and whether Mr Tye had told her anything significant about Mr Harker's death. She gave evidence that he did not and that all he said was that he didn't want to talk about it.[81]

66 I asked her about the reference in her statement to Mr Tye telling her that he was holding his grandfather's hand when he died and whether she thought that this was a significant event; she agreed that it was. I asked her why, bearing this reference in mind, she had given evidence that Mr Tye had not told her of any significant event when he returned to Canberra. Ms Tye said that,

> "*...We're having some – I feel like we're having some fine grammatical issues, because English is not my first language...*".[82]

67 Ms Squires did not elaborate on any difficulty that she was having with English. While she was giving evidence I did not see any sign of her not understanding or

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[76] T.267-268.
[77] T.268-270.
[78] T.273-280.
[79] T.280.
[80] T.285-290.
[81] T.286.
[82] T.286.

misunderstanding questions. The recording of Ms Squires evidence is consistent with my perception.

68 Ms Squires went on to say that she didn't think that Mr Tye holding his grandfather's hand was significant because:

> *"…'cause most people hold – get – have their hands held while they're dying, so to me it's just ……"*[83]

69 When asked about this apparent contradiction Ms Squires said that she didn't understand the question.[84]

70 I asked Ms Squires about her whether she had concerns about Mr Tye being involved actively in Mr Harker's death. She said that she did not.[85] I asked her about a reference in her statement to her having said;

> *"If something did happen that it didn't change our relationship at all and that is how I still feel."*[86]

which apparently contemplated Mr Tye having had something to do with Mr Harker's death.

71 After having been given time to consider her response Ms Squires later gave evidence that when Mr Tye returned to Canberra on 5 December 2015 she directly asked him about "his involvement in Mr Harker's death" and that that was a significant event.[87] Ms Squires also said that Mr Tye told her that he was playing music for his grandfather and that she had a clear recollection of Mr Tye telling her that he was holding his grandfather's hand when he died.[88]

72 Ms Squires evidence changed as she was asked questions which is, in and of itself, not necessarily significant or uncommon. However, Ms Squires sometimes answered a general question in one way and specific questions on the same issue differently. Her explanation for inconsistencies in her evidence including that English was her second

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[83] T.287.
[84] T.287.
[85] T.287.
[86] T.287-288.
[87] T.288.
[88] T.289-290.

language were unconvincing.[89] Ms Squires seemed to obfuscate and prevaricate. I was left with the impression that Ms Squires made decisions and choices about what she thought was in Mr Tye's interests, and indeed what was not and gave evidence accordingly. I did not generally find her evidence convincing.

73 Having said that, Ms Squires was adamant that Mr Tye told her that he was in the room when his grandfather died.[90] I accept that Mr Tye told her that.

Senior Constable Ferguson and Constable Kennedy

74 At 5.29pm, 1 December 2015 Senior Constable Ferguson and Constable Kennedy arrived at the Alfred Hospital and spoke to Mr Tye. Senior Constable Ferguson asked Mr Tye a number of questions about Mr Harker and his death including:

"I said, "Have you spoken to any of the nurses about putting a pillow over his face?"

He said "No."

I said, "Why would they be concerned and have called us about what you've said?"

He said, "My sister and I earlier spoke about in the event, or make things happen earlier, prevent things"

I said, "When did you talk about it?"

He said, "About 5 hours ago"

I said, "What happened next?"

He said, "That was it"

I said, "What did you mean by 'prevent things'?"

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[89] T.286.
[90] T.290.

He said, *"Talk to the nurses, it will be good to prevent things, make things happen earlier"*

I said, *"What do you mean?"*

He said, *"The nurses said going through pain... it's very traumatic. Yeah, that's what was discussed"*

I said, *"What about the pillow over his face?"*

He said, *"No. The discussion of that... the pillow was on there"*

I said, *"I don't understand"*

He said, *"When you get the things... you can slap them across...that's what I slapped across"*

TYE then motioned with his hands has if he were dragging something with both hands.

I said, *"I still don't understand Angus"*

He said, *"They have these land rights going across. I don't know if they're there"*

I said, *"Have you had anything to drink today?"*

He said, *"Some whiskey"*

...

I said, *"Who are you staying with?"*

He said, *"My sister"*

I said, *"Where does she live?"*

He said, *"Caulfield....It's funny when you talk to Police ... never mind"*

I said, *"Did you express to the nurses that you put a pillow over Ward's face?"*

He said, *"No"*

I said, *"Why would they say that then?"*

He said, *"No idea"*

I said, *"Are you here with any other family?"*

He said, *"No"*

...

I said, *"Angus we've been informed that you have told the nurses that you'veplaced a pillow over your grandpa's face and suffocated him. We have to investigate these allegations."*

He said, *"I didn't. I simply said if I would do that, I'd do it"*

I said, *"Can you explain that further?"*

He said, *"If I was going to do something, would I then do something? ... I feel pretty shit. I've been sitting for the last 4 hours just watching him and now it's like, what have I done?"*

...

I said, *"When did you know that Ward had passed away?"*

He said, *"2 weeks ago. I got removed from a course and got here and now it's got to the point where pretty much"*

I said, *"What do you mean by two weeks ago?"*

He said, *"He got pretty sick and was going to die and then went into the cemetery"*

I said, *"How did you know he had passed away?"*

He said, *"I was sitting there with him"*

I said, *"What made you realise he had passed away?"*

He said, *"He stopped breathing and doing this .... "*

TYE then made noises as if imitating someone struggling to breathe.

He said, *"and then it stopped"*

I said, *"What did you do then?"*

He said, *"Nah man, he just stopped"*

I said, *"Did you tell anyone?"*

He said, *"I told the nurses"*

I said, *"What did you say?"*

He said, *"I said that he'd stopped breathing"*

I said, *"What did the nurses say to you?"*

He said,	*"Going down...look...I'm not sure. It's at the point where I've done a lot of first aid training and I thought of everything I could think of... what am I under arrest for?"*
I said,	*"At this stage, possibly murder. We are making some enquiries."*
He said,	*"Cool. Can I have a cigarette?"*
I said,	*"Not just yet. Maybe later? Would you tell me if you did stop him breathing or if you placed a pillow over his face?"*
He said,	*No.*
I said,	*"You wouldn't tell me?"*
He said,	*"No. This is a shit time here in Melbourne. I'm here in handcuffs."*[91]

Dr Matthew Lynch

75 On 2 December 2015, Dr Matthew Lynch, a Senior Forensic Pathologist practising at the Victorian Institute of Forensic Medicine performed an autopsy upon Mr Harker's body. Dr Lynch provided a written report, dated 2 March 2016, in which he opined that the cause of Mr Harker's death was:

> *"Multisystem failure complicating sepsis (secondary to perforated viscus) with circumstantial history of external airway obstruction"*

76 In his report, Dr Lynch noted:

> *"...There are no subconjunctival petechiae noted. There are no petechiae noted on the periorbital skin."*[92]
>
> *"Mouth: Edentulous. No buccal mucosal petechiae noted. Two small areas of mucosal haemorrhage on upper lip on right each measuring 2mm."*[93]

[91] Inquest Brief Statement of Senior Constable Jake Ferguson dated 1 December 2015 pp.89 – 98.
[92] Inquest Brief, Autopsy Report of Dr Matthew Lynch dated 2 March 2016, p.3.

"Larynx: No mucosal petechia. The thyroid bone and thyroid cartridge are intact. Layered strap muscle dissection performed and no strap muscle haemorrhage noted."[94]

"Oral Cavity: *...There are two areas of haemorrhage on the mucosa of the upper lip, each measuring approximately 2 mm in maximum dimension, situated 2 and 3 cm to the right of the midline..."*[95]

"Skin: *Two areas of petechial haemorrhage were noted on the mucosa of the upper lip on the right as described...Examination of the face...showed no evidence of additional haemorrhage."*[96]

"*Lip: ...(section 9) showed focal sub mucosal haemorrhage . No haemorrhage seen in lateral section (slide 10)."*[97]

77 Later in his report, at page 6, Dr Lynch commented that there was no specific site of perforation of the bowel and he goes on to remark at page 12 that Mr Harker had significant natural disease in the form of peritonitis coronary artery atherosclerosis and myocardial infarction.

78 Dr Lynch gave viva voce about examining Mr Harker's face, including under the skin of his face looking for subconjunctival petechiae and found none. Dr Lynch explained that such petechiae can be seen when a person has had their airway, mouth and nose obstructed but that such petechiae would not always be present when such obstruction occurred. In particular, said Dr Lynch, such petechiae may not be seen in older people, the physically infirm and children even if they die as a result of airway obstruction.[98] Dr Lynch said that given Mr Harker's physical condition subconjunctival petechiae may not necessarily be seen even if his external airway had been obstructed.

79 Dr Lynch said that the two areas which in his report where he described "suspected areas of bruising"[99] were on the inner lining of Mr Harker's upper lip on the right were pinpoint size areas of red discolouration, bruising that each measured 1 to 2 millimetres

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[93] Inquest Brief, Autopsy Report of Dr Matthew Lynch dated 2 March 2016, p.3.
[94] Inquest brief, Autopsy Report of Dr Matthew Lynch dated 2 March 2016, p.6.
[95] Inquest brief, Autopsy Report of Dr Matthew Lynch dated 2 March 2016, p.6.
[96] Inquest brief, Autopsy Report of Dr Matthew Lynch dated 2 March 2016, p.8.
[97] Inquest brief, Autopsy Report of Dr Matthew Lynch dated 2 March 2016, p.9.
[98] T.160-162.
[99] T.163.

and that they were "non-specific". That is to say that they may have been caused by an external obstruction of the airway or they have been otherwise caused.[100] Dr Lynch also refers to the absence of petechiae on other areas of Mr Harker's body as being also "non-specific."

80 Dr Lynch gave evidence that he saw no unequivocal evidence of airway obstruction[101] and that the 'bruises' he had identified could have been a result of Mr Harker's airway having been obstructed or that they could also have come about by other means.

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Identity of the Deceased pursuant to section 67(1)(a) of the *Coroners Act 2008*

81 On 7 December 2015 Elizabeth Joan Tye identified the deceased as her father Ward Harker born on 14 May 1922.

82 There is no dispute about the identity of the deceased and therefore requires no further investigation.

Cause of death pursuant to section 67(1)(b) of the *Coroners Act 2008*

83 Dr Lynch made clear that on the basis of his examination of Mr Harker's body that he could not say that a, far less the, cause of Mr Harker's death was the external obstruction of his airway. Dr Lynch nominated the cause of Mr Harker's death as:

> "*Multisystem failure complicating sepsis (secondary to perforated viscus) with circumstantial history of external airway obstruction.*"

Circumstances in which the death occurred pursuant to

Section 67(1)(c) of the *Coroners Act 2008*

84 During his viva voce evidence and when questioned, RN Saunders made a genuine effort to actually recall what happened on 1 December 2015 and gave evidence in a considered,

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[100] T.163.
[101] T.166

careful manner. I accept RN Saunder's evidence including what he said that Mr Tye told him that he had done. That is that Mr Tye told him that he had:

(a) Done it – put Mr Harker to sleep.[102]

(b) Smothered Mr Harker.[103]

(c) Put a pillow over Mr Harker's face.[104]

85 Whilst Mr Tye was affected by having consumed alcohol when he spoke to Senior Constable Ferguson, that fact alone does not make what he told Senior Constable Ferguson untrue albeit that it may affect its reliability. I take into account Mr Tye's denials that he told Senior Nurse Saunders of having smothered Mr Tye. When Mr Tye spoke to Senior Constable Ferguson, he made clear that he understood that he was talking to police, and that he would not tell Senior Constable Ferguson if indeed he had put a pillow over Mr Harker's face as had been suggested.

86 That Senior Constable Ferguson's account of what Mr Tye said to him and RN Saunder's account of what Mr Tye said are in some respects consistent in material elements is significant.

87 I accept that Mr Tye told Senior Constable Ferguson that he (Mr Tye) was in the room when his grandfather passed away but explicitly denied that he had told any of the nurses that he put a pillow over Mr Harker's face.[105]

88 Mr Tye told Senior Constable Ferguson that he was sitting with Mr Harker when he passed away. He said his grandfather stopped 'doing this' - which Senior Constable Ferguson said Mr Tye demonstrated by making noises imitating someone struggling to breathe - and then stopping breathing.

89 Mr Tye's text messages to Ms Squires on 1 December 2015 make clear that Mr Tye was considerably distressed by his grandfather's condition as he sat with him effectively waiting for him to die.[106] It is also clear from those messages that putting a pillow over

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[102] T.133.
[103] T.135.
[104] T.139.
[105] Inquest brief, Statement of Senior Constable Jake Ferguson dated 1 December 2015 p.94
[106] Inquest brief, Exhibit 4, p.155-160

Mr Harker's face, smothering him was on Mr Tye's mind. The evidence of RN Tooth and RN Simpson places Mr Tye in Mr Harker's room at least shortly before his death.[107] Mr Coutts' evidence of Mr Tye telling him that he was in the room when his grandfather died is significant[108] as is Mr Tye having told Senior Constable Ferguson the same or a similar thing. Ms Squires evidence that Mr Tye told her unequivocally that he was in Mr Harker's room when he took his last breath is also significant.

90 Whilst each of those pieces of evidence is circumstantial and significant in its own right, together the pieces have a cumulative effect that builds a more readily acceptable version of events to the exclusion of other possibilities.[109] When relying upon individual pieces of evidence as part of web of circumstances from which a conclusion is to be drawn, it is not necessary to rely upon facts that are indispensable links in reasoning toward a conclusion, previously characterised as 'links in a chain' circumstantial evidence.[110] Rather, I may rely upon several individually dispensable facts to support a conclusion as these fact create 'strands in a cable', the analogy serving to demonstrate that just as the more strands a cable has, the stronger the cable is, the more circumstances pointing towards the conclusion, the stronger the case for reaching it.[111]

91 When considered together all the evidence referred to constitutes a cohesive corpus of evidence upon which I can, and do, find that some time shortly before about 3.30pm on 1 December 2015 Mr Tye placed a pillow over Mr Harker's face. I cannot say anything about how long the pillow was on Mr Harker's face or anything about the effect of Mr Tye putting it there. I can say nothing about any connection between Mr Tye's conduct and Mr Harker's death. Dr Lynch gave clear evidence that his examination of Mr Harker's body revealed no unequivocal evidence that Mr Harker's breathing had been obstructed and so could not say that any airway obstruction had been a cause of his death.

92 That some people receiving palliative care appear to others, especially loved ones to be needlessly and grievously suffering is notorious. Palliative care seeks to provide such

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[107] Inquest brief, Statement of Catherine Tooth, dated 2 December 2015 p.35; Inquest brief, Statement of Ryan Simpson, dated 5 December 2015 p.42
[108] Inquest brief, Statement of Andrew Coutts, dated 4 December 2015 p.57
[109] *Shepherd v R* (1990) 1790 CLR 573.
[110] *Young v R* [2016] VSCA 149; *Director of Public Prosecutions v Asling* (No 8) [2017] VSC 84.
[111] *Shepherd v R* (1990) 1790 CLR 573, 582.

people with comfort; despite appearances, whether Mr Harker was actually suffering as described and no doubt felt by Mr Tye is not clear.

93 Voluntary assisted dying legislation recently introduced in Victoria seeks to provide autonomy to those suffering fatal diseases by facilitating their ability to end their lives.[112] The legislation as is would not have assisted Mr Harker. As a general proposition only, a desire to end a loved one's perceived suffering, however well-meaning and benevolent, does not justify criminal conduct.

COMMENTS

Section 49(1) Coroners Act

94 In 2016 the then Director of Public Prosecutions (**DPP**) decided not to prosecute Mr Tye in relation to Mr Harker's death.

95 Section 49(1) of the Act provides that the court's principal registrar,

> *"...must notify the Director of Pubic Prosecutions if the coroner investigating the death or fire believes an indictable offence may have been committed in connection with the death or fire."*

96 The section sets-out a subjective test for the coroner investigating the death and mandates events that are to follow that satisfaction being reached. The section's function is simply to alert the Director to the possibility that an indicatable offence may been committed in connection with the death so that the Director can consider prosecution.

97 Compared to its antecedent section 23(1) of the Coroner Act 1985 Act, section 49(1) substantially reduces the requisite state of the coroner's mind from 'a belief that an indictable offence *has* been committed' to 'a belief that an indictable offence *may* have been committed' (my emphasis). The combined effect of terms 'may' and 'in connection with' set the bar for satisfaction of the test quite low.[113] Explicitly the offence must be indictable, with the unadorned phrase 'in connection with' providing a wide scope of

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[112] *Voluntary Assisted Dying Act* (2017)
[113] *Finding into death without Inquest of Molly Bunnett,* COR 2017 2081.

indictable offences to be considered.[114] Indictable offences, all of which are axiomatically serious, include inchoate and completed offences.

98 Having undertaken an inquest and read the entirety of the Inquest Brief, I believe that an indictable offence may have been committed in connection with Mr Harker's death.

Submissions of the Alfred Health

99 Mr McLachlan the Director Non-Clinical Support Services at the Alfred Hospital provided a statement for the Inquest[115] and gave evidence. Ms Weir-Phyland the Chief Nursing Officer and Executive Director for Nursing Services at the Alfred also provided a written statement for the Inquest.[116]

100 Mr McLachlan gave evidence in relation to the Alfred utilising 'codes', that is announcements of events being allocated a 'code' and the 'code' being announced over the public address system. In particular, he referred to Code Grey and Code Black the criteria for each of which is set out in pages 200 – 262 of the Inquest Brief. Mr McLachlan gave evidence about amongst other things:

(a) Whether given the circumstances of Mr Harker's death a 'code' ought to have been called in particular a code black.

(b) Whether the Alfred Hospital conducted a review in relation to the circumstances surrounding Mr Harker's death. [117]

101 I was provided with written submissions on behalf of the Alfred Hospital dealing with item (c) in the Scope of Inquest *Examination of the Alfred Hospital's security arrangements for Ward Harker and visitors.* In his submissions Mr Oldfield referred to a recommendation:

"*Alfred Health's Clinical Aggression, Code Grey and Restraint Committee conduct review of Alfred Health's response to the incident – so that any improvements to the*

[114] *Patric Cini v The Commissioner of the Australian Federal Police* [2016] VSCA 227 [51].
[115] Inquest Brief, Statement of Gary McLachlan dated 16 October 2018, p.122a-b.
[116] Inquest Brief, Statement of Gary McLachlan dated 16 October 2018, p.122c-d.
[117] T.360-361.

security system may be identified and, where appropriate, incorporated into Alfred Health's guidelines and relevant training programs."[118]

102 RN Hesketh gave evidence that after RN Saunders told her that Mr Tye had told him that he had smothered Mr Harker[119] she did not close the door to Mr Harker's room and place a security guard there to secure what she had been told may have been the scene of a serious crime. RN Hesketh gave evidence that she was unaware of any working protocols or standing orders in relation to when that ought to occur.[120]

103 At the inquest Mr McLachlan gave evidence that the installation of CCTV cameras in the common areas of the ward was being implemented.[121] Such surveillance, if in place at the time of Mr Harker's death, would not have filmed the alleged incident although it would have showed all those coming and going from Mr Harker's room. Mr Oldfield submitted that it would not be reasonable or appropriate to have patient rooms under constant surveillance on the basis that:

(a) The Alfred is a public hospital.

(b) It is well recognised that patient care and rehabilitation is enhanced by having family and friends visit and such visits are to be encouraged.

(c) It is necessary that families have privacy and be trusted to behave appropriately when this is provided.[122]

104 I accept Mr Oldfield's submissions that constant surveillance of patient rooms would not be appropriate or desirable but and endorse the intention that common areas of the ward be subject to CCTV.

FINDINGS AND RECOMMENDATIONS

105 Having held an inquest into the death of Ward Harker 4, 5 & 6, December 2018 at Melbourne, I find pursuant to section 67(1) of the *Coroners Act 2008* that:

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[118] D C Oldfield, 'Outline of Submissions on behalf of Alfred Health', Submission in *Inquest touching upon the death of Ward Harker*, COR2015/6083, 28 February 2019.
[119] T.108.
[120] T.101,109.
[121] T.364.
[122] D C Oldfield, 'Outline of Submissions on behalf of Alfred Health', Submission in *Inquest touching upon the death of Ward Harker*, COR2015/6083, 28 February 2019.

(a) Ward Harker died on the Alfred Hospital on 1 December 2015.

(b) The cause of Mr Harker's death was multisystem failure complicating sepsis secondary to perforated viscus.

(c) in the circumstances set out above in paragraphs 84 – 93.

106 I recommend that:

"Alfred Health's Clinical Aggression, Code Grey and Restrain Committee conduct review of Alfred Health's response to the incident – so that any improvements to the security system may be identified and, where appropriate, incorporated into Alfred Health's guidelines and relevant training programs including protocols for training staff to deal with potential crime scenes."

107 Pursuant to section 73(1) of the *Coroners Act 2008,* I order that this Finding be published on the internet.

108 I direct that a copy of this finding be provided to the following:

(a) Ms Elizabeth Tye.

(b) Mr Angus Tye.

(c) Professor Andrew Way, Chief Executive Officer, Alfred Hospital.

(d) Detective Senior Constable Scott Riley, Coroner's Investigator.

(e) Detective Inspector Michael Hughes, Homicide Squad, Victoria Police.

(f) Commissioner for Senior Victorians, Mr G Manson.

Signature:

D.J. Bracken
Coroner

Date: 21 FEBRUARY 2020.

SCHEDULE OF CORRECTION OF ERRORS

The Contents page has been amended to update page numbering.

Paragraph 30 which previously read: *'In his written statement provided to police RN Ryan Simpson said that sometime on 27 November Mr Geoff Harker asked him if he could give Mr Harker a little extra morphine. RN Simpson explained that was illegal; he could not. RN Simpson also refers to Mr Geoff Harker asking him on - he thinks - Monday 29 November 2015, how much longer Mr Harker would remain as he was. On the morning of Tuesday 1 December 2015, at approximately 8.30am, RN Simpson took a telephone call at the nurses' station from Mr Geoff Harker who again asked how much longer it would be before Mr Harker died. RN Simpson told Mr Harker that he could not give a definite time frame. Mr Geoff Harker was asked about these discussions when he gave evidence and he said that he was concerned about his father being in on going pain.'*

has been amended to read: *'In his written statement provided to police RN Ryan Simpson said that sometime on 27 November one of Mr Harker's sons asked him if he could give Mr Harker a little extra morphine. RN Simpson said he could not recall the name of the person to whom he spoke but remembered that he had grey hair and glasses and he thought it may have been Mr Geoff Harker. RN Simpson told this person that his request was in fact illegal. RN Simpson also refers to the same person asking him on—he thinks—Monday 29 November 2015, how much longer Mr Harker would remain as he was. On the morning of Tuesday 1 December 2015, at approximately 8.30am, RN Simpson took a telephone call at the nurses' station from a man who RN Simpson thought was one of Mr Harker's sons, indeed in his statement he refers to thinking that it was the same son that he had spoken to twice before, who again asked how much longer it would be before Mr Harker died. RN Simpson told this person that he could not give a definite time frame. Mr Bruce Harker's evidence at the inquest was consistent with it being him that spoke to RN Simpson on 27 November, not his brother Geoff. Further, Mr Bruce Harker gave evidence that his brother Geoff is bald and does not wear glasses "so it was obviously me" [that RN Simpson described in his statement]. Mr Bruce Harker gave evidence about having had the conversations with RN Simpson but did not agree that they were in the terms set-out in RN Simpson's statement. When asked about the discussions he had with RN Simpson he gave evidence that he was concerned about and referred to his father being in ongoing pain.'*

Paragraph 105(c) which read: *'in the circumstances set out above in paragraphs 85 – 94'*

Has been amended to read: *'in the circumstances set out above in paragraphs 84 – 93'*