Office of the State Coroner

Annual Report

2005 – 2006

State Coroner Western Australia

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Our Ref : A-1
Your Ref :

30th June, 2006

The Honourable Jim McGinty
BA Bjuris(Hons) LLB JP MLA
Attorney General

Dear Minister

In accordance with Section 27 of the Coroners Act 1996 I hereby submit for your information and presentation to each House of Parliament the report of the Office of the State Coroner for the year ending 30 June, 2006.

The Coroners Act 1996 was proclaimed on 7 April, 1997 and this is the ninth annual report of a State Coroner pursuant to that Act.

Yours sincerely

Alastair Hope
STATE CORONER

State Coroner's Overview

Appointment of a new office Manager

On 13 February 2006 Gary Cooper commenced to work in the role of Office Manager for the Coroner's Court and on 8 May 2006 his appointment in that capacity became official.

The position of Manager of the Coroner's Court had been vacant from the time of the retirement of Glenn Spivey on 12 August 2004.

It had been necessary to reclassify the position to take into account the changing role of Office Manager, particularly to take into account the important role of that position in respect of potential disaster management and disaster victim identification. In the event of a major disaster, the Office Manager will have a pivotal role liaising with managers in other states and providing leadership and direction within Western Australia in respect of issues relating to bodies.

In addition to this important role, the Office Manager is increasingly involved in the range of activities in which the Coroner's Court is involved and it is required to negotiate contracts in respect of body movement within the state etc.

For much of the period while the position of Manager has been vacant, Simon Walker acted in that position, ably assisted by David Dent.

Mr Walker's normal role, as a grief counselor, was filled for a period of over twelve months by Phillip Riseborough.

While the lengthy period of uncertainty pending the appointment of the Office Manager was not helpful for the office, thanks to the efforts of all staff and particularly Mr Walker and Mr Dent, the office was able to continue to operate in a professional and efficient manner.

My thanks go to all staff involved and also to Mr Riseborough who unfortunately was only placed with the office on a contract basis, and on the return of Mr Walker, did not have a position with the office. Mr Riseborough's work at the Coroner's Court was of the highest standard and he interacted particularly well with the staff and with grieving families.

The 15th Annual Australasian Coroner's Society Inc. Conference

The Coroner's Society Conference was held in Perth on 16-18 November 2005 at the Duxton Hotel. This was the first occasion on which the conference had been hosted in Perth since 1996 and preparation for the conference and the necessary organization required a considerable commitment of the Western Australian Coroner's Court.

The conference was opened by the Hon. Jim McGinty BA BJuris(Hons) LLB JP MLA, Attorney General and Minister for Health, whose speech included reference to the Government's ongoing commitment to the coronial jurisdiction in Western Australia and support for a number of the safety recommendations and proposals of the Court.

The main topics addressed by the conference were indigenous health and disaster management.

Speakers included Dr Jayne Freemantle, who provided information drawn from her current research relating to the deaths of infants, children and young people which identified a number of worrying trends in respect of indigenous people falling within those categories.

Dr Norman Tuppin, a medical practitioner practicing in Wiluna, spoke of the important role which medical professionals have in remote country regions. He spoke about the ways health issues facing indigenous people can be addressed in a country setting and provided a very practical and "hands on" account of dealing with these health issues on a daily basis.

Christopher Cresp, Manager of Palyalatju Maparnpa Health Committee (from Balgo Community), spoke about the problem of suicide associated with petrol sniffing and similar problems in Balgo and similar communities. Mr Cresp also provided feedback as to the effectiveness, or otherwise, of government funding together with other actions which have been taken to improve the Balgo Community and similar communities.

Sven Silburn and Adele Cox, from the Telethon Institute for Child Health Research, presented a paper dealing with mental health issues for indigenous children and young persons and also presented a report entitled "The Social and Emotional Well-being of Aboriginal Children and Young People".

Magistrate Sue Gordon spoke of her involvement with the Gordon Inquiry and discussed the responses of government to the report following that inquiry. She also spoke of her role as Chairperson of the National Indigenous Council and explained the aims of that Council.

The conference heard from a number of speakers who dealt with various issues which resulted from recent major disasters.

Dr Andrew Reid, the Coroner for Inner North District, London, spoke about his involvement with the tube bombings in London and discussed lessons which had been learnt by the United Kingdom Coronial System.

Dr Peter Ellis, Director of Forensic Medicine at the Westmead Hospital, spoke about his involvement in the disaster victim identification process as one of the first Australian contingent at the scene of the Tsunami Disaster.

Dr Fiona Wood, Australian of the Year, spoke about the actions which had been taken to treat burn victims following the first Bali tragedy. She explained some of the processes involved in dealing with burn injuries and explained some of the reasons for possible negative outcomes.

Dr Stephen Knott AO, Odontologist, provided information in respect of recent developments which have taken place in respect of dental identification of deceased persons. He also spoke about issues which have been addressed in using dental means to identify bodies following the first Bali disaster and the Tsunami disaster and discussed issues relating to software available for dental identification.

Kevin Tavener, a barrister and former Crown Prosecutor, gave a presentation in respect of his recent involvement in prosecuting war crime trails in Sierra Leone. Mr Tavener spoke about a number of similarities and differences between the way in which war crime trials are conducted in accordance with International Law, compared with how inquests are conducted in Australia.

Richard McElrea, Chair of the Coroners' Council in New Zealand spoke about the developments which have taken place in New Zealand towards a national coronial system.

The Chief Magistrate from Papua New Guinea, John Numapo, gave an interesting presentation in relation to cultural issues in Papua New Guinea, including references to sorcery related deaths.

Lauren Young and Kate Fris, from the Forensic Counselling Service at the Glebe Coroner's Court, spoke about about strategies which they have employed for supporting suicide bereaved in the coronial process. Their presentation included video recorded responses by grieving family members who spoke openly about the challenges which they had faced following suicide of a loved one.

Dr Karin Margolius, Forensic Pathologist, and Kristine Trevaskis, Grief Counsellor, gave a thought stimulating and informative presentation relating to issues associated with co-sleeping of adults and babies. They specifically addressed concerns about the number of cases where overlay has caused death when adults and babies sleep together.

Following the conference I received very positive feedback from a number of delegates. The smooth running of the conference involved a considerable effort by all staff of the Coroner's Court who had to deal with the day to day work of the office at the same time as assisting with the running of the conference.

Special thanks go to Dawn Wright, Administrator of Office of State Coroner, who organized the conference without resort to professional conference organizers, and Ms Evelyn Vicker SM, Deputy State Coroner, who not only took part in the running of the conference but played a major role in ensuring that the day to day office work did not fall behind.

Website

The Coroner's Court website at www.coronerscourt.wa.gov.au was launched in late November 2005 and became fully operational in January 2006.

An important purpose of the site is to provide information to the public about the functions and procedures of the Coroner's Court.

The site also provides information about inquest hearings and a number Coroner's findings are located on the site, together with brochures and annual reports.

My thanks go to the Attorney General, the Hon Jim McGinty, for his support in relation to provision of the website address.

Involvement of Relatives

The *Coroners Act 1996* involves relatives of deceased persons in the coronial process to a far greater extent than previously was the case.

The Act requires a Coroner to provide information to one of the deceased person's next of kin about the coronial process in every case where the Coroner has jurisdiction to investigate the death.

In practice the information is contained in a brochure which is provided by a police officer who is also required to explain the brochure. A police officer is further required to record details about the provision of the information on a mortuary admission form which is viewed by the Coroner or a delegate prior to any decision being made about whether or not a post mortem should be conducted.

During the year 1 July 2005 - 30 June 2006 a total of 2,315 deaths were referred to the Coroners Court. In 569 cases a death certificate was issued at an early stage and the body was not taken to the mortuary. Of the remaining 1,746 cases, a total of 122 objections were made to the conducting of a post mortem examination.

In the majority of cases the objection was accepted and no internal post mortem examination was conducted.

In a number of cases the objection was subsequently withdrawn, either immediately or when a Coroner had overruled the objection. In some cases it appears that while family members were at first concerned about a post mortem examination, later the family members realised that it would be important to know the cause of death with reasonable certainty.

Where objections are made, every effort is taken to attempt to ascertain the extent to which a cause of death can be determined without an internal post mortem examination.

It is a rare case in which there are no external factors which would give some insight into a likely cause of death.

The following charts detail statistics relating to objections to post mortem examinations for the year. The cases where a death certificate was issued by a doctor and the body did not reach the mortuary have not been included.

Deaths Referred to the Coroners Court from 1 July 2005 - 31 December, 2005

	Jul	Aug	Sept	Oct	Nov	Dec	*Total*
Death Certificate issued although the body was admitted to the Mortuary	**20**	**26**	**16**	**14**	**17**	**8**	**101**
Immediate post mortem ordered (usually these are homicide cases)	**1**	**0**	**1**	**0**	**3**	**2**	**7**
No post mortem because body missing etc.	**3**	**1**	**1**	**0**	**1**	**0**	**6**
No objection to post mortem examination	**123**	**124**	**129**	**94**	**122**	**115**	**707**
Objection received by the Coroners Court	**8**	**14**	**9**	**6**	**10**	**5**	**52**
TOTAL NUMBER OF DEATHS	**155**	**165**	**156**	**114**	**153**	**130**	**873**

Developments in Cases where an Objection was initially received

	Jul	Aug	Sept	Oct	Nov	Dec	*Total*
Objection withdrawn prior to a ruling being given by a Coroner	**3**	**7**	**7**	**2**	**6**	**2**	**27**
Objection accepted by a Coroner and no post mortem ordered	**4**	**5**	**1**	**4**	**2**	**3**	**19**
Objection over-ruled by a Coroner*	**1**	**2**	**1**	**0**	**2**	**0**	**6**
TOTAL	**8**	**14**	**9**	**6**	**10**	**5**	**52**

Deaths Referred to the Coroners Court from 1 January 2006 - 30 June 2006

	Jan	Feb	Mar	Apr	May	Jun	*Total*
Death Certificate issued although the body was admitted to the Mortuary	**19**	**11**	**9**	**13**	**23**	**24**	**99**
Immediate post mortem ordered (usually these are homicide cases)	**6**	**2**	**4**	**0**	**1**	**2**	**15**
No post mortem because body missing etc.	**0**	**1**	**1**	**2**	**0**	**0**	**4**
No objection to post mortem examination	**121**	**92**	**122**	**124**	**116**	**110**	**685**
Objection received by the Coroners Court	**16**	**17**	**6**	**11**	**10**	**11**	**70**
TOTAL NUMBER OF DEATHS	**162**	**123**	**142**	**150**	**150**	**147**	**873**

Developments in Cases where an Objection was initially received

	Jan	Feb	Mar	Apr	May	Jun	*Total*
Objection withdrawn prior to a ruling being given by a Coroner	**8**	**5**	**0**	**5**	**2**	**4**	**24**
Objection accepted by a Coroner and no post mortem ordered	**8**	**7**	**6**	**6**	**7**	**5**	**39**
Objection over-ruled by a Coroner	**0**	**4**	**0**	**0**	**1**	**2**	**7**
TOTAL	**16**	**16**	**6**	**11**	**10**	**11**	**70**

It can be seen from the above charts that of the total number of deaths referred to the Coroners Court there were relatively few objections to the conducting of post mortem examinations.

In the majority of cases where an objection was received the decision which was ultimately made was in accordance with the wishes of the family. There were a total of 122 objections of which 51 were withdrawn prior to a ruling being given by a Coroner and 58 were accepted by a Coroner and no post mortem examinations were ordered. In only 13 cases did a Coroner order that a post mortem examination should be conducted.

In the vast majority of cases relatives of deceased persons who died suddenly during the year appreciated the importance of a thorough examination of the circumstances of the deaths. In many cases the results of the post mortem examinations provided important information for family members who would otherwise have been left with many unanswered questions surrounding the deaths.

Counselling Service

REFERRALS - CORONIAL COUNSELLING SERVICE
1 July, 2005 – 30 June, 2006

TOTAL NEW CONTACTS
(letters to Next of Kin or referral from clients, other agencies or police)

3,782

Information			
Objection	**Coronial Procedure**	**Retention**	**File Viewing**
123	**2,033**	**159**	**110**

Counselling		
Phone	**Office**	**Home**
1,022	**158**	**91**

Support	
Scene Mortuary	**Court**
18	**68**

Coronial Ethics Committee

The Committee attempts to strike a balance between family concerns (including privacy, confidentiality and consent issues), and the possible benefits of research to the community at large. The Committee then makes recommendations to the State Coroner to assist him to decide whether to approve a project or to allow access to coronial records.

The considerable efforts of the Ethics Committee during the year are very much appreciated by the Coroner's Court particularly when it is considered that the Committee works on a voluntary basis and all members fit Committee work into otherwise very busy schedules

The Coroner's Court together with the Ethics Committee acknowledged the very considerable contribution made by Dr Gerard Cadden, forensic pathologist, who resigned on the 30 June 2006 from the Ethics Committee. Dr Cadden assisted in setting up and establishing the Coronial Ethics Committee, which was established with the first meeting convened on 17 March 1998 and was a member of the committee for over eight years, his contribution has been invaluable.

Thanks are also due to Jan Battley, Pam McKenna and Clive Deverall who resigned from the committee in 2005.

Ms Sarah Wisbey has ably assisted the Committee as the Secretary while Mrs Zempilas has been on maternity leave.

The Committee welcomed as a new member, aboriginal respresntative, Mr Neville Collard.

The members of the Committee are as follows:

Associate Professor Jennet Harvey	*Chairperson* Department of Pathology, UWA
Mrs Felicity Zempilas and Ms Sarah Wisbey	*Secretary* Lawyer, Coroner's Office
Ms Evelyn Vicker S.M.	Deputy State Coroner
Dr Jodi White	Forensic Pathologist, PathCentre
Dr Adrian Charles	Paediatric Pathologist, Princess Margaret Hospital
Ms Martine Pitt	Executive Director, Communicare
Mr Jim Fitzgerald	Lay member
Ms Heather Leaney	Lay member
Mr Neville Collard	Aboriginal member

The Committee has addressed the following projects during the last financial year as indicated in the table below.

Number of Projects Considered	Number of projects approved	Number of projects not approved
11	8	3

The considerable efforts of the Ethics committee during the year are very much appreciated by the Coroners Court, particularly when it is considered that the Committee works on a voluntary basis and all members fit Committee work into otherwise very busy schedules.

Counsel to Assist Coroners

In January, 2006 Mrs Felicity Zempilas commenced maternity leave and was replaced by Ms Sarah Wisbey, who has been seconded from the Office of Director of Public Prosecutions.

In addition the Police Service continues to provide assistance to the Coroner's Court in the form of two police officers who act as officers assisting, namely Sergeant Peter Harbison and Sergeant Geoff Sorrell. These officers bring a wealth of experience and relevant knowledge to the task.

In a number of more complex cases Mr Dominic Mulligan was retained as counsel assisting. Mr Mulligan was the first counsel assisting appointed at the Coroner's Court in 1997-1998 and he now practices as a Barrister and Solicitor in private practice.

Inquests

A chart follows detailing the Inquests conducted during the year. It is not proposed to detail the Findings in relation to each of these Inquests in this report as in most cases the Record of Investigation into the Death is publicly available and can be found on Coroner's Court website www.coronerscourt.wa.gov.au

It should be noted that in respect of the cases which are not Inquested, each of these cases is investigated and in every case findings are made by a Coroner and a Record of Investigation into Death document is completed detailing the results of the investigations which have been conducted.

INQUESTS FOR THE YEAR 1 JULY, 2005 - 30 JUNE, 2006

NAME	DATE OF DEATH	DATE OF INQUEST	NUMBER OF SITTING DAYS	CORONER	COURT SITTING	FINDING	DATE OF FINDING
BARICEVIC	26/02/2004	05/07/05	1	Deputy	Perth	Accident	23/08/05
GREAVES	18/03/2004	18-19/08/05	2	Deputy	Perth	Accident	15/09/05
MITCHELL	02/05/2002	16-17/08/05	2	State	Perth	Open Finding	19/08/05
VISSER	08 or 09/11/2004	23-24/08/05	2	Deputy	Perth	Accident	15/09/05
DONATELLI	07/02/2003	06-08/09/05	3	Deputy	Perth	Natural Causes	27/09/05
ABBOTT	19/12/2003	13-14/09/05	2	Deputy	Perth	Suicide	23/09/05
STRAHAN	On Or About 27/12/1948	11/10/05	1	State	Perth	Suicide	11/10/05
SAMSON	23/09/2003	25-29/07/05 & 20-21/09/05	7	Deputy	Broome Perth	Accident	13/12/05
HILTON	31/08/2003	02-03/11/05	2	Deputy	Busselton	Suicide	04/11/05
SINCLAIR	12/07/2002	25-27/10/05	3	Deputy	Perth	Natural Causes	09/12/05
WARETINI	08/09/2002	08-09/11/05 & 10/11/05	3	Deputy	Northam Perth	Natural Causes	25/11/05
DUNNE-HEYNIS	25/06/2004	28/11-02/12/05	5	Deputy	Exmouth	Suicide	20/12/05
GRIERSON LEWIS HANCOCK	01/10/2000 01/09/2001 01/09/2001	24/11/04, 05-16/12/05 & 06-10/02/06	14	State	Perth	Unlawful Homicide	21/04/06
SALVAGE	26/01/2005	20-21/02/06	2	Deputy	Albany	Accident	22/02/06
DONALDSON	02/09/2004	27/02-02/03/06	4	State	Perth	Suicide	17/03/06
BASIAK	19/06/2004	08/03/06	1	Deputy	Perth	Accident	
NILON	25/02/2003	20-24/03/06 & 20/04/06	6	State	Busselton Perth	Misadventure	31/05/06
PAYNE	01/10/2003	27-29/03/06	3	Deputy	Perth	Suicide	20/07/06
WILKINS	22/11/2003	03-05/04/06	3	Deputy	Perth	Suicide	20/07/06
JENKINS	02/03/2005	10-11/04/06	2	Deputy	Perth	Suicide	20/07/07
MALE	16/08/2005	27/04/06	1	State	Perth Esperance	Adj sine die	
BASSANELLI	31/10/2002	01-03/05/06 & 05/05/06	4	State	Perth	Open Finding	08/08/06
SCALE		08-16/05/06	7	State	Perth	Open Finding	09/08/06
STODART	04/07/2004	1/2/06	1	Deputy	Perth	Natural Causes	8/02/06
HAMBRIDGE	28/11/2003	08-09/05/06 & 11-12/05/06	4	Deputy	Kalgoorlie Perth	Suicide	10/07/06
ELKINGTON	12/03/2001	10/05/06 & 17/05/06	2	Deputy	Kalgoorlie Perth	Suicide	17/07/06
NEWBY	28/01/2005	22-26/05/06 & 31/05/06	6	State	Perth	Open Finding	07/08/06
BARNARD	24/07/2004	30/05/06	1	Deputy	Perth	Natural Causes	21/07/06
POWER	26/11/2003	30/05/06	1	Deputy	Perth	Natural Causes	21/07/06
HIGGINS	25/10/2004	30/05/06	1	Deputy	Perth	Natural Causes	21/07/06
WALTERS, D	On or about 04/01/2005	31/05/06	1	Deputy	Perth	Accident	01/06/06
WALTER, K	On or about 04/01/2005	31/05/06	1	Deputy	Perth	Accident	20/07/06
WALSH	08/09/2001	07-08/06/06	2	Deputy	Perth	Accident	21/07/06
TUCKER	16/03/2004	19-20/06/06	2	Deputy	Perth	Natural Causes	18/08/06
TYSON	06/08/2004	26-28/06/06	3	State	Perth	Accident	09/08/06

Deaths In Custody

An important function of the Coronial System is to ensure that deaths in custody are thoroughly examined. Section 22 of the *Coroners Act 1996* provides that an Inquest must be held into all deaths in custody.

Pursuant to section 27 of the *Coroners Act 1996* the State Coroner is required to provide a specific report on the death of each person held in care. The following contains reports on Inquests held during the year into deaths in care together with charts detailing the position of all deaths in care during the year.

It is not proposed to summarise the findings in relation to each of these inquests in this report as the Record of Investigation into Death documents are publicly available and can be readily accessed on the Coroner's Court website www.coronerscourt.wa.gov.au under the heading "Coroner's Inquest Findings".

Inquests – Persons Under Care of a Member of the Police Service

The definition of a ***"person held in care"*** includes the case of a person under, or escaping from, the control, care or custody of a member of the Police Service. Section 22(1)(b) of the Act provides that a Coroner who has jurisdiction to investigate a death must hold an Inquest if it appears that the death was caused, or contributed to, by any action by a member of the Police Service.

In this context while there were three relevant inquests where there was a concern that section 22(1)(b) might apply, it was ultimately determined that only one case came within this category, namely the inquest into the death of Peter Samson.

Inquests – Deaths In Care – Ministry of Justice (now the Department for Corrective Services)

During the year 6 Inquests were conducted into the deaths of persons who died while in the custody of the Department of Justice, now the Department for Corrective Services.

It is not proposed to detail the Findings in relation to each of these Inquests in this report as in each case the Record of Investigation into the Death is publicly available and can be found on the website www.coronerscourt.wa.gov.au

The following chart details the position in respect of all deaths in care since January 2003 where the deceased was either in prison custody

or there was police involvement (note : only the more recent inquest findings are available at www.coronerscourt.wa.gov.au)

Date of Death	Date of Inquest	Name of Deceased	Custody	Place of Death	Finding
31/1/03	30/11/04-2/12/04	GROOTHEDE Jan Hendrik	Prison	Hakea Prison	Suicide
1/2/03	9/6/04	NEUMANN Raymond Murray	Karnet Prison Farm	Bushland Glen Forrest	Suicide
1/3/03	9-11/3/04	KEEN Donald Lenard	Prison	Hakea Prison	Suicide
5/4/03	14-16/12/04	GARLETT Damien George	Prison	Hakea Prison	Suicide
6/4/03	26-28/6/06	WINGO Veronica	Police Lockup	Geraldton Police Station	
6/5/03	13-16/9/04	GAMBLE Charles Raymond	AIMS	Prison Van	Suicide
17/5/03	13-14/7/04	HERRICK Michael John	Prison	Acacia Prison Sir Charles Gairdner Hospital	Natural Causes
23/9/03	25-29/7/05 and 20-21/9/05	SAMSON Peter Darryl (aka) Leyley	Police Lockup	Derby Police Station	Accident
26/11/03	30/5/06	POWER Edward Charles	Prison	Casuarina Prison	Natural Causes
28/11/03	8-12/5/06	HAMBRIDGE David Lee	Prison	Eastern Goldfields Regional Prison	Suicide
6/12/03	9/6/05	O'NEILL Reginald Brian	Prison	Karnet Prison Farm	Natural Causes
4/4/04	11/2/05	CHAPMAN Allan	Prison	Hakea Prison Murdoch Community Hospice	Natural Causes
24/7/04	30/5/06	BARNARD Peter	Acacia Prison	RPH	Natural Causes
2/9/04	27/2-2/3/06	DONALDSON Leon John	Prison	Casuarina Prison	Suicide
14/9/04		MOURISH Jack	Prison	Hakea Prison	
17/10/04		WONGAWOL Phillip	Prison	RPH Acacia Prison	
25/10/04	30/5/06	HIGGINS Rodney Scott	Prison	RPH Casuarina Prison	Natural Causes
1/11/04		MARTIN Noel	Prison	Albany Regional Prison	
26/12/04		AXFORD Michael John	Prison	RPH	
21/5/05		HICKS Lawrence	Prison	Nickol Bay Hospital Karratha	
10/7/05		WHEELOCK Laurence Noel	Prison Parole	Carnarvon	
3/9/05		HENDERSON Gordon James	Prison	Casuarina Prison	
7/10/05		BIRNIE David John	Prison	Casuarina Prison	
19/10/05		TRIMMER Billy	Prison	Wyndham Work Camp	
1/5/2006		PARRE Donald Edwin	Prison	Albany Regional	
19/5/2006		ROCHFORD Simon	Prison	Albany Regional	
12/6/2006		ZUPEC John	Karnet Prison	Fremantle Hospital	
2/8/2006		BROWN Robert Geoffrey	Prison	Bethesda Hospital	

Deaths Referred to the Coroners Court
1 July 2005 – 30 June 2006

A total of 1,746 deaths were referred to the coronial system during the year.

Of these deaths, in 200 cases death certificates were ultimately issued by doctors. In many cases there were initial problems experienced in locating a treating doctor or a treating doctor had initial reservations about signing a certificate which were ultimately resolved.

In the Perth area there were 1,106 Coroner's cases and in the country regions there were 440 Coroner's cases.

Coroner's cases are 'reportable deaths' as defined in section 3 of the *Coroners Act 1996*. In every Coroner's case the body is in the possession of the Coroner until released for burial or cremation. In all Coroner's cases an investigation takes place and either on the basis of that investigation or following an Inquest subsequent to the investigation, a Coroner completes Findings as to the identity of the deceased, how the death occurred and the cause of death.

Statistics relating to the manner and cause of deaths referred to the Coroner for investigation are detailed below. In a number of cases a Finding by a Coroner had not been made at the time of compilation of the statistics, but an apparent manner and cause of death has been provisionally determined from the circumstances in which the body was found and from other information available.

Deaths referred to a Coroner for investigation for the Metropolitan area

1 July, 2005 - 30 June, 2006

Natural		653
Suicides		190
Accidents		107
Traffic		96
Homicide		21
Open		9
Misadventure		1
Inconclusive		29
No Jurisdiction		0
Subsequent referral to Coroner		
	TOTAL	**1106**

Deaths referred to a Coroner for investigation for the Country area

1 July, 2005 - 30 June, 2006

Natural		216
Suicides		78
Accidents		36
Traffic		81
Homicide		14
Open		5
Inconclusive		8
Misadventure		2
	TOTAL	**440**