IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2019 4895

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
*Section 67 of the **Coroners Act 2008***

Findings of:	Paresa Antoniadis Spanos, Coroner
Deceased:	Daniel Patrick Frawley
Date of birth:	8 September 1963
Date of death:	9 September 2019
Cause of death:	1(a) Multiple injuries sustained in a motor vehicle incident (driver)
Place of death:	Millbrook, Victoria

INTRODUCTION

1. Daniel Patrick Frawley was 56 years old when he died in a motor vehicle accident at Millbrook on 9 September 2019. Mr Frawley ordinarily resided with his wife Anita Frawley in Brighton but was residing elsewhere in the days immediately preceding his death.

2. Mr Frawley was the son of Brian and Shirley Frawley and had five siblings. He was the father of Chelsea, Danielle and Keely and would say of his wife and children that they were his greatest achievement.[1]

3. Mr Frawley was a physically fit and strong man in his younger years when he played Australian rules football professionally and, later, coached. When he died, Mr Frawley had a known medical history that included heart disease, high blood pressure and depression.

THE CORONIAL INVESTIGATION

4. Mr Frawley's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (the Act). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury. As Mr Frawley died as a result of a motor vehicle collision, it is clear that his death was properly reportable.

5. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

6. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

7. The Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Mr Frawley's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses including Mr Frawley's wife, mother and psychiatrist, a witness to the collision scene and attending police and submitted a coronial

[1] "My secret pain", Herald Sun, 14 October 2017.

brief of evidence. Specialist collision investigation members of Victoria Police also submitted statements that were include in the coronial brief.

8. This finding draws on the totality of the coronial investigation into the death of Mr Frawley, including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities. [2]

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

Identity of the deceased

9. Daniel Patrick Frawley, born 8 September 1963, was visually identified by his brother Michael Frawley who signed a formal Statement of Identification dated 11 September 2019 before a member of Coronial Admissions and Enquiries staff at the Coronial Services Centre, Southbank.

10. Identity is not in dispute and requires no further investigation.

Medical cause of death

11. Dr Linda Iles, Head of Forensic Pathology at the Victorian Institute of Forensic Medicine (**VIFM**), conducted a partial autopsy confined to the head on 11 September 2019 and provided a written report of her findings dated 7 February 2020.

12. Dr Iles advised that post-mortem imaging showed extensive injuries to the face, head and neck, chest, abdomen, pelvis and limbs. Furthermore, Dr Iles advised that at autopsy, there was evidence of significant brainstem injury such that death would have been inevitable and almost certainly rapid in onset.

13. On external examination there were bilateral symmetrical lacerations of the skin and soft tissue at the front of each shoulder, which suggested that Mr Frawley's hand was on the steering wheel at impact. Dr Iles found no evidence of any medical condition or acute medical episode that precipitated the collision, or which would account for the distance

[2] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

travelled by the vehicle on the grass verge without evidence of steering input or braking on the driver's part.

14. Routine toxicological analysis of post-mortem samples was undertaken and detected prescription medications desmethylvenlafaxine,[3] dothiepin[4] and olanzapine,[5] all at broadly therapeutic levels, as well as a sub-therapeutic level of zoplicone.[6] No alcohol or illicit drugs were detected.

15. Dr Iles provided an opinion that the medical cause of death was '1(a) Multiple injuries sustained in a motor vehicle incident (driver)'.

16. I accept Dr Iles' opinion as to the medical cause of Mr Frawley's death.

Other expert medical evidence – Chronic Traumatic Encephalopathy.

17. Special examination of the brain by Associate Professor Michael Buckland at the Australian Sports Brain Bank demonstrated features of chronic traumatic encephalopathy (CTE), Stage I with no other evidence of other neurodegenerative disease.

18. A/Prof Buckland subsequently de-identified and referred Mr Frawley's case to the Boston University CTE Centre, Boston, USA,[7] for a second opinion. Neuropathologist Thor D. Stein considered that Mr Frawley's presentation was most consistent with low stage (Stage II of IV) CTE. A/Prof Buckland submitted a supplementary report incorporating Dr Stein's findings and explaining that Stage I and II pathology are often grouped together as 'low stage' or 'mild' CTE which has been frequently associated with mood and behavioural symptoms and slightly less frequently with cognitive and memory impairment. Accordingly, the clinical interpretation in A/Prof Buckland's original report remains unchanged.

[3] Desmethylvenlafaxine is the major active metabolite of venlafaxine with comparable antidepressant activity.
[4] Dothiepin is a tricyclic antidepressant, structurally related to amitriptyline.
[5] Olanzapine is an atypical (second-generation) antipsychotic drug with a similar structure to clozapine which is also clinically indicated for mood stabilization and as an antimanic drug.
[6] Zopiclone is a cyclopyrrolone derivative used in the short-term treatment of insomnia available in Australia as Imovane.
[7] Boston University's Chronic Traumatic Encephalopathy (CTE) Centre conducts high-impact, innovative research on CTE and other long-term consequences of repetitive trauma in athletes and military personnel. Their mission is to conduct state-of-the-art research on CTE, including its neuropathology and pathogenesis, clinical presentation, genetics and other risk factors, biomarkers, methds of detection during life, and methods of prevention and treatment.

Circumstances in which the death occurred

19. Mr Frawley was a professional Australian Football League (AFL) player, coach and commentator. He played 240 games over his professional career[8], which spanned 1984 to 1995 and captained the St Kilda Football Club for nine seasons. During his career he sustained about 20 concussions, including losing consciousness, severe headaches and vision problems. He was admitted to The Epworth Hospital between five and six times for treatment for concussion.

20. Between 1996 and 2000 Mr Frawley was a coach for the Collingwood AFL team and then was appointed senior coach of Richmond, where he remained until 2004. Towards the end of his tenure at Richmond, issues arose that led to Mr Frawley being attacked in the press and heckled by crowds, which caused him significant distress.

21. Mrs Frawley first noticed symptoms of mental illness once her husband finished up with the Richmond football club. He began a radio commentating career and later became the Chief Executive Officer (CEO) of the AFL Coaches Association. Mrs Frawley felt that on the one hand, Mr Frawley's exit from Richmond had left him with low feelings of self-worth, and on the other hand, his media career fed his ego and feelings of self-importance. In her appraisal, this led to wildly oscillating moods that were only seen by his family.

22. As CEO of the AFL Coaches Association during a drug scandal involving the Essendon Football Club, Mr Frawley was in the invidious position of having to support all AFL coaches while still being seen to condemn the alleged conduct of the Essendon Football Club. During this time, Mrs Frawley observed her husband's behaviour became more erratic and he would often disappear, purportedly to the gym, but in reality his whereabouts were largely unknown.

23. To assist with his declining mental state, in about June 2014 Mr Frawley began treatment with consultant psychiatrist Dr Brendan Hayman. Mr Frawley presented with a history of a depressive breakdown in the setting of stressors related to his work with the AFL Coaches Association. He had a significant constellation of depressive symptoms[9] including significant insomnia, depressive ruminations, relative anhedonia, self-reproachment,

[8] Prior to commencing his professional career, Mr Frawley played for East Ballarat in the Ballarat Football League and Bungaree in the Central Highlands Football League.

[9] Dr Hayman arranged a full organic workup that included a CT brain and haematological tests to exclude any organic basis for the depression. The results were unremarkable.

amotivation, difficulty functioning and episodic passive suicidality. He had also engaged in poor decision- making and conduct that caused conflict in his marriage.

24. Mrs Frawley felt that it took her husband at least a year to recover after he commenced treatment with Dr Hayman, but he was never the same. To his family, Mr Frawley would lie in bed all week and be extremely needy, but he would be able to put on a brave 'public face' and give the appearance of normal functioning.

25. Mr Frawley developed a good therapeutic relationship with Dr Hayman. In the initial stages of treatment, Dr Hayman described him as particularly needy in the context of his fragile emotional state and required frequent sessions and review. Mr Frawley remained on various anti-depressants and medications to help his insomnia, which was a significant source of worry.

26. In May 2014, Mr Frawley was admitted to The Albert Road Clinic with agitated depression, insomnia and mood-congruent depressive thinking. Mr Frawley's condition slowly improved, and he attended regular, intensive outpatient appointments with Dr Hayman thereafter.

27. Over the next five years, Mr Frawley became a public advocate for men's mental health while he dealt with his own mental health challenges. According to Mrs Frawley, he never revealed the extent of his struggles to friends or the general public, or how it affected his closest relationships.

28. Between 2017 and 2018, Mr Frawley saw Dr Hayman every month or two and remained on medication. In about mid-June 2018 Mr Frawley raised the idea of ceasing medication with Dr Hayman who noted that it would have to be under supervision and might be possible in late-2018.

29. Mr Frawley missed a scheduled appointment with Dr Hayman in November 2018 but when contacted, returned in December 2018. He reported having decreased the dosage of Pristiq (desmethylvenlafaxine) without consultation. Dr Hayman cautioned him against unilaterally changing his medications but otherwise noted that he was doing well.

30. An appointment was booked with Dr Hayman in February 2019, which Mr Frawley cancelled, saying he would make another appointment when he needed it. Mr Frawley did not make any further appointments with Dr Hayman.

31. By January 2019, Mr Frawley and his wife were making plans to transition away from football. They were working together to build up their horse racing property in Ballarat and Mr Frawley's demeanour seemed to be the best it had been since his breakdown in 2014. However, Mr Frawley admitted to ceasing his medication, which he told his wife was with the permission of his doctor. Mr Frawley also said that he had stopped seeing Dr Hayman.

32. Mr Frawley's media presence waned considerably after January 2019 and this appeared to Mrs Frawley to bruise his ego. From about April 2019, she observed that he became increasingly erratic and began to eat and drink in excess. Mr Frawley stopped turning up to planned bike rides with his friends and was consumed by his own needs with little apparent regard for his family.[10]

33. In late June 2019 Mr Frawley's decision making was still erratic and his personality had changed. He became even more self-absorbed and had gained about 25 kilograms. He avoided his family's Christmas in July celebrations, preferring to spend the time with a country AFL team that he had been coaching.

34. At Mrs Frawley's behest, the couple attended a session with Dr Hayman in August 2019. Mr Frawley reported having taken himself off all medications in December 2018[11] and increasing alcohol use.[12] He reported having significant stressors in his life at that time and felt his star power was dimming with the emergence of new media personalities. This had caused a precipitous drop in his income. Dr Hayman considered Mr Frawley was having a relapse in his depressive state in the setting of eschewing all medication and disengaging with treatment as he had felt "bulletproof."

35. Dr Hayman recommenced Mr Frawley on medication[13] and engaged in intensive weekly counselling[14] during which they discussed the impact of the loss of his former roles on his sense of self and his increasing "court jester" persona on television. Mr Frawley's mood slowly improved but there was significant ongoing lability as he had only just recommenced medication. Mr Frawley's behaviour had dramatically impacted his marriage. According to

[10] Dr Hayman commented that Mr Frawley had an obsessional personality style and had a narcissistic need for affection and affirmation. He had a tendency to fixate on a particular matter. For example, when he was overly preoccupied with his own wellness, he exercised obsessively while neglecting the needs of his wife and family. Such conduct pre-dated his depressive breakdown.

[11] He also admitted that he had stopped taking medication for a cardiac issue two years prior.

[12] In the order of five bottles of wine and 15 beers per week.

[13] Following a case review, it appeared to Dr Hayman that Mr Frawley did best on Pristiq 150mane, Dothep 75mg nocte and Imovane 7.5mg nocte.

[14] A risk assessment was conducted at each session and Dr Hayman noted on 28 August 2019 "no active suicidality but has passive suicidality."

Dr Hayman, his patient's overall mental state was very much tied to how his wife felt about him (and about their relationship).

36. On 6 September 2019, Mr Frawley attended what would turn out to be his last appointment with Dr Hayman. He had recently returned from a pre-arranged trip to Hong Kong with his wife. Mr Frawley admitted to episodic dark thoughts when he thought about his marriage but vehemently denied any active suicidal intent or plan.[15] Mr Frawley declined an admission to hospital to address his poor sleep and overall mental state. Dr Hayman was of the view that Mr Frawley did not meet the criteria for an involuntary admission and appeared much the same as he had in the preceding five years.

37. Over the following weekend, Mrs Frawley told her husband that they needed to take a break and he needed to move out for a while to give themselves some space. Regardless, Mrs Frawley felt he appeared to be doing well. On Sunday 8 September 2019, Mr Frawley celebrated his birthday with friends and family at a birthday dinner and appeared happy spending time with them.

38. At about 9.00am on 9 September 2019 Mr Frawley telephoned Dr Hayman's rooms, asked to reschedule his 10.00am appointment for that day and was rebooked for 4:30pm.

39. Shirley Frawley, Mr Frawley's mother, telephoned her son at about 10:30am and 11:30am but he did not answer. At midday, Shirley Frawley left a voicemail message asking him to call her back. Mr Frawley returned her call and said he would come over the next day for dinner. Shirley Frawley felt her son sounded well and did not notice anything amiss.

40. Between about midday and 1.00pm, Dr Hayman's receptionist received a phone call. She could not hear anything on the line and after about 15 seconds, disconnected the call.[16] The receptionist could not confirm the caller's number.

41. At about 1:40pm Ashley Rowland was driving along Old Melbourne Road, Millbrook, when she saw motor vehicle debris on the road. Up ahead was a severely damaged white utility vehicle (the ute) near a tree. Ms Rowland approached a motionless man in the driver's seat of the ute and called emergency services.

42. Ambulance Victoria paramedics responded a short time later but after assessing the driver, later identified as Mr Frawley, they did not render active treatment. Victoria Police

[15] Mr Frawley had considered self-harm by motor vehicle accident but had no active intent.
[16] An examination of Mr Frawley's phone showed he made the call at 12:11pm and was in Brighton North at that time.

members also responded and attended the scene, including Senior Constable Charmaine St John from the Ballarat Highway Patrol who investigated Mr Frawley's death and compiled the brief of evidence on which this finding is largely based.

Investigation of the collision

43. Detective Sergeant Robert Hay from the Victoria Police Collision Reconstruction and Mechanical Investigation Unit attended the scene and formulated a reconstruction of the collision. He noted that Old Melbourne Road, Milbrook, is a two lane, two-way bitumen road in good repair. The speed limit is 80 kilometres per hour. About 176 metres after the intersection at Ryan's Road is a large, established tree on the western side of the road. Mr Frawley's car left the road about 55 metres south of the tree[17] and his vehicle left straight rolling tyre prints directly towards it.[18] The vehicle collided head on with the tree and then moved 3.9 metres from the tree in a clockwise rotation before coming to rest on a rural wire and post fence.

44. The airbag module from the vehicle was downloaded[19] and provided a 15-page report. Having analysed the available data, Detective Sergeant Hay estimated that Mr Frawley's vehicle was travelling at a minimum speed of 132 kilometres per hour when it struck the tree. Due to the extent of vehicle damage, the data download was incomplete so D/Sgt Hay could not provide an opinion on braking, acceleration or any of the pre-impact data that is typically available. D/Sgt Hay advised that the fact that the airbag module yielded only limited data spoke to the severity of the collision.[20]

45. Sergeant Mathew Craine from the Victoria Police Mechanical Investigation Unit examined Mr Frawley's vehicle, a white 2013 Holden Colorado utility with current Victorian registration (the ute). He identified major impact to the front and front driver's side that had damaged, distorted and misaligned most of the ute and its components.

46. The driver's seatbelt had scuffing and an abrasion on the buckle. The buckle was still in place during the examination indicating that the seatbelt was worn during the collision.

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[17] The tree measured about 2.6 metres in diameter and was about 5.2 metres from the road edge.

[18] The tyre marks were rolling prints, flat and inline. Detective Sergeant Hay identified them as rolling prints because the grass had only been flattened, not torn out. This indicated the car was not out of control prior to impact. No speed can be calculated from a rolling print.

[19] The primary function of the airbag module is to control the deployment of supplemental restraint devices fitted to the vehicle. This normally includes the seatbelt pretensioners and front, side, knee, curtain and/or rollover airbags if fitted.

[20] The airbag control module contains accelerometer/s and a microcontroller. It senses a developing collision, decides whether the devices need to be deployed and deploys the devices as appropriate based on the programming of the microcontroller.

47. Sgt Craine examined the tyres and rims, brakes, suspension, steering, exhaust, the airbags and the accelerator. The rear lighting assemblies were intact and there was no sign of filament distortion on the brake light globes, indicating that they were not illuminated at the time of the collision, consistent with the brakes not being applied at the time of the collision.[21] The examination did not reveal any mechanical fault, failure or condition in the ute that could have caused or contributed to the collision.

Coroners Prevention Unit

48. Given the known circumstances, I referred Mr Frawley's death to the Coroners Prevention Unit (CPU)[22] for an appraisal by one of the court's in-house Mental Health Investigators (MHI), in this case a psychologist, of the clinical management and care provided to Mr Frawley in the period preceding his death, and for advice about the role that chronic traumatic encephalopathy (CTE) may have played in his death.

Clinical management and care provided by Dr Hayman

49. The MHI considered that Dr Hayman's treatment was appropriate. Suitable medications were prescribed, and changes made when indicated. Mr Frawley was engaged in psychotherapy and the frequency of appointments varied in accordance with Mr Frawley's mental state.

50. When Mr Frawley disengaged in treatment, he had been advised to continue his medication at their current doses and attend appointments every three months. Mr Frawley chose not to follow Dr Hayman's advice however at that time his mental state was stable. Accordingly, there was no reason to force him to continue his medication or to attend appointments.

51. When Mr Frawley re-engaged with treatment in August 2019, Dr Hayman recommenced Mr Frawley on appropriate medications and offered him an in-patient admission. While Mr Frawley was known to have had transient suicidal thoughts, he did not have a history of suicide attempts, was amenable to treatment in the community and was seeing Dr Hayman once or twice a week. Mr Frawley did not present as an immediate risk of harm and

[21] Sergeant Craine was unable to test the electrical brake circuit or brake light fuse to determine if the globes could operate as intended prior to the collision.

[22] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

accordingly, did not fit the criteria for an involuntary admission pursuant to the *Mental Health Act 2014 (Vic)*.

Chronic traumatic encephalopathy and mental illness

52. The MHI noted A/Professor Buckland's Stage I CTE diagnosis and Thor D. Stein's Stage II CTE diagnosis. They commented that there is an incomplete understanding of the extent or distribution of pathology required to produce neurological dysfunction. There is also no agreement currently regarding staging the severity of CTE pathology. Accordingly, pathologists typically provide an opinion (as opposed to a firm diagnosis), thereby acknowledging that another pathologist might reasonably reach a different conclusion on the same case.

53. CTE is a degenerative disease *associated* with repeated blows to the head,[23] though a combination of other factors such as genetics, substance abuse and age have not been sufficiently researched to establish a causal link between CTE and blows to the head. An association has also been suggested between CTE and other forms of neurodegenerative diseases. Currently, CTE can only be diagnosed post-mortem by specialist examination of the brain of the deceased following (at least a partial) autopsy.

54. Although the clinical syndrome of CTE has not yet been fully defined and the neuropathological criteria are preliminary, there is broad consensus that symptoms usually comprise cognitive deficits such as memory and concentration, personality and behavioural changes that can include aggression, depression, impulse control issues and paranoia. Symptoms can emerge years or decades after the brain injury was sustained.

55. CTE is diagnosed in four stages based on stereotyped patterns of structural changes on post-mortem examination.[24] Although suicidal ideation has been described in individuals with CTE, particularly those in the later stages, no strong causal link has yet been established between CTE and suicide.

56. The incidence of CTE in Australia is unknown. The Australian Sports Brain Bank (ASBB) recently diagnosed CTE in two former Australian National Rugby League players (Stage II and III), and one former AFL player. Although the prevalence of CTE is unknown, studies have suggested that at least 17% of people who experience repetitive concussions or mild

[23] It has been found in boxers, American footballs players and other sports people overseas.
[24] Typically, Stage I is characterised by headaches, loss of attention and concentration. Stage II progresses to depression, explosivity and short-term memory loss. Stage III involves executive dysfunction and cognitive impairment and Stage IV includes dementia, word-finding difficulties and aggression.

traumatic brain injury develop CTE. The severity of the disorder appears to correlate with the length of time engaged in the sport and the number of traumatic injuries. However, the MHI explained that a clear link between recurrence of head injuries and severity of head injuries has yet to be established.

57. CTE is associated with head injuries and is a degenerative condition which cannot be diagnosed during life. It has been suggested that prevention opportunities in sport involve actions to limit exposure to head injuries, such as penalising intentional strikes to the head and adhering to strict return-to-play guidelines. With respect to the latter, there are currently no reliable or specific measures of neurological dysfunction after concussion and most recommendations focus on resolution of acute symptoms. However, risks have been noted to continue beyond the presentation of acute symptoms.

58. Appropriate treatment when head injury occurs *may* reduce the likelihood of CTE. The Australian Sports Commission (ASC) recommends that any athlete with a suspected concussion should be removed from the sport, medically assessed, monitored for deterioration, and not return to play on the day of the injury.

59. The MHI noted that Mr Frawley played football between the ages of 16 and 34. He experienced 20 concussions, including loss of consciousness, and was admitted to The Epworth Hospital emergency department five or six times. During these incidents, he experienced vomiting and was unable to lift his head. Despite this, Mr Frawley always returned to the playing field the following week.

60. Dr Hayman described Mr Frawley's pre-morbid personality as a likeable and affable 'knockabout guy' with significant narcissistic and obsessional traits and a sense of neediness. The MHI stressed that Dr Hayman only knew Mr Frawley for the five years preceding his death, which was well after he had sustained multiple head injuries. As Mr Frawley commenced his playing career at age 16, his personality was not yet well established. Accordingly, the MHI could not determine which aspects of Mr Frawley's personality and behaviour were due to his intrinsic personality style and which aspects might be attributable to CTE. Similarly, since CTE can only be diagnosed after death, it would be challenging to establish the onset of CTE with any confidence or to determine when Mr Frawley may have begun to manifest symptoms, if at all.

61. It was apparent to the MHI that although Mr Frawley was diagnosed with major depression in 2014, he may well have experienced depression for several years prior. Mr Frawley's

mental state began deteriorating in the months before his death and appeared to coincide with ceasing his medication and several psychosocial stressors. He re-engaged with treatment and resumed taking medication five weeks prior to his death. The MHI explained that an anti-depressant response is usually discernible in the first two weeks of treatment and remission usually takes about six weeks after a suitable medication and dosage rate has been identified.

The Mental Health Investigator's conclusions

62. When Mr Frawley re-engaged with treatment, Dr Hayman considered that his presentation was similar, but not a severe as in 2014 and felt that he would respond to recommencing the same medications as before. At the time, there were no known acute stressors in Mr Frawley's life, save for his fears whether founded or not, that his marriage was in peril.

63. Despite Mr Frawley being diagnosed with Stage II CTE after death, the MHI could not ascertain to what degree, if any, CTE had contributed to his mental health difficulties and/or death. Although CTE has long been associated with mental health symptoms including depression and aggression, no strong causal link with suicide has been established. Further, since CTE can only be diagnosed post-mortem, it is impossible to establish at what point CTE began and whether this coincided with any changes in mood or behaviour.

64. Quite apart from CTE, Mr Frawley experienced major stressors, such as the 2004 coaching season, his role as CEO of the AFL Coaches Association and his conduct, which affected his marriage and family life. The MHI considered that these stressors likely impacted Mr Frawley's mental state entirely independent of CTE. Similarly, the MHI commented that it is difficult to delineate Mr Frawley's intrinsic personality traits from those that could have been influenced by CTE, especially since his football career and associated head injuries, began at a time when his personality style was fully established.

Current positions on CTE – The Concussion in Sport Australia Position Statement

65. In light of Mr Frawley's diagnosis of low stage CTE (Stages I and II) and its *potential* relevance to his death, it was important to understand the current state of play in Australia with respect to CTE and to consider whether there is scope for improvements in player safety.

66. The Concussion in Sport Australia Position Statement[25] (the Position Statement) is a joint initiative of the Australian Institute of Sport, the Australian Medical Association, the Australasian College of Sport and Exercise Physicians and Sports Medicine Australia. It has been adopted by many major sporting bodies, including the AFL.

67. The Position Statement notes that there is concern about potential long-term consequences of concussion or an accumulation of sub-concussive head impacts resulting from ongoing participation in contact, collision and combat sports. It also notes that there is some association between a history of multiple concussions and cognitive deficits later on in life. However, it considers that there is currently no reliable evidence clearly linking sport-related concussion with CTE and characterises it as a condition with unclear clinical diagnostic criteria.

68. According to the Position Statement, the evidence purporting to show a link between sport-related concussion and CTE consists of case reports, case series, and retrospective and post-mortem analyses. Accordingly, due to the nature of the studies, and their reliance on retired athletes volunteering for an autopsy diagnosis, there is significant selection bias in many of the reports. The studies to date have not adequately controlled for the potential contribution of confounding variables such as alcohol abuse, drug abuse, genetic predisposition and psychiatric illness.

69. Given that concussion is very common and the number of cases of CTE reported is extremely small, the Position Statement considers that the link between sport-related concussion and CTE remains tenuous. That said, the Position Statement recognised that the potential link between concussion and CTE is of concern, and that there is a need for well-designed prospective epidemiological studies that take into account the potential confounding variables.

The Australian Football League

70. In light of Mr Frawley's post-mortem diagnosis of low stage CTE and the advice of the MHI that there may be an association between CTE and mental health symptoms, I sought a statement from the AFL's governing body, the AFL Commission (AFLC) to ascertain their current position and policies with respect to CTE.

[25] Last updated February 2019

71. Stephen Meade, Head of Legal and Regulatory provided a consolidated response on behalf of the AFLC that drew on the expertise of their Medical Director, Head of Health, Safety & Laws, and their concussion consultant.

72. With respect to their position, the AFLC acknowledges that there may be an association between head trauma and neurodegenerative disease such as CTE. The AFLC endorses the views in the Position Statement that further exploration of the potential link between concussion and CTE should be subjected to epidemiological studies that account for the potential confounding variables.

73. The AFLC indicated their support for further research and better understanding of concussion and sub-concussive impacts, neurodegenerative disease and CTE. They stated that the recent diagnosis of CTE in Mr Frawley and another AFL player have underlined the importance of the AFLC's support for further research and understanding. While studies and research can continue to evolve, the AFLC consider that their current policies and procedures for the prevention of head trauma and concussion have, and will continue to have, a positive impact on the future incidence of neurodegenerative disease.[26]

74. The AFLC does not have a specific policy or other document that specifically addresses the prevention of CTE on the basis that the pathophysiology of concussion has not yet been settled and concurs with the Position Statement in this regard. That is, that while there are concerns about the long-term consequences of concussion or the accumulation of sub-concussive head impacts, the current evidence around the clinical correlates of post-mortem changes of CTE are yet to be fully elucidated.

75. Nevertheless, the AFLC does have a head trauma and concussion strategy that provides for education and awareness training, the prevention/reduction of risk and the management of head trauma. This strategy is premised on the medical advice that there may be an association between head trauma/concussion and CTE.

76. Club doctors provide briefings to players on concussion when they take the player's annual baseline measurements using the Standardised Concussion Assessment Tool (SCAT)[27] modules. The briefings comprise an explanation or reiteration of what concussion is, the

[26] By way of aside, the AFLC pointed out that the current understanding of how to prevent head trauma and concussion well post-dates the careers of players with confirmed CTE diagnoses, as in the case of Mr Frawley and Graham "Polly" Farmer. No such policies or guidance regarding the prevention of CTE were in existence in the years that Mr Frawley played professional AFL and the existence of CTE did not arise until 2005. The main focus during Mr Frawley's playing years was a prohibition on head or high contact play. That was punishable "in-game" by a free kick and further punishable by suspension depending on the severity of the incident.

[27] SCAT is an internationally recommended standardised tool for evaluating concussions.

AFLC's policies and processes in relation to the management of concussion, and the importance of honest and candid reporting of symptoms if head trauma occurs.

77. An annual briefing on the AFL Concussion Management Guidelines occurs with club doctors at the AFL Doctors Association (AFLDA) professional development weekend. Periodic updates are also sent out from the AFL Head of Safety & Laws, the AFL Medical Director and expert concussion consultants during the monthly AFLDA meeting. Guidance is also provided to club doctors via the AFL Club Medical Handbook to assist them in discharging their functions in compliance with the AFL rules.

78. All Australian Football matches, including the AFL, are governed by the Laws of Australian Football (the laws).[28] One of the stated purposes of the laws is to prevent injuries to players participating in matches so far as the objective can be reasonably achieved in circumstances where Australian Football is a body contact sport. These Laws have been amended over the years to reflect greater understanding and changes to game play.

79. According to Mr Meade, one of the objectives underlying changes to the laws is to ensure that player health and safety is protected and to ensure that in-game contact is within acceptable bounds. One such change made in 2020 was by way of amendment to the guidelines, upgrading impact categorisations based on the potential to cause serious injury. Technology plays an important role in shaping the laws via the use of their CSx concussion management app and real time video platforms such as 'Hawkeye' to monitor in-match play.

80. Players are coached to contest and take possession of the ball in a way that protects the head and minimises potential head contact and concussion. High contact is prohibited, whether it is intentional or because of careless or, in some circumstances, accidental or incidental contact. Immediate deterrence within the game is achieved via a free kick and for more serious or habitual offending, post-game deterrence through player suspensions or financial sanctions.

81. AFL Regulation 35 prohibits medically unfit players from playing or training. Club Medical doctors must abide by the AFL Concussion Management Guidelines (AFLCMG).[29] Essentially, the AFLCMG focuses on acute management, return to play and investigation and management of complex cases.

[28] The laws specific to the AFL comprise the AFL Rules and the AFL Regulations.
[29] The AFLC advised that these guidelines closely follow or at times exceed the requirements of the Consensus Statement from the Fifth International Conference on Concussion in Sport (Berlin 2016).

82. Identification of concussion is via a bespoke AFL Head Injury form (HIA)[30] in conjunction with the SCAT. The HIA and the SCAT are incorporated into the concussion management app, CSx. The return to play is determined using a multifaceted clinical approach that is managed and determined by the club doctor. Complex cases can be referred to an independent clinician and may be referred to a Concussion Panel.

83. As the AFLC adopts the Position Statement, no specific changes have been made to prevent CTE. However, their prevention and management strategies relating to head trauma and concussion have evolved over time to reflect the empirical evidence as to the presentation of injury or risk of injury,[31] and incremental understanding of concussion and head trauma informed by the medical literature, which in practice, is characterised by an increased level of conservatism.

84. Between about 2017 and 2020, the AFLC contributed about $300,000 to research projects that are directed towards the prevention and management of concussion. Some of the 15 current research projects concerning concussion may potentially be relevant to CTE.

Australian Football Players' Association

85. As the peak body representing the interests of players, I asked the AFL Players' Association (AFLPA) to provide their perspective on CTE for completeness.[32] James Gallagher, General Manager of Legal and Player Affairs provided a response on behalf of the AFLPA. Mr Gallagher indicated that the risks to the health and safety of its members due to concussion and repetitive head knocks are an important area of focus for the AFLPA.

86. The AFLPA's focus on concussion falls into five areas: education, appropriate assessments, advocating for all reasonable steps to be taken to protect players from concussion, support to address health and wellbeing issues related to playing AFL and advocating for the support of research into concussion, particularly in the context of AFL.

87. As the AFLPA is a representative body and not an employer, Mr Gallagher explained that they are not responsible for the medical treatment of concussion or the implementation of a

[30] This is a rapid sideline screening tool that has been mandated to standardise the assessment following head trauma on game day.
[31] Including responding to changed styles of play and/or tackling techniques that manifest as new or increased risk that can be addressed by a rule change.
[32] The AFLPA acts as the voice of players to advance the professional and industrial interests of members contracted to play AFL through unified representation. They advocate for the continuing development of policies and procedures as they relate to safety and welfare issues. The AFLPA maintains a program that addresses professional support and counselling in a wide range of matters and provide information, assistance and advice to members.

safe workplace. As such, the AFLPA does not employ medical practitioners with expertise in concussion. Instead, the AFLPA takes advice about concussion from external sources to inform their advocacy position.

88. The AFLPA noted the advice of the Position Statement. It is their position that a clear link between sport-related concussion and CTE has not yet been established but they agree that there may be a link. Further that, even if such a link is a mere possibility, they consider it essential that all reasonable actions are taken to limit the risk of head knocks insofar as possible in a robust contact sport. They advocate for a conservative approach to be adopted when a player returns to training or play after any concussive event. While the AFLPA do not consider the diagnoses of Mr Frawley and Mr Farmer to indicate a pattern or trend, these diagnoses do give credence to their position that a conservative approach should be taken until more is known.

89. Mr Gallagher stated that the AFLPA is strongly of the view that past AFL players' health and wellbeing should be supported long after they cease playing, and they support continued research into concussion and CTE. For its part, the AFLPA supports players through the AFL Players Injury and Hardship Fund.[33] They also run a specialised in-house mental health and wellbeing team that can be accessed by past and present players and their immediate family members.

90. The AFLPA annually surveys players about concussion. Mr Gallagher informed me that over recent years, survey data has shown that 94.5% of respondents were satisfied with the current concussion protocols and practices. On the other hand, in 2019, 6% of respondents reported experiencing a concussion that they did not report to a medical practitioner;[34] 7.9% of respondents reported continuing to train and/or play after a concussion and not seeking medical attention; while in 2017, 10% of respondents reported continuing to train or play without seeking medical attention after a concussion.

91. Mr Gallagher indicated that this is a continued area of focus for the AFLPA and posited the theory that improvements could be attributed to the implementation of video technology to assist medical practitioners in their identification of potential concussive incidents.

[33] Alumni members are eligible for reimbursement of medical costs and expenses related to certain conditions and/or injuries, hardship support, hospital excess cover, football ending injury payments and payment for delisted players who are unable to work.
[34] In 2016, 9% of respondents reported they experienced a concussion and did not see a medical practitioner.

92. During collective bargaining in 2017, the AFLPA advocated for increased expenditure by the AFL to support research projects into concussion. The AFL is now contractually obliged to invest a minimum of $250,000 annually into research products related to concussion and head trauma. The AFLPA facilitates these activities through supporting the involvement of players as research subjects.

FINDINGS AND CONCLUSION

93. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

(a) the identity of the deceased is Daniel Patrick Frawley, born 8 September 1963;

(b) the death occurred on 9 September 2019 at Millbrook, Victoria;

(c) the medical cause of Mr Frawley's death is multiple injuries sustained in a motor vehicle incident as a driver;

(d) the weight of the available evidence supports a finding that Mr Frawley intentionally took his own life;

(e) in the period immediately preceding his death, Mr Frawley was experiencing a number of personal and professional stressors, and a significant deterioration in his mental state, with an exacerbation of the anxiety and depression he had been suffering for some five years;

(f) at its highest, CTE is a potential contributor to the depression that Mr Frawley suffered for some years preceding his death;

(g) the available evidence does not enable me to determine which particular suicide stressor caused or contributed to Mr Frawley's death; and

(g) the weight of the available evidence does not support a finding that there was any want of clinical management or care on the part of Dr Hayman that caused or contributed to Mr Frawley's death.

COMMENTS

Pursuant to section 67(3) of the Coroners Act 2008, I make the following comments connected with the death, including matters relating to public health and safety or the administration of justice:

1. Like many professional football players, Mr Frawley began his football career in his formative years and likely experienced head trauma before his personality was well established. This coupled with the inability to diagnose CTE before death, confounds evaluation of the contribution of CTE to personality, behaviours, any cognitive deficits, or lability of mood.

2. Mr Frawley retired from professional football prior to the discovery of CTE and the implementation of current AFL policies and procedures aimed at minimising the consequences of concussions and repeated sub-concussive injuries.

3. In their submissions to the coronial investigation of Mr Frawley's death, the AFL and AFLPA have adopted positions in relation to CTE that are consistent with each other and consistent in their explicit reliance on The Concussion in Sport Australia Position Statement.

4. There is a strong consensus that more research into CTE is needed to improve understanding of the condition, its diagnosis and the prevention or at least minimisation of the impacts of CTE in AFL players. It is commendable that the AFL is committed to supporting research in this important area of player health and safety. The AFLPA's role in this regard is also noted.

RECOMMENDATIONS

Pursuant to section 72(2) of the Coroners Act 2008, I make the following recommendation/s, including recommendations relating to public health and safety or the administration of justice:

1. That the Australian Football League actively encourages players and, their legal representatives after their death, to donate their brains to the Australian Sports Brain Bank in order to make a meaningful contribution to research into Chronic Traumatic Encephalopathy and thereby improve the safety of future generations of footballers and others engaged in contact sports.

2. That the Australian Football League Players' Association actively encourages players and, their legal representatives after their death, to donate their brains to the Australian Sports Brain Bank in order to make a meaningful contribution to research into Chronic Traumatic Encephalopathy and thereby improve the safety of future generations of footballers and others engaged in contact sports.

3. That, in order to enhance research into CTE, the State Coroner and the Director of the Victorian Institute of Forensic Medicine, ensure that, as far as possible, coronial processes and practices:

3.1 Recognise that currently, CTE can only be diagnosed at autopsy and requires a careful brain examination and sampling of the appropriate areas of the brain for histological and immunohistochemical assessment to determine whether the pathological changes ascribed to CTE are present.

3.2 Improve timely identification of cases in which there is a history of head trauma, be that major trauma or minor repetitive trauma, such as may be sustained in sporting activities, so that consideration of the need for an autopsy can be appropriately informed.

3.3 While brain examination and tissue sampling needs to be adequate for CTE assessment and this is ideally achieved by retention of the brain for examination in an appropriate centre, such as the Australian Sports Brain Bank, this option may not be acceptable to the senior next of kin. Therefore, a histological brain sampling protocol should be developed to ensure that appropriate sections are available to allow adequate assessment for the presence or absence of CTE changes without the need for long term retention of the whole brain.

PUBLICATION OF FINDING

Pursuant to section 73(1B) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

DISTRIBUTION OF FINDING

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

Ms Anita Frawley, Senior Next of Kin

Mrs Shirley Frawley

Dr Brendan Hayman, Consultant Psychiatrist

Australian Sports Brain Bank c/o A/Prof Michael Buckland, Department of Neuropathology, Royal Prince Alfred Hospital, New South Wales

Australian Football League c/o Mr Stephen Meade

Australian Football League Players' Association c/o Mr James Gallagher

His Honour Judge John Cain, State Coroner

Professor Noel Woodford, Director, Victorian Institute of Forensic Medicine

Ms Kate Lockery, Crown Solicitor's Office, New South Wales

WorkSafe Victoria

Sen/Const Charmaine St John (#37990) c/o O.I.C. Moorabool Highway Patrol Unit

Signature:

Paresa Antoniadis Spanos

Coroner

Date: 23 February 2021

CC: Manager, Coroners Prevention Unit

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.
