OFFICE

of the

STATE CORONER

for

WESTERN AUSTRALIA

ANNUAL REPORT

2016-2017

State Coroner Western Australia

Central Law Courts
Level 10, 501 Hay Street
PERTH WA 6000

Telephone: (08) 9425 2900
Facsimile: (08) 9425 2901

Our Ref : Annual Report

2 October 2017

Hon John R Quigley LLB JP MLA
Attorney General
10th floor, London House
216 St George's Terrace
PERTH WA 6000

Dear Attorney

ANNUAL REPORT 2016-2017

In accordance with section 27(1) of the *Coroners Act* 1996 I submit my report on the operations of the Office of the State Coroner for the year ended 30 June, 2017.

Yours sincerely

R V C FOGLIANI
STATE CORONER

Table of Contents

State Coroner's Overview

Executive Summary of Outcomes

Under section 8 of the *Coroners Act 1996* (Coroners Act) one of my functions is to ensure that the State Coronial system is administered and operates efficiently. The outcomes for the Office of the State Coroner for 2016/17 are outlined below:

- Backlog of cases decreased from 466 as at 30 June 2016 to 347 as at 30 June 2017. This was primarily due to the submission to the coroner, and finalisation, of an increased number of investigation reports where the death was older than 12 months

- Of those 347 backlog cases:

    - 136 were backlog inquest cases.
    - 194 were cases where no further finalisations were possible as at 30 June 2017 because the coroner was awaiting completion of aspects of the coronial investigation by external entities.
    - 17 cases were with Counsel Assisting for review or advice as directed by the State Coroner.

- By continuing to list the oldest cases for inquest wherever possible, the statistics show a greater than usual time to hearing; however, this also reflects that, appropriately, the older matters are being progressed as a priority.

- A total of 2419 investigations were finalised in 2016/17:

    - 2366 finalised by administrative finding of which 903 (38%) were backlog cases.
    - 53 finalised by inquest all of which were backlog cases at the time of completion and just over half were mandated inquests.
    - 1463 (61%) of the cases finalised were under 12 months old.
    - 956 (39%) of the cases finalised were over 12 months old.

- The number of inquests finalised decreased from 58 in 2015/16 to 53 in 2016/17.

- The number of administrative findings finalised increased from 1991 in 2015/16 to 2366 in 2016/17.

- The number of total cases on hand over 24 months old reduced to 6.4% in 2016/17 compared to 6.7% in 2015/16 compared to 8.4% 2014/15 compared to 10% in 2013/14, 9.8% in 2012/13 and 13% in 2011/12. This represents a continuing gradual reduction in aged matters.

- Reports of deaths to the coroner increased to 2422 in 2016/17 compared to 2214 in 2015/16 compared to 2192 in 2014/15, 2009 in 2013/14, 2155 in 2012/13 and 1916 in 2011/12. This is to be expected given the population increase.

- The number of cases on hand was 2173 at 30 June 2017 compared to 2178 at 30 June 2016. Despite the significant increase in number of reportable deaths for 2016/17 (up by 208 from the previous year) the number of closures was 370 more than the previous year.

- The number of death certificates received in 2016/17 was 1174 compared to 1198 in 2015/16 compared to 908 in 2014/15. These are cases where the coroner has determined that the reported death does not require further investigation and the doctor's death certificate is accepted.

- Counselling Service contacts and referrals increased from 10106 in 2015/16 to 11241 in 2016/17.

- The number of objections to the performance of post mortem examinations for the purpose of investigating deaths increased to 319 in 2016/17 compared to 246 in 2015/16.

- A procedure for non-invasive post mortem examinations was piloted and introduced over the financial year, resulting in 227 coronial approvals to pathologists' recommended external post mortem examinations.

- A procedure for the finalisation of non-narrative natural cause administrative findings by the Principal Registrar was piloted and introduced from January 2017, resulting in the finalisation of 264 cases by 30 June 2017.

Structure of the Report

The first part of this Report provides statistical and other information on the operations of the Office of the State Coroner in the past financial year ended 30 June 2017 (2016/17).

The second part of this Report contains the specific reports that I am required to provide on the death of each person held in care under section 27(1) of the Coroners Act.

The legislative requirement to provide a specific report on the death of each person held in care reflects the community's concern with the quality of the supervision, treatment and care of persons who have been taken into care and/or persons whose freedoms have been removed by operation of law. They include children the subject of protection orders, persons under the custody of police, prisoners and involuntary mental health patients.

Investigations that have not been finalised are not the subject of a specific report. An investigation is finalised when the coroner has made the findings required, if possible, to be made under section 25(1) of the Coroners Act. Generally, in approximately 97% of cases, an investigation is finalised without holding an inquest. An inquest is part of an investigation.

The Coroner's Court of Western Australia – information available to the public

It is said that the role of the Coroner's Court is to speak for the dead and to protect the living. This two fold role is a vital component of a civil society.

As an independent judicial officer, the coroner investigates a reportable death to find how the deceased died and what the cause of death was. It is a fact finding exercise, aimed not at apportioning blame, but at establishing the circumstances attending the manner of the death. It is in the public interest for there to be a careful and thorough review of the information so that a sudden, unnatural or unexplained death is properly investigated and the cause and manner of that death is properly found and recorded.

A significant function of the Coroner's Court is to provide an opportunity for grieving relatives and friends of the deceased to witness the proceedings involving their loved ones at a public inquest, in open court. For people who are emotionally distraught and suffering intense feelings of loss, the Coroner's Court can provide much needed answers about how their loved one died and in some cases, whether isolated or systemic changes may be introduced so as to avoid a death in similar circumstances in the future. It may be a comfort to know what happened to their loved one; it has the possibility of allaying rumours or suspicion; it may show that no other person caused or contributed to the death; it may show otherwise; it may explain complex medical procedures that had previously not been understood or known by the family; it may shed light on the quality of medical care afforded to the deceased; it may increase medical knowledge and awareness. It provides much needed information.

In these cases the principles of open justice serve the grieving family and friends of the deceased as well as the witnesses, persons involved in the care of the deceased and the wider community who has an interest in the proceedings.

When an investigation is finalised other than by inquest, the coroner's record of investigation is referred to as an administrative finding.

There were 2366 administrative findings finalised by coroners in the 2016/17 year comprising approximately 97.8% of all reportable deaths investigated for this year. For these matters the coroner makes findings on the evidence before him or her, in chambers. They are not public proceedings. These findings are provided to the deceased's next of kin and they are not published on the Coroner's Court website.

There were 53 inquests finalised by coroners in the 2016/17 year comprising approximately 2.2% of all reportable deaths investigated for this year. As Inquests are public proceedings, the coroner takes evidence in open court (unless otherwise ordered). The coroner's written findings are published on the Coroner's Court website. Where the coroner has made a recommendation, the written response by the Minister or responsible entity is also published on the website.

The focus over the 2016/17 year: The Backlog of Coronial Cases and Reform

As with the previous reporting years, much of the effort across all levels at the Office of State Coroner has been aimed towards addressing the accumulated backlog of cases. The backlog cases are determined by reference to the date that a reportable death is reported to the coroner. When the date of that report is more than 12 months old, that case enters into backlog and becomes a priority.

The backlog is a dynamic figure because cases are constantly being finalised and equally, at the 12 month anniversary, cases are also coming into backlog, on a daily basis. As outlined in the Executive Summary, as at 30 June 2017 the backlog stood at 347.

That does not mean that all reportable deaths are able to be investigated by a coroner in the order of the date of the report of the death. Other factors impact upon the prioritisation of cases, most significantly the complexity of the investigation and/or the availability of witnesses or other evidence. Another factor that may result in prioritisation is where a matter connected with a death raises an issue of concern in the area of public health or safety.

With respect to reform, as outlined in last year's annual report, I have completed my input into the Department's Briefing Note to the Attorney General in respect of the 113 recommendations made by the Law Reform Commission of Western Australia in its *Review of Coronial Practice in Western Australia, project no. 100*, January 2012. The Department has presented its position on each of the recommendations to the new Attorney General for his consideration.

As at the time of writing this report, two of those recommendations have been progressed. They are recommendation 55, directed to enabling a coroner to make an administrative finding excluding the narrative of the circumstances attending the death and recommendation 56, directed to empowering the coroner to discontinue an investigation in specified circumstances in relation to certain natural cause deaths.

These two recommendations are part of a reform process that is aimed at reducing unnecessary delays and facilitating a more timely response to families of the deceased. The two recommendations have found expression in the *Coroners Amendment Bill* 2017. The Bill has been passed by the Legislative Assembly and is now in the Second Reading in the Legislative Council.

The range of cases that could be more efficaciously progressed under this reform process would be expanded if a dedicated computed tomography (CT) scanner is made available to the forensic pathologists at the State Mortuary due to the depth and quality of information afforded by this medium at an early stage.

As at the time of writing this report I can advise that steps have been taken to assist in this area. In relation to the installation of a CT Scanner at the State Mortuary, the Department of Justice has taken the lead in developing a business case for the consideration of Government. In addition to facilitating the earlier finalisation of coronial cases, a CT Scanner would also support the intent of recommendation 102 of the *Review of Coronial Practice in Western Australia, project no. 100,* to the effect that a forensic pathologist conducting a post mortem examination should use the least invasive procedure that is available and appropriate in the circumstances.

Report on inquests that are required by law to be held (mandated inquests)

Under section 22(1) of the Coroners Act, a coroner who has jurisdiction to investigate a death must hold an inquest under the circumstances specified in that section.

Where the Coroners Act mandates the holding of an inquest, the inquests are sometimes referred to as "mandated inquests" although that term is not used in the legislation.

Overall there were 53 investigations finalised by inquest in the past financial year and of those, a total of 29, being approximately 55%, comprised investigations where an inquest was mandated by law.

The 29 mandated inquests were finalised by coroners in the following categories and these are described below:

- 14 mandated inquests in relation to persons held in care immediately before death;
- 6 mandated inquests where it appeared that the death was caused, or contributed to, by an action of the police force; and
- 9 mandated inquests in relation to the suspected deaths of missing persons.

(a) Mandated inquests - persons held in care immediately before death

A deceased will have been a "person held in care" under the circumstances specified in section 3 of the Coroners Act. They include children the subject of a protection order under the *Children and Community Services Act* 2004, persons under the control, care or custody of a member of the Police Force, persons in custody under the *Prisons Act* 1981 and involuntary patients under the *Mental Health Act* 1996, and since November 2015, the *Mental Health Act 2014*.

Under section 3 of the Coroners Act, all Western Australian deaths of persons held in care are reportable deaths.

Under section 27(1) of the Coroners Act, my annual report is required to include a specific report on the death of each person held in care. A Table of the investigations into deaths of persons held in care that were finalised by inquest in the past financial year appears at pages 35 of this report. Following that Table, at page 36 to 53 are the specific reports on the deaths of each person held in care, arranged in the order in which they appear on the Table.

In the past financial year there were 14 investigations of deaths of persons held in care finalised by inquest. Of those:

- Six investigations were finalised by inquest in respect of deaths of persons held in custody under the *Prisons Act* 1981;
- Two investigations were finalised by inquest in respect of deaths of persons under the control, care or custody of members of the Police Force;
- Three investigations were finalised by inquest in respect of a child who was the subject of a protection order under the *Children and Community Services Act 2004*; and
- Three investigations were finalised by inquest in respect of the death of an involuntary patient within the meaning of the *Mental Health Act* 1996.

In respect of all of the 14 investigations of deaths of persons held in care finalised by mandated inquest this past reporting year, the coroner was required under section 25(3) of the Coroners Act to comment on the quality of the supervision, treatment and care of the person while in that care.

In six out of the 14 mandated inquests, the coroner made adverse comment about the quality of supervision, treatment and/or care of the deceased (Ms DHU, Ms MIHAJLOVIC, Mr BENNELL, Mr STUART, Ms MANDIJARRA and KLD [name suppressed]).

(b) Mandated inquests – where it appeared the death was caused, or contributed to, by any action of a member of the police force.

Six investigations were finalised by inquest where it appeared that the death was caused, or contributed to, by any action of a member of the police force.

Three concerned police pursuits or intercepts. The other three concerned protocols and procedures following police involvement.

In each instance, the coroner found that the death was not caused or contributed to by any action of a member of the police force.

A Table of the six investigations appears at page 32 of this Report.

(c) Mandated inquests – suspected deaths

Nine investigations into the suspected deaths of missing persons were finalised by inquest.

Where a person is missing and the State Coroner has reasonable cause to suspect that the person has died and that it is a reportable death, the State Coroner may direct that the suspected death of the person be investigated. Where such a direction has been given, under section 23(2) a coroner must hold an inquest into the circumstances of the suspected death.

In each instance, the coroner found that the death of the missing person had been established beyond all reasonable doubt.

A Table of the nine investigations appears at page 33 of this Report.

Report on inquests that are held pursuant to an exercise of discretion by the coroner (discretionary inquests)

Under section 22(2) of the Coroners Act, a coroner who has jurisdiction to investigate a death may hold an inquest if the coroner believes it is desirable. These inquests are sometimes referred to as "discretionary inquests," although that term is not used in the legislation.

In exercising the discretion under this statutory function the coroner will have regard to whether an inquest will assist in reaching the findings required to be made, if possible, under section 25(1) of the Coroners Act and/or whether there are reasons for highlighting issues of public health or safety in connection with the death. The coroner will also take account of the

reasons provided by any person who makes a request for an inquest under section 24(1) of the Coroners Act.

Of the 53 investigations finalised by inquest in the past financial year, a total of 24, being approximately 45%, comprised investigations where the inquest was discretionary.

A Table of all of the investigations that were finalised by inquest appears at pages 28 to 31 of this Report. The mandated inquests are marked as such, leaving the remainder on that Table, a total of 24, as the discretionary inquests.

The Coronial Counselling Service

Under section 16 of the Coroners Act, the State Coroner is to ensure that a counselling service is attached to the Coroners Court of Western Australia. Any person coming into contact with the coronial system may seek the assistance of the counselling service and, as far as practicable, that service is to be made available to them.

Over this reporting year, the Coronial Counselling Service has focussed on its core function which is to ensure, as far as practicable, that persons coming into contact with the coronial system are able to speak with an experienced counsellor who will endeavour to address their questions and concerns and explain the coronial process to them. The service dealt with over 7000 telephone contacts.

The range of services provided by the Coronial Counselling Service and statistical information on work output is set out at page 22 of this Report.

The Death Prevention Role and the Coronial Ethics Committee

Over the course of a coronial investigation important information is gathered about the cause and manner of death, including the circumstances attending the manner of death. This is reflected in the findings of the coroners, though not exclusively so. The material gathered, including in the form of statistics where that is amenable, can provide vital information about matters such as the prevalence of disease, it may reflect upon the state of mental health within the community, and can be of invaluable assistance in identifying where resources could usefully be applied to provide the most effective assistance, with the ultimate aim of preventing deaths in the future in similar circumstances.

Only the coronial findings on inquest are made public, and they comprise less than 3% of all investigations. Following an inquest a coroner may make specific recommendations in connection with the death that may result in practices being changed, for example at hospitals or at workplaces, to assist in preventing similar deaths in the future. This is part of the death prevention role of the coroner.

The Office of the State Coroner has a working relationship with the Department of Health, the Patient Safety Surveillance Unit (PSSU). Their specialist medical consultant reviews coronial findings and related information. The salient points are de-identified and where necessary summaries are published in the booklet “From Death We Learn” which is then distributed to relevant clinical areas.

The Office of the State Coroner has also entered into a working relationship with the Therapeutic Goods Administration (TGA) in recognition of the importance of identifying any reportable deaths that may have been associated with the use of medicines, vaccines or medical devices. To assist the TGA with monitoring the safety of therapeutic products, the Office of the State Coroner has developed a notification system whereby relevant information is de-identified and provided to the TGA. There were 139 such notifications to the TGA this financial year.

The working relationships with the PSSU and the TGA are also in furtherance of the coroner's death prevention role.

For reasons of confidentiality, a considerable amount of coronial information that may potentially assist in the prevention of future deaths is not accessible to the public, nor generally to persons conducting research.

There are occasions where, under strict guidelines, access to specific types of information may be made available to persons conducting research connected with the death prevention role. This is done through the Coronial Ethics Committee attached to the Coroner's Court of Western Australia. The Coronial Ethics Committee considers incoming requests for coronial data and makes recommendations to me on the ethical considerations involved in proposed research projects or matters touching on the use of coronial information.

Pursuant to paragraph 8 of the Guidelines for the Coronial Ethics Committee, I am required to report annually on the operations of the Coronial Ethics Committee, including a specific report on any recommendation of the Coronial Ethics Committee which I have rejected. The report on the operations of the Coronial Ethics Committee during the past reporting year appears at page 23 to 24 of this Report.

A case management system

The project to implement an electronic case management system for the Coroner's Court that was scheduled to commence in later part of 2016/17 will now commence in 2017/18 with an anticipated completion date in 2018/19.

In last years' annual report I had stated that the work output of the Coroner's Court of Western Australia would be optimised with the introduction of an electronic case management system.

Full implementation will ultimately facilitate the allocation of caseloads to coroners from the time the death is reported, for case management by the same coroner, until completion.

Another benefit includes the efficient retrieval of information for statistical purposes and/or within the context of the death prevention role.

Acknowledgements

I wish to acknowledge the endeavours on the part of Deputy State Coroner Evelyn Vicker, Coroner Barry King and Coroner Sarah Linton to finalise investigations and reduce the backlog. This year, due to an increase in the volume of investigation reports the court has also been assisted by Coroner Kelvin Fisher for a month, and I am grateful for his contribution.

Every Magistrate in Western Australia is contemporaneously a coroner and I acknowledge their considerable efforts in the area of coronial work.

The Principal Registrar Mr Gary Cooper has assumed additional delegated functions that have included a delegation to make non-narrative natural cause findings. I acknowledge his contribution to the progression and finalisation of investigations within that remit.

All of the staff members at the Coroner's Court of Western Australia have been exceptionally dedicated to one of the central tasks of the court, which is to try and find answers for grieving family members and to communicate that with accuracy and sensitivity. They have shown an unwavering commitment to this task.

Every member of the police force of Western Australia is contemporaneously a coroner's investigator. The Coroner's Court of Western Australia continued to be well supported by all of the coroner's investigators, including those at the Coronial Investigation Squad, the forensic pathologists and other PathWest staff, and the toxicologists and other ChemCentre staff. I use this opportunity to express my gratitude to these officers and staff members in all of these agencies that ably assist the Coroner's Court on a daily basis.

I am grateful for the assistance of a number of officers from the Department of Justice over the past year in connection with the progression of the reform proposals. These initiatives take time and energy and the Coroner's Court has been well served by their efforts.

I am pleased to present the 2016/17 Annual Report of the Office of the State Coroner.

R V C FOGLIANI
STATE CORONER

Office Structure

The office structure of the Coroner's Court of Western Australia comprises the State Coroner, Deputy State Coroner and two Coroners supported by 23 full time employees (FTE's) as shown Table 'A' below. Office Manager and Coroner's Registrar Ms Susan Wilde continues to capably manage the operations of the Office and has been instrumental in the administration of the files and the workflow operations and so as to facilitate the reduction of the backlog. Staffing levels were stable over the reporting year.

Table A

Coroners and Inquest staff	Management and Registry Staff	Counselling Service
State Coroner	Principal Registrar	Senior Counsellor
Deputy State Coroner	Office Manager	Counsellor
Coroner	Registry Manager	Counsellor
Coroner	Assistant Registry Officer	
Principal Counsel Assisting	Systems Information Officer	
Counsel Assisting	Senior Findings Clerk	
Counsel Assisting	Findings Clerk	
Listings Manager	Customer Service Officer	
Administrator	Customer Service Officer	
Customer Service Officer	Customer Service Officer	
Customer Service Officer	Customer Service Officer	
Customer Service Officer	Customer Service Officer	

Registry and Statistics

The Registry is the repository of the statistical information concerning the work of the Coroner's Court of Western Australia. Registry staff members record the salient details of the coroner's findings, including the deceased's name, date of death, the cause and manner of death and date of the coroner's finding.

The legal requirements to report a death that is or may be a reportable death to the coroner are set out in section 17 of the Coroners Act. Under section 19 of the Coroners Act, a coroner has jurisdiction to investigate a death if it appears to the coroner that it is or may be a reportable death. One of the functions of the State Coroner is to ensure that all reportable deaths reported to a coroner are investigated.

A reportable death is a Western Australian death that occurs in the circumstances set out in section 3 of the Coroners Act and includes a death that appears to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from injury; that occurs during an anaesthetic, or as a result of an anaesthetic (and is not due to natural causes); of a person who immediately before death was a person held in care; that appears to have been caused or contributed to while the person was held in care; that appears to have been caused or contributed to by any action of a member of the Police Force; of a person whose identity is unknown; and/or where the cause of death has not been certified by a doctor in accordance with the *Births, Deaths and Marriages Registration Act* 1998.

Under section 14 of the Coroners Act every member of the Police Force of Western Australia is contemporaneously a coroner's investigator. They investigate the reportable deaths and prepare a report for the coroner.

The coroners investigate the reportable deaths and if possible, make findings in relation to the cause and manner of death.

With capable guidance from Registry Manager and Coroner's Registrar Ms Rachel Whalen, the Registry has been responsible for the administration of the coronial files upon the initial report of the occurrence of a reportable death and upon finalisation of the coroner's investigation, either by administrative finding or by inquest.

At all levels in the Coroner's Court, the main focus in the past financial year continued to be on clearing the backlog of coronial cases (that is cases where the death was reported to the coroner 12 months ago, or more). Staff members within the Registry close the coronial files after the coroner has finalised the investigation.

The number of cases about to enter into backlog in any given month is calculated; and the Coroner's Court endeavours to finalise more than that number in an effort to prevent the backlog from increasing. A total of 2422 reportable deaths were reported to the coroner for full investigation in the past financial year and 2419 cases were completed representing a clearance rate of nearly 100%.

With regard to the 2419 cases completed in the past reporting year the breakdown is as follows:

- 2366 – the number of investigations finalised by administrative finding, of which 903 (38%) were backlog cases, and

- 53 - the number of investigations finalised by inquest, of which 53 (100%) were backlog cases.

At the conclusion of the reporting year, the cases on hand referred to the Coroner's Court of Western Australia for investigation by a coroner amounted to 2173, of which 347 were backlog cases (over 12 months old).

The backlog decreased from 466 in 2015/16 to 347 in 2016/17.

Of those 347 backlog cases, 136 were inquest cases waiting to be heard or pending finalisation by a coroner.

The following Tables provide an overview of the work of the Coroner's Court in the 2016/17 year.

Table B

CASES RECEIVED	*PERTH*	*COUNTRY*	*TOTAL*
Full Investigation	**1796**	**626**	**2422**
Death Certificates	**1174**	**n/a**	**1174**

CASES COMPLETED	*PERTH*	*COUNTRY*	*TOTAL*
Finalised by Inquiry	**1722**	**644**	**2366**
Finalised by Inquest	**34**	**19**	**53**
TOTALS	**1756**	**663**	**2419**

BACKLOG	*PERTH*	*COUNTRY*	*TOTAL*
	232	**115**	**347**

CASES ON HAND	*PERTH*	*COUNTRY*	*TOTAL*
	1628	**545**	**2173**

FINALISATION RATIO		
Finalised by Inquiry	**97.8%**	**2366**
Finalised by Inquest	**2.2%**	**53**

Table C

Table C below shows the age of a coronial file when closed calculated from the date of death. It will be seen that 61% (1463) of files were closed in under 12 months and 39% (956) of files were over 12 months old at closure (i.e. backlog files).

	INQUIRY		**INQUEST**	
TIMELINES	*PERTH*	*COUNTRY*	*PERTH*	*COUNTRY*
< 3 mths	**173**	**42**	**0**	**0**
3-6 mths	**137**	**159**	**0**	**0**
6-12 mths	**706**	**246**	**0**	**0**
12-18 mths	**569**	**129**	**2**	**0**
18-24 mths	**95**	**43**	**3**	**2**
>24 mths	**42**	**25**	**29**	**17**
TOTALS	**1722**	**644**	**34**	**19**

Table D

Table D below shows the total number of deaths reported and cases completed during the 2016/17 year for Perth and Regional WA.

TOTAL NUMBER OF DEATHS REPORTED TO THE CORONER			
Death certificates			1174
Metropolitan deaths	1796		
Regional deaths	626		
• **Albany**		94	
• **Broome**		34	
• **Bunbury**		209	
• **Carnarvon**		32	
• **Islands**		1	
• **Geraldton**		74	
• **Kalgoorlie**		64	
• **Kununurra**		22	
• **Northam**		52	
• **Port Hedland**		44	
TOTAL NUMBER OF REPORTABLE DEATHS	2422		1174
CASES COMPLETED	**PERTH**	**COUNTRY**	**TOTAL**
Finalised by Inquiry	1722	644	2366
Finalised by Inquest	34	19	53
TOTALS	1756	663	2419

Table E

Table E below shows the statistics relating to coroners findings on the manner of death for the past five financial years. They represent investigations that were finalised by a coroner in those financial years, either by administrative finding or by inquest.

MANNER OF DEATH	*2012-2013*	*2013-2014*	*2014-2015*	*2015-2016*	*2016-2017*
Accident	645	622	580	635	700
Misadventure	19	34	25	44	61
Natural Causes	975	849	915	851	1039
No Jurisdiction	7	0	5	3	7
Open Finding	120	125	103	105	139
Self Defence	1	1	0	1	3
Suicide	383	336	340	322	420
Unlawful Homicide	75	69	53	88	53
TOTALS	**2225**	**2036**	**2021**	**2049**	**2422**

Post Mortem Examinations

Under section 25(1)(c) of the Coroners Act a coroner investigating a death must find, if possible, the cause of death.

Under section 34(1) of the Coroners Act, if a coroner reasonably believes that it is necessary for an investigation of a death, the coroner may direct a pathologist or a doctor to perform a post mortem examination on the body. A post mortem examination is a detailed medical examination of the body of a person who has died, undertaken for the purpose of investigating the death.

Post mortem examinations for the Coroner's Court of Western Australia are performed at the direction of the coroner by experienced forensic pathologists. They prepare a confidential report for the coroner and provide an opinion on the cause of death. The post mortem report may also provide information that is relevant to manner of death. The coroner takes this information into account when making a finding.

Under section 36 of the Coroners Act, any person can ask the coroner who has jurisdiction to investigate a death to direct that a post mortem examination be performed on the body. If the coroner refuses the request an application may be made to the Supreme Court for an order that a post mortem be performed. Applicants have two clear working days after receiving the coroner's notice of refusal to apply to the Supreme Court unless an extension of time has been granted by the Supreme Court.

Objections to Post Mortem Examinations

Under section 37 of the Coroners Act, except where the coroner decides that a post mortem examination must be performed immediately, the senior next of kin may object to the conduct of a post mortem examination.

The senior next of kin in relation to the deceased means the first person who is available from the categories of persons referred to in section 37(5) of the Coroners Act, in the order of priority listed in that sub section.

A Coroner's brochure entitled "When a person dies suddenly" is served upon the senior next of kin by attending police officers as soon as possible following a death. That brochure explains the procedure for making an objection to the conduct of a post mortem examination. The senior next of kin may give notice of an objection to a post mortem examination to the Western Australia Police at any hour, or directly with Coroner's Court of Western Australia during office hours.

The reasons for objections to a post mortem examination by a senior next of kin vary from person to person. In the normal course they are discussed with a member of the coronial counselling service who will convey them to the coroner. In a number of cases the coroner, after considering the other evidence that could assist in determining the likely cause of the death, will accept the objection and no post mortem examination will be performed.

In other cases, the coroner after carefully considering the reasons for the objection may nonetheless decide that a full internal post mortem examination is necessary and will overrule the objection. The coronial counsellor communicates the coroner's decision and reasons for overruling the objection to the senior next of kin. Also, under section 37(1) of the Coroners Act, the coroner must immediately give notice in writing of that decision to the senior next of kin and to the State Coroner. Within two clear working days of receiving notice of the coroner's decision (or before the end of any extension of time granted) the senior next of kin may apply to the Supreme Court for an order that no post mortem examination be performed. The Supreme Court may make an order to that effect if it is satisfied that it is desirable in the circumstances.

The discussions between the senior next of kin and the members of the coronial counselling service are a vital component of the process for objections. The counsellors have experience in dealing compassionately with sensitive matters and are cognisant of cultural issues that may impact upon decision making in this area. The work of the coronial counselling service is further addressed at pages 21 to 22 of this Report.

Table F

Table F below shows the number of post mortem examinations and the number of objections received in the 2016/17 year and the outcomes:

Deaths reported to Coroner's Court of Western Australia:

REPORTED DEATHS	
Immediate post mortem	**51**
No objection to post mortem	**1996**
Objection to post mortem	**319**
No post mortem conducted (missing person, death certificate originally issued or by order of coroner etc)	**56**
NUMBER OF REPORTED DEATHS	**2422**

Outcomes in cases where an objection was initially received:

OBJECTIONS TO POST MORTEMS	
Objection accepted	**248**
Objection withdrawn	**69**
Objection withdrawn after coroner overruled	**2**
Applications to Supreme Court	**0**
TOTAL OBJECTIONS TO POST MORTEMS	**319**

Pathologist Recommended External Post Mortem Examinations

Consistent with the Law Reform Commission of Western Australia's recommendations 100 to 103 in its *Review of Coronial Practice in Western Australia, project no. 100* and pending external review of this component of the recommendations, this financial year the State Coroner has piloted a scheme to support the forensic pathologist's use of the least invasive procedures that are available and appropriate in the conduct of post mortem examinations.

The process has involved forensic pathologists recommending to the coroner, where considered appropriate, that an external post mortem examination together with a review of available medical records and/or toxicological information is sufficient to enable them to form an opinion on cause of death. In each instance the senior next of kin are consulted, and the coroner makes a decision as to whether to approve the forensic pathologist's recommendation.

Whilst this pilot is necessarily limited due to there being no dedicated CT scanner available to forensic pathologists, given its early success, it has been adopted within the metropolitan area with plans to extend in regional areas on a case by case basis.

Table G below shows the number of pathologist recommended external post mortem examinations approved by the coroner, and the number of instances where the coroner has directed a full internal post mortem examination.

Table G

Outcomes in PRE (Pathologists Recommended External Post Mortem Examinations).

PATHOLOGIST RECOMMENDED EXTERNAL (PRE)	
PRE recommended by Pathologist	**233**
PRE approved by Coroner or Principal Registrar	**227**
PRE not approved by Coroner - Full PM	**1**
PRE rejected by next of kin - Full PM	**1**
PRE approved – Partial PM	**4**
TOTAL PATHOLOGIST RECOMMENDED EXTERNAL	**233**

Coronial Counselling Service Functions

The State Coroner's obligation under section 16 of the Coroners Act is to ensure that a counselling service is attached to the court. This is met through the Coronial Counselling Service (CCS). Any person coming into contact with the coronial system may seek the assistance of the CCS and, as far as practicable, that service is to be made available to them.

The CCS is staffed by a clinical psychologist, Dr Francesca Bell, and two psychologists, Mr Phil Riseborough and Ms Teresa McGlynn. The service provides information, counselling, and liaison to those affected by sudden death and to numerous government and non-government agencies. The CCS is assisted by several valuable volunteers who have offered a court companion service facilitated by the CCS. The CCS is on call from 7:00 am to 6:00 pm every day of the year including public holidays.

Over the past reporting year, the coronial counsellors have spent many hours communicating with people who come into contact with the Coroner's Court. They aim to impart clear and accurate information, with compassion. They have a deep understanding of grief and loss.

Coronial counsellors provide information to the next of kin about the progress through the coronial system of the investigation into their family member's death. They explain the process and the timelines involved when a senior next of kin objects to a post mortem examination, discuss tissue retention issues, provide advice on body release dates, and facilitate connections to agencies that may assist with other aspects of the process.

Coronial counsellors are able to offer counselling in relation to grief, loss, and trauma. Where appropriate they will offer information about referral options. They run education sessions with various professional groups and liaise closely with a number of different government departments to ensure that a person's death and its ramifications are handled as appropriately as possible.

Coronial counsellors are able to facilitate the viewing of selected case material from the coronial files to assist next of kin to better understand what happened to their family member. This process involves supporting the next of kin during the viewing as appropriate and being available to answer questions.
Coronial counsellors are able to attend at the State Mortuary to support next of kin if they require that support when viewing their loved one. They will conduct home visits if required and if it is possible.

In respect of information concerning post mortem examinations, the 2016/17 financial year saw the piloting and introduction of Pathologist Recommended External Post Mortem Examinations (PRE). The CCS was involved in this process. Coronial counsellors contacted family members to ascertain their views on an external examination and review of medical records and or images. Feedback on the PRE process indicates that its introduction has largely brought relief to families, who often prefer that no full internal post mortem examination is performed.

The Perth based CCS has continued to establish productive links with on-site counselling services in regional and/or remote areas, to better service the needs of persons in those

areas who would benefit from personal (as opposed to telephone) contact. The liaison with on-site services has worked well, and community members have engaged with the outreach.

In the coming year, it is also proposed that the CCS will begin to develop a network of clinicians willing to assist, should an incident requiring initiation of the Disaster Victim Identification Protocols occur.

Table H

Table H below shows the number and types of referrals dealt with by the Coronial Counselling Service for the past five reporting years.

TYPE OF SERVICE	*2012-2013*	*2013-2014*	*2014-2015*	*2015-2016*	*2016-2017*
Phone, Office/Home Visits	**6251**	**6529**	**6979**	**6993**	**7274**
Offers of Service	**933**	**1092**	**1377**	**547**	**577**
Mortuary/file viewings	**1971**	**2129**	**2397**	**2566**	**3390**
TOTAL CONTACTS	**9155**	**9750**	**10753**	**10106**	**11241**

For the 2016/17 year the above categories are explained as follows:

- Phone, Office/Home visits refers to all telephone calls (7041) visits to home addresses (7) and attendances at other offices or attendances by others at the Court (226);
- Offers of Service refers to letters offering counselling (577); and
- Mortuary/file viewings refers to emails (1253), interoffice liaison (2134) and mortuary contact (3).

Coronial Ethics Committee Functions

The Coronial Ethics Committee was established pursuant to section 58 of the Coroners Act and operates in compliance with the National Health and Medical Research Council's National Statement on Ethical Conduct in Human Research and its associated guidelines.

Coronial data is confidential. An application for the provision of coronial data must be accompanied by a detailed written submission to the Coronial Ethics Committee. Applications are primarily made for research purposes. As the level of business for the Committee has increased over time, so have the number of meetings the Committee holds. On average, this past reporting year, the Coronial Ethics Committee has met bi-monthly to consider applications. In decision-making, the Committee members attempt to strike a balance between family concerns (including privacy, confidentiality, and consent issues), and the benefits of research to the community at large. Once an application has been considered, the Coronial Ethics Committee makes its recommendation to the State Coroner about whether the coronial data sought should be released, and under what conditions.

The membership of the Coronial Ethics Committee is drawn from a range of representative categories to allow for a broad cross section of views to be considered during discussions. The Coroner's Court of Western Australia is well served by the considerable work done by Coronial Ethics Committee members, who volunteer their time. The subject matter is sensitive and the Committee makes a vital contribution to the coroner's death prevention role.

The members of the Coronial Ethics Committee are as follows:

Associate Professor Alistair Vickery	Chairperson, Associate Professor, UWA
Dr Jodi White	Deputy Chairperson, Forensic Pathologist, PathWest
Associate Professor Jennet Harvey	Department of Pathology, UWA
Mr Barry King	Coroner
Ms Simone Brand (from February 2017)	Member with counselling background
Ms Natalie Gately (from December 2016)	Lay Member
Reverend Brian Carey	Member with a pastoral background
Ms Christine Pitt	Legal Member
Ms Kate Ellson	Secretary, Legal Member, Principal Counsel Assisting

In November 2016, Mr Jim Fitzgerald resigned from the Committee. Mr Fitzgerald was a member of the Committee for many years and contributed to its business significantly during his membership.

In December 2016 the Committee welcomed Ms Natalie Gately as a new lay person member of the Committee. In February 2017 Ms Simone Brand joined the Committee as a member with counselling experience. Both new members have contributed to the work of the Committee, and have provided valuable input from their respective backgrounds.

Ably chaired by A/Professor Vickery and with the support of Committee Secretary, Ms Kate Ellson, the whole committee has provided the State Coroner with valuable reviews and recommendations. Administrative assistance has been provided by Ms Catherine Broissand throughout the year. Ms Fleur Allen has assisted with Secretary functions as required.

This past reporting year, the Coronial Ethics Committee met six times and addressed the following number of projects, as indicated in the Table I below. The State Coroner did not reject any of the Ethics Committee's recommendations.

Table I

Number of Projects Considered	**Number of projects approved**	**Number of projects not approved**
21	20	1
Number of Requests for renewal Considered	**Number of Requests for renewal Approved**	**Number of Requests for renewal Not approved**
3	3	0
Number of Amendments to Applications	**Number of amendments approved**	**Number of amendments not approved**
3	3	0

Principal Registrar and Coroner's Registrars

The Principal Registrar and the Coroner's Registrars have again worked hard to discharge their functions in a timely fashion and when necessary on an urgent basis, in the furtherance of the efficient administration of the coronial system for Western Australia. They continue to meet the challenges of an increasing workload with care and diligence.

Coroner's registrars are appointed under section 12 of the Coroners Act. They have statutory functions under section 13 of the Coroners Act and they exercise the powers or duties of a coroner that are delegated to them by the State Coroner in writing under section 10 of the Coroners Act. There are six coroner's registrars at the Coroner's Court of Western Australia, four of whom exercise delegated functions under section 10 of the Coroners Act, one of whom is the Principal Registrar, Mr Gary Cooper. They exercise their delegations contemporaneously with their other functions.

In addition, registrars of Magistrates Courts may act as coroner's registrars if an investigation is held at a courthouse where the Magistrates Court sits.

A coroner's registrar's delegated functions under section 10 and statutory functions under section 13 include, but are not limited to, receiving information about a death which a coroner is investigating other than at an inquest, issuing summonses requiring witnesses to attend at inquests, directing that a pathologist or a doctor perform a post mortem examination, authorising the release of the body following the post mortem examination and authorising tissue donations under the *Human Tissue and Transplant Act* 1982.

The Principal Registrar and three other coroner's registrars have specific delegated functions empowering them to restrict access to a place where the death occurred, or where the event which caused or contributed to the death occurred.

Of necessity, arrangements are in place so that a coroner's registrar is contactable at any time of the day or night, every day of the year. The Principal Registrar provides mentoring and support to all coroner's registrars.

As of 1 January 2017, pursuant to section 10 of the Coroners Act the State Coroner delegated additional functions to the Principal Registrar to authorise and sign non-narrative natural cause administrative findings, to authorise coroner's investigators to enter a specified place and take possession of things, and to approve external post mortem examinations when recommended by a forensic pathologist.

The execution of these functions by the Principal Registrar has enabled the coroners to focus on more complex and/or pressing matters. This financial year the Principal Registrar finalised 264 non-narrative natural cause administrative findings and approved 100 pathologist recommended external examinations.

The Principal Registrar deals with incoming notifications and requests to the Coroner's Court of Western Australia and assesses those incoming matters for referral to the State Coroner where they involve complexities and/or the exercise of non-delegated statutory functions.

The Principal Registrar executes the State Coroner's directions in relation to the conduct of coronial investigations. The Principal Registrar manages all mandatory inquest files up to and including allocation to counsel assisting and identifies potential matters for inquest, submitting recommendations to the State Coroner.

The Principal Registrar represents the State Coroner at a variety of internal and external forums/meetings. On behalf of the State Coroner, he liaises with members of the Western Australia Police, officers from the Department of Health and the Western Australian Ombudsman, and numerous other government and non-government agencies. He continues to provide education and information sessions to health and legal professionals and other organisations on a regular basis as part of a community education strategy.

In more recent times the Principal Registrar and other senior officers of the Department of Justice have been engaged in preparing a business case for the installation of a CT scanner at the State Mortuary. In addition they have been assisting with the progression of draft legislation through the WA Parliament which is based upon two recommendations of the Law Reform Commission of Western Australia in its *Review of Coronial Practice in Western Australia, project no. 100*, January 2012.

Counsel Assisting the Coroner

There are three legal counsel who assist the coroners with the preparation, management and conduct of inquest hearings. Ms Kate Ellson continued her work as principal counsel assisting for the coroners and as secretary to the Coronial Ethics Committee throughout the past reporting year. She continued to co-ordinate counsel assisting's timely listing of matters in the Coroner's Court's call-over system, and the work of counsel assisting generally.

Mr Toby Bishop has continued to work diligently to ensure matters in his practice are finalised in a timely way. Ms Fleur Allen commenced as counsel assisting at the Coroner's Court on 12 September 2016, replacing Ms Ilona O'Brien who had resigned as at 8 January 2016. Ms Allen bought with her a background in prosecuting and mental health advocacy and has worked diligently to list matters for inquest.

Ms Aneta Sukoski left the Court at the end of June 2017 after completing her secondment from Department of Commerce for two six month periods. Ms Sukoski ably assisted the Court to clear a backlog of cases arising as a result of the vacancy in a counsel position.

In addition to the preparation and conduct of inquest matters, the counsel assisting provide advices and recommendations to the State Coroner in respect of the exercise of statutory functions, most notably in connection with the exercise of the discretion where a person has asked the State Coroner to hold an inquest under Section 24 of the Coroners Act.

All the counsel assisting have diligently executed their functions with care and attention to detail. They have primarily focused on preparing the backlog inquests for hearing. Through their efforts, they have assisted in reducing the number of aged matters awaiting hearing by a coroner.

Police Assisting the Coroner

Sergeant Lyle Housiaux and Senior Constable Eric Langton have continued to serve as a critical link between the Coroner's Court and the Coronial Investigation Squad of the Western Australia Police Service.

They provide significant assistance to the coroners in the preparation of matters for inquest, including the gathering of evidence where necessary.

They also provide ongoing assistance to coroner's investigators state-wide in relation to practices and procedures for the conduct coronial investigations, thereby contributing to consistency of practice in this area.

Sergeant Housiaux has continued to ably perform the role of assisting the coroner in Court in relation to the conduct a number of inquests throughout the year, thereby assisting with the work flow in this area.

Both police officers through their efforts continue to make a valuable contribution to the conduct and/or finalisation of a significant number of coronial investigations.

Inquests

Table J

Table J below shows the total number of inquests **(53)** finalised in the 2016/17. An inquest is finalised when the coroner signs the inquest finding.

SURNAME OF DECEASED	*DATE OF DEATH*	*DATE OF INQUEST*	*FINDING*	*DATE OF FINDING*
GLENDINNING Heather CUZENS Jessica Rose CUZENS Jane Lesley Margaret	5/12/2011	1-5/2/2016	Suicide Homicide Homicide	21/7/2016
#DAVEY Sara-Lee	On or about 14/1/1997	6/4/2016	Open	1/9/2016
^WILLIAMSON Ewan Louis	21/12/2012	9-11/2/2016	Accident	22/8/2016
SELLAKATHIRKGAMAN Anandakumar	4/1/2013	10/8/2016	Suicide	8/9/2016
RAHMAN Sajidu	1/6/2013	3/5/2016	Natural Causes	9/9/2016
#EURA Anthony Charles	Between 1/11/2006 and 30/11/2006	26/7/2016	Open	13/9/2016
*Baby Z	3/4/2011	14-17/3/2016	Open	27/9/2016
BROADRIBB Donald Richard	13/10/2012	2/12/2015	Natural Causes	28/9/2016
*ROGINSON Troy Allan	22/4/2014	19/9/2016	Unlawful Homicide	29/9/2016
DEVINE Janene	16/3/2007	1/6/2016	Unlawful Homicide	30/9/2016
*HEIJNE Gerardus Gerritt	26/3/2013	24/5/2016	Suicide	7/10/2016
SAYED Hayder	22/8/2010	14/9/2016	Natural Causes	10/10/2016

^RYAN Giovani Wade	5/10/2013	5-6/7/2016	Unlawful Homicide	18/10/2016
*WAYMOUTH David	20/11/2014	18/10/2016	Natural Causes	24/10/2016
^ROWE Simon John	12/4/2012	13/7/2016 1-3/8/2016	Suicide	4/11/2016
^MURPHY Shannon Elizabeth	27/4/2012	16-17/8/2016 & 29/8/2016	Misadventure	17/11/2016
#HASSAN Mohammad #NOOR Mohammad #SABIBULLAH Mr	Between 24-29/1/2013	22/8/2016	Misadventure	16/11/2016
NICEFORO Maria Carmel	7/2/2014	30/6/2016 & 4-7/7/2016 & 11/7/2016 & 14/9/2016	Natural Causes	22/11/2016
*JBA	26/5/2015	21/11/2016	Natural Causes	28/11/2016
^WINCHESTER Jason Barry	29/1/2014	1-2/9/2016	Misadventure	2/12/2016
*DHU Ms	4/8/2014	23/11/2015-3/12/2015 & 14-24/3/2016 & 28/9/2016	Natural Causes	15/12/2016
CAMMILLERI Jasmine Lilian	11/2/2013	5/4/2016	Accident	28/12/2016
#COOK Rowan Wallace	Unknown	12/9/2016	Open	3/1/2017
*MIHAJLOVIC Radinka	1/5/2012	19-20/4/2016	Suicide	5/1/2017
ULLRICH Tamika Patricia Carol	30/12/2012	19/9/2016 & 3/10/2016	Natural Causes	20/1/2017
STRONER Christine Pearl	3/4/2013	21/10/2016 & 26/10/2016	Open	17/2/2017
*BENNELL Jayden Stafford	6/3/2013	29/8/2016-1/9/2016	Suicide	28/2/2017

*STUART Barry Matt	16/11/2013	24/11/2016	Suicide	7/3/2017
#JOHNSTON Colin John	Unknown	28/11/2016	Open	28/2/2017
^D'ERCOLE Sharon Ann	12/4/2012	6-7/9/2016 & 13/9/2016	Accident	28/2/2017
MOSBY Masaly	On or about 6/10/2011	9-10/1/2017	Natural Causes	21/3/2017
CHANDRA Subhas	Between 3-4/11/2013	6-7/2/2017	Natural Causes	23/3/2017
*ST	20/11/2014	30/11/2016	Natural Causes	29/3/2017
MURRAY Troy William	11/3/2012	20/2/2017	Suicide	30/3/2017
WINTER Anna Maria	20/5/2014	10 & 12/10/2016	Natural Causes	31/3/2017
HOUGHTON John	11/7/2014	11-12/10/2016	Natural Causes	31/3/2017
*MANDIJARRA Ms	30/11/2012	22-25/2/2016 & 12/4/2016	Natural Causes	31/3/2017
SERJEANT Robert Stephan Hamiora	13/7/2011	5/12/2016	Accident	18/4/2017
OVENS Leslie Troy	24/7/2013	21-23/9/2016 & 6/10/2016	Misadventure	26/4/2017
BEE Edith Catherine	4/9/2013	27/3/2017	Misadventure	3/5/2017
HOURAREAU Jemmy Vincent	On or about 25/11/2011	6-7/2/2017	Open	3/5/2017
VELMURUGU Arulselvam	1/5/2013	12/12/2016	Natural Causes	12/5/2017
McBRIDE Shaun	4/6/2011	17-18/5/2016 & 26/5/2016	Accident	30/5/2017
BEARFOOT Wendy	1/11/2012	31/10/2016-4/11/2016	Accident	12/6/2017

#MILLER (aka Herb Miller) Keven Herbert Leban	On or about 12/2/2009	30/5/2017	Open	13/6/2017
#SANTEN Robyn Louise	On or about 9/8/2015	9/1/2017	Open	15/6/2017
*SILVER Annette	2/1/2015	19/1/2017	Suicide	22/6/2017
*MEHINOVIC Ejub	On or about 23/11/2015	24/1/2017	Natural Causes	29/6/2017
*KLD	22/8/2012	12-13/1/2017 & 16-18/1/2017 & 20/1/2017	Open	30/6/2017

^ = Death that appeared to be caused or contributed to by any action of a member of the police force (6)

= Missing person (9)

* = Person held in care (14)

The balance of the matters listed (24) were discretionary inquests

Total Inquests : 53

I acknowledge the considerable assistance rendered by the Coroner's Court's Listing Manager Ms Dawn Wright and my Administrator Ms Sue Sansalone in their management of the court's listing requirements, their preparation of matters for hearing and all of the guidance they provide to staff members for the preparation of inquest briefs.

The Tables appearing after Table J (Tables K, L and M) are subsets of the information contained in Table J, and the following Tables all relate to mandated inquests.

DEATHS THAT APPEARED TO BE CAUSED, OR CONTRIBUTED TO, BY ANY ACTION OF A MEMBER OF THE POLICE FORCE

Under section 22(1)(b) of the Coroners Act, a coroner who has jurisdiction to investigate a death must hold an inquest if the death appears to be a Western Australian death and it appears that the death was caused, or contributed to, by any action of a member of the Police Force.

Table K

Table K below shows the number of inquests **(6)** finalised in 2016/17 year into deaths that appeared to be caused, or contributed to, by any action of a member of the Police Force.

NAME	*DATE OF DEATH*	*DATE OF INQUEST*	*FINDING*	*DATE OF FINDING*
^WILLIAMSON Ewan Louis	21/12/2012	9-11/2/2016	Accident	22/8/2016
^RYAN Giovani Wade	5/10/2013	5-6/7/2016	Unlawful Homicide	18/10/2016
^ROWE Simon John	12/4/2012	13/7/2016 1-3/8/2016	Suicide	4/11/2016
^MURPHY Shannon Elizabeth	27/4/2012	16-17/8/2016 & 29/8/2016	Misadventure	16/11/2016
^WINCHESTER Jason Barry	29/1/2014	1-2/9/2016	Misadventure	2/12/2016
^D'ERCOLE Sharon Ann	12/4/2012	6-7/9/2016 & 13/9/2016	Accident	28/2/2017

Three of the investigations concerned the coroner's independent scrutiny of police pursuits and/or vehicle intercepts.

The other three investigations concerned the coroner's independent scrutiny of police responses to emergency call outs and/or protocols and procedures following police involvement.

In five of the cases the coroner found that the police did not cause or contribute to the death. In one case (Ms D'ERCOLE) the coroner found the actions of the police officers in the police vehicle caused the death of the deceased, however, those actions were undertaken during the course of legitimate law enforcement activities which require a police driver to make split second risk assessments.

The coroners' findings and the responses appear on the website of the Coroner's Court of Western Australia.

SUSPECTED DEATHS

Under section 23 of the Coroners Act where a person is missing and the State Coroner has reasonable cause to suspect that the person has died and that the death was a reportable death, the State Coroner may direct that the suspected death of the person be investigated. Where the State Coroner has given such a direction a coroner must hold an inquest into the circumstances of the suspected death of the person, and if the coroner finds that the death of the person has been established beyond all reasonable doubt, into how the death occurred and the cause of the death.

Table L

Table L below shows the number of inquests **(9)** finalised in 2016/17 year into suspected deaths.

NAME	*DATE OF DEATH*	*DATE OF INQUEST*	*FINDING*	*DATE OF FINDING*
#DAVEY Sara-Lee	On or about 14/1/1997	6/4/2016	Open	1/9/2016
#EURA Anthony Charles	Between 1/11/2006 and 30/11/2006	26/7/2016	Open	13/9/2016
#HASSAN Mohammad #NOOR Mohammad #SABIBULLAH Mr	Between 24-29/1/2013	22/8/2016	Misadventure	16/11/2016
#COOK Rowan Wallace	Unknown	12/9/2016	Open	3/1/2017
#JOHNSTON Colin John	Unknown	28/11/2016	Open	28/2/2017
#MILLER (aka Herb Miller Keven Herbert Leban)	On or about 12/2/2009	30/5/2017	Open	13/6/2017
#SANTEN Robyn Louise	On or about 9/8/2015	9/1/2017	Open	15/6/2017

In each case the coroner found that the death of the person had been established beyond all reasonable doubt. The coroners' findings appear on the website of the Coroner's Court of Western Australia.

PERSONS HELD IN CARE

Under section 3 of the Coroners Act a "person held in care" means:

(a) a person under, or escaping from, the control, care or custody of –

(i) the CEO as defined in section 3 of the *Children and Community Services Act* 2004; or
(ii) the Chief Executive Officer of the department of the Public Service principally assisting the Minister administering the *Prisons Act* 1981 in its administration; or
(iii) a member of the Police Force;

or

(aa) a person for whom the CEO as defined in the *Court Security and Custodial Services Act* 1999 is responsible under section 10, 13, 15 or 16 of that Act, whether that person is at a custodial place as defined in that Act, is being moved between custodial places or escapes, or becomes absent, from a custodial place or during movement between custodial places.

(b) a person admitted to a centre under the *Alcohol and Other Drugs Act 1974*;

(ca) a resident as defined in the *Declared Places (Mentally Impaired Accused) Act 2015* section 3;

(c) a person

(i) who is an involuntary patient under the *Mental Health Act 2014*; or
(ii) who is apprehended or detained under that Act; or
(iii) who is absent without leave from a hospital or other place under section 97 of that Act; or

(d) a person detained under the *Young Offenders Act 1994*;

Table M overleaf shows the number of inquests **(14)** finalised in 2016/17 into deaths of persons held in care.

In accordance with section 27(1) of the Coroners Act, the specific report on the death of each person held in care appears after Table M.

The coroners' findings and the responses appear on the website of the Coroner's Court of Western Australia.

Table M

Deaths of persons held in care finalised in the 2016/17 year

NAME	DATE OF DEATH	DATE OF INQUEST	FINDING	DATE OF FINDING
*Baby Z	3/4/2011	14-17/3/2016	Open	27/9/2016
*ROGINSON Troy Allan	22/4/2014	19/9/2016	Unlawful Homicide	29/9/2016
*HEIJNE Gerardus Gerrit	26/3/2013	24/5/2016	Suicide	7/10/2016
*WAYMOUTH David	20/11/2014	18/10/2016	Natural Causes	24/10/2016
*JBA	26/5/2015	21/11/2016	Natural Causes	28/11/2016
*DHU Ms	4/8/2014	23/11/2015-3/12/2015 & 24/3/2016 & 28/9/2016	Natural Causes	15/12/2016
*MIHAJLOVIC Radinka	1/5/2012	19-20/4/2016	Suicide	5/1/2017
*BENNELL Jayden Stafford	6/3/2013	29/8/2016-1/9/2016	Suicide	28/2/2017
*STUART Barry Matt	16/11/2013	24/11/2016	Suicide	7/3/2017
*ST	20/11/2014	30/11/2016	Natural Causes	29/3/2017
*MANDIJARRA Ms	30/11/2012	22-25/2/2016 & 12/4/2016	Natural Causes	31/3/2017
*SILVER Annette	2/1/2015	19/1/2017	Suicide	22/6/2017
*MEHINOVIC Ejub	On or about 23/11/2015	24/1/2017	Natural Causes	29/6/2017
*KLD	22/8/2012	12-13/1/2017 & 16-18/1/2017 & 20/1/2017	Open	30/6/2017

PERSONS HELD IN CARE – specific reports

Baby Z (Subject to Suppression Order)
Inquest held in Perth 14-17 March 2016, investigation finalised 27 September 2016

Baby Z [name suppressed] (the deceased) died on 3 April 2011 at Bandyup Women's Prison. The deceased was one month old. The cause of death was unascertained and the coroner was unable to find the manner of death. Accordingly, an open finding was made as to the manner of death.

Immediately before death the deceased's mother was a "person held in care" under section 3 of the *Coroners Act 1996* because she was a sentenced prisoner and, pursuant to the *Prisons Act 1981,* she was in the custody of the Chief Executive Officer of the Department of Corrective Services. The deceased's mother was serving her sentence at Bandyup Women's Prison during her pregnancy. After being born at King Edward Memorial Hospital and receiving some initial medical treatment the deceased was permitted to transfer to Bandyup Women's Prison and stay with his mother as a 'visitor' pursuant to a prison policy. While the mother was expected to assume full responsibility for the child's care and safety while residing in prison, the Department also accepted that it continued to owe a duty of care to the child and provided services within the prison to promote the safety and wellbeing of the child. Given the circumstances of the deceased's death, the death was treated as a death of a person held in care.

The deceased was found unresponsive by his mother overnight. The deceased's mother was uncertain as to the sleeping location and position of the deceased at the time she found him unresponsive. It was unclear whether or not the deceased was in his cot at the time he was found. The coroner concluded that the deceased's mother had no clear recollection of what occurred on that night. After considering the evidence the coroner was satisfied that the deceased's mother had engaged in co-sleeping with the deceased on occasions, but there was insufficient evidence to make a finding that the deceased was co-sleeping with his mother at the time he died.

A post mortem examination was performed on the deceased and examination revealed an apparently normally developed male infant with no evidence of significant natural disease or injury to account for his death. Extensive further investigations were carried out to try and establish a cause of death, but it remained unascertained. Given the cause of death was not established and the known circumstances raised the possibility of both natural and accidental causes, the coroner was unable to reach a conclusion as to the manner of death.

The coroner concluded that on 3 April 2011 the deceased died suddenly while residing with his mother at Bandyup Women's Prison. The coroner noted that the evidence indicated that overall the systems which are in place to manage mother and newborns in the Western Australian prison system are well-designed and implemented, although also noting that there is always room for improvements.

The coroner observed a number of government agencies who were involved in the deceased's short life, including staff at King Edward Memorial Hospital, Department of Child Protection and Bandyup Women's Prison, all acted to the best of their abilities to ensure that the deceased remained safe and well, while maintaining a bond with his mother.

In conclusion, the coroner found that despite some communication failures, the overall management of the deceased's treatment, care and supervision in his few weeks of life was of a high standard and his tragic death cannot be attributed to any of the agencies involved in his care.

The coroner did not make any recommendations.

The Finding is on the website of the Coroner's Court of Western Australia.

Troy Allan ROGINSON
Inquest held in Perth 19 September 2016, investigation finalised 29 September 2016

Mr Troy Allan Roginson (the deceased) died on 22 April 2014 at Royal Perth Hospital. The coroner found the manner of death was unlawful homicide. The cause of death was head injury in a man with chronic liver disease. He was 35 years old.

Immediately before his death the deceased was a "person held in care" under section 3 of the *Coroners Act 1996* because he was a sentenced prisoner and, pursuant to the *Prisons Act 1981,* he was in the custody of the Chief Executive Officer of the Department of Corrective Services. The deceased was serving his sentence at Wooroloo Prison Farm.

On 21 April 2014 the deceased became involved in a verbal altercation with some prisoners. The argument escalated and the deceased received a single punch to his chin, causing him to fall backwards and strike his head on a concrete path. He sustained a fatal head injury and died as a result.

The coroner heard evidence that this was considered to be the first recorded serious assault by one prisoner of another in Woorooloo, a minimum security prison.

The deceased's assailant was charged with unlawful assault causing the death of the deceased and returned to a maximum security prison. On 5 February 2015 he pleaded guilty to the charge and was sentenced to 2 years and 8 months imprisonment.

The coroner was satisfied that there was nothing the Department of Corrective Services did or failed to do that contributed to the deceased's death.

The coroner found his medical care on the day of the incident was of a high standard.

The coroner did not make any recommendations.

The Finding is on the website of the Coroner's Court of Western Australia.

Gerardus Gerritt HEIJNE
Inquest held in Perth 24 May 2016, investigation finalised 7 October 2016

Mr Gerardus Gerritt Heijne (the deceased) died on 26 March 2013 at Acacia Prison. The Deputy State Coroner found the manner of death was suicide. The cause of death was ligature compression of the neck (hanging). He was 49 years old.

Immediately before death the deceased was a "person held in care" under section 3 of the *Coroners Act 1996* because he was a sentenced prisoner, and pursuant to the *Prisons Act 1981* he was in the custody of the Chief Executive Officer of the Department of Corrective Services. The deceased was serving his sentence at Acacia Prison.

On the morning of 26 March 2013 the deceased was located by a fellow prison inmate, hanging from his locked cell door by a ligature that the deceased had secured to the outer door handle, following unlock earlier that morning.

On the evidence, the Deputy State Coroner did not believe the fact the deceased would suicide, or when, were reasonably apparent to Acacia prison authorities. While in prison the deceased had furthered his education in business and related studies as well as applied for a number of short term courses. The deceased had formed an emotional attachment and had become engaged towards the end of 2009. He had been assessed for his suitability to participate in cognitive skills and violent offending programs for which he received extensive assessment in February 2011. He lived in a self-care pod.

The Deputy State Coroner concluded that the deceased's suicide was reasonably premeditated and not an impulsive act, and that risk factors were present which would account for his decision. The Deputy State Coroner had regard to the lengths that the deceased went to in order to secure the ligature and formed the view that availability of incidental hanging points were not an issue.

The deceased had had regular contact with his fiancé using the prison telephone access to specified numbers. These calls between the deceased and his fiancé were accessed following the deceased's death and indicated the deceased had specified concerns in the days before his death.

The Deputy State Coroner found that with the provision of the deceased's recorded telephone calls and review of the very competent assessments of the deceased by the prison system, it was possible to understand the deceased's denial strategies for coping with stressors he experienced.

In this context the Deputy State Coroner made a recommendation in respect to the mandatory provision of telephone calls recorded prior to the death of a prisoner to the Coroners Court.

The Finding is on the website of the Coroner's Court of Western Australia.

David WAYMOUTH
Inquest held in Perth 18 October 2016, investigation finalised 24 October 2016

Mr David Waymouth (the deceased) died on 20 November 2014 at Bunbury Hospital. The coroner found the manner of death was natural causes. The cause of death was multi organ failure and sepsis complicating ulcerating colitis and intestinal obstruction in a man with severe constipation, methadone use and recent repair of a right hip fracture. He was 47 years old.

Immediately before his death the deceased was a "person held in care" under section 3 of the *Coroners Act 1996* because he was a sentenced prisoner and, pursuant to the *Prisons Act 1981*, he was in the custody of the Chief Executive Officer of the Department of Corrective Services. The deceased was serving his sentence at Bunbury Regional Prison.

The deceased fell from his bed in his cell overnight on 3 to 4 November 2014. He was taken to the prison health centre in a wheelchair as he was experiencing pain and unable to walk. The deceased was later conveyed via ambulance to Bunbury Hospital where he underwent an X-ray and CT scan of his right hip. The results confirmed a right sub-capital fracture of the neck of femur and he was admitted as an inpatient. He underwent a successful hip replacement, although the surgery carried a number of risk factors for the deceased due to his co-morbidities.

The deceased returned to prison from hospital on 8 November 2014 but that same morning he fell again and re-injured his hip and was returned to hospital. Following readmission the deceased developed several complications. Despite further surgical intervention, he was unable to recover and ultimately died as a result of those complications.

The coroner found the deceased had an extensive medical history. The various records and medical reports indicated throughout his many prison terms the deceased received regular medical treatment by prison doctors and nurses for a variety of ailments. He was seen by specialists and transferred to hospital for more extensive medical treatment whenever required. The coroner found the treatment provided to the deceased for his medical conditions while in prison was reasonable and appropriate and his management at the Bunbury Hospital was also of a reasonable and appropriate standard.

The coroner was satisfied that there was nothing the Department of Corrective Services did or failed to do that contributed to the deceased's death.

The coroner did not make any recommendations.

The Finding is on the website of the Coroner's Court of Western Australia.

Ms DHU
Inquest held in Perth 23 November 2015 to 3 December 2015 and 14 to 24 March 2016 and 28 September 2016, investigation finalised 15 December 2016

Ms Dhu (the deceased) died on 4 August 2014 at Hedland Health Campus. The State Coroner found the manner of death was natural causes. The cause of death was as a result of staphylococcal septicaemia and pneumonia in a woman with osteomyelitis complicating a previous rib fracture. She was 22 years old.

Immediately before death the deceased was a "person held in care" under section 3 of the *Coroners Act 1996* because she was under the control, care or custody of members of the Police Force, namely members of the Western Australia Police Service. Specifically the deceased had been detained on Warrants of Commitment issued under s 53 of the *Fines, Penalties and Infringement Notices Enforcement Act 1994*. The deceased was held in a cell in the South Hedland Police Station Lock Up.

The deceased had been arrested on a number of Warrants of Commitment for unpaid fines totalling $3,622.34 on 2 August 2014 and conveyed to the South Hedland Police Lock-up and admitted to custody on that date. She died less than 48 hours after being taken into custody. The provisions of *The Coroners Act* 1996 require that the death of a person while in police custody be examined by way of inquest, and the supervision, treatment and care of the deceased while in custody be commented upon.

On the evening of 2 August 2014 shortly after being admitted to custody and detained in a cell at the lock-up the deceased complained of being unwell. Police conveyed the deceased to the Hedland Health Campus for assessment in the police van. The deceased was medically assessed and medical staff provided police with a signed fit to be held in custody form. The deceased was returned to the police lock-up where she remained in her cell for the rest of the night.

On the following afternoon, 3 August 2014 the deceased again complained of being unwell. Police conveyed her to the Hedland Health Campus for a second assessment. The deceased was seen and treated by medical staff and police were provided with a further fit to be held in police custody form. The deceased was returned to the lock-up in the evening.

Unfortunately on the occasions of 2 and 3 August 2014 the clinicians at Hedland Health Campus essentially diagnosed the deceased with behavioural issues, meaning that she was not thought to have a medical illness. On the first occasion, the deceased did not display signs of infection, but on the second occasion, she did display some signs of infection but errors were made, resulting in a missed opportunity to treat the deceased with antibiotics on 3 August 2014, which would have been potentially life-saving.

The State Coroner found that the deceased's medical treatment at Hedland Health Campus on 3 August 2014 was deficient as a result of premature diagnostic closure, and that her treatment and care at Hedland Health Campus on 2 and 3 August fell below the standards that should ordinarily be expected of a public hospital.

On the morning of 4 August 2014 the deceased was still complaining of being unwell. Unfortunately the police thought she was feigning her symptoms. Over the course of the morning, the deceased's life-threatening condition continued to progress and she suffered a catastrophic decline in her health. After midday police made the decision that the deceased required further medical assessment and arrangements were made to convey the deceased to the Hedland Health Campus in the police van.

The State Coroner found the behaviour towards the deceased by a number of police officers was unprofessional and inhumane, and that the deceased's supervision, treatment and care and the lock-up, particularly on 4 August 2014, fell well below the standards that should ordinarily be expected of police.

Upon presentation at the Emergency Department of the Hedland Health Campus medical staff became alert to the deceased's serious medical condition and immediate resuscitation attempts were made. Despite their efforts the deceased could not be revived.

The State Coroner found that the deceased died on 4 August 2014 from staphylococcal septicaemia and pneumonia in a woman with osteomyelitis complicating a previous rib fracture and that death occurred by way of natural causes.

The State Coroner made 11 recommendations directed towards alternatives to imprisoning fine defaulters and also directed towards the improvement of conditions for Aboriginal persons held in custody including the consideration of a Custody Notification Service and matters concerning cross-cultural diversity training, monitoring of detainees, and staffing levels at lock-ups.

The Finding is on the website of the Coroner's Court of Western Australia.

JBA (Subject to a Suppression Order)
Inquest held in Perth 21 November 2016, investigation finalised 28 November 2016

JBA (the deceased) died on 26 May 2015 at Lockyer. The coroner found the manner of death was natural causes. The cause of death was bronchopneumonia following epileptic seizure in a boy with history of cerebral palsy. He was 17 years old.

Immediately before his death the deceased was a "person held in care" under the *Coroners Act 1996* because he was subject to a protection order pursuant to the *Children and Community Services Act 2004*.

At a young age the deceased had been placed into the care of the Chief Executive Officer of the Department for Child Protection and Family Support for the period until he turned 18 years old. As he was nearing his 18th birthday, plans were being made for the deceased's care to transfer to the Disability Services Commission. However, as he died prior to his 18th birthday he was still in the care of the Department at the time of his death.

The deceased was born with severe global developmental delay, cerebral palsy, epilepsy and a number of other conditions related to an underdeveloped cerebellum. He was confined to a wheelchair and required permanent 24-hour care. His mother had difficulties coping with his significant care needs, which led him to be placed in the care of the Department. The deceased was placed by Department with a permanent foster family in Albany. The Department provided equipment as needed and extra funding to assist with modifications to the house and respite care.

The deceased's health deteriorated as he grew older. His spinal condition made it more difficult for him to breathe and he suffered from recurrent chest infections and increased epileptic seizures. In April 2015 following a seizure, the deceased lapsed into a coma from which he did not recover. He died on 26 May 2015. His death appeared to have been due to a natural progression of his condition.

The coroner concluded that the evidence before the Court showed that the deceased was cared for by the same foster carers from 2003 until his death. His foster carers provided a safe, nurturing and caring environment for the deceased throughout his relatively short life. They were still caring for him right up until the time of his death. The coroner was satisfied his care and supervision was appropriate and of a very high standard.

The coroner did not make any recommendations.

The Finding is on the website of the Coroner's Court of Western Australia.

Radinka MIHAJLOVIC
Inquest held in Perth 19-20 April 2016, investigation finalised 5 January 2017

Ms Radinka Mihajlovic (the deceased) died on 1 May 2012 on the train tracks at Maylands Train Station, Whatley Crescent, Maylands. The Deputy State Coroner found the manner of death was suicide. The cause of death was multiple injuries. She was 47 years old.

Immediately before death the deceased was a "person held in care" under the *Coroners Act 1996* because she was an involuntary patient under the *Mental Health Act 1996.* The deceased had been placed on a Community Treatment Order.

The deceased had been residing in Western Australia since 1999 and suffered from bipolar affective disorder and post-traumatic stress disorder. One of the manifestations of the deceased's mental health issues was her belief that her treatment was making her physically unwell. The deceased's care was managed through both the public and private mental health systems. Unfortunately the deceased's concern with confidentiality restricted full and appropriate communication between the public system and her private practitioners.

It was considered appropriate that the deceased be treated by way of depot medication, to avoid her requiring daily oral medication. While an inpatient she was provided with depot olanzapine on 6 March 2012 with the expectation she would be provided with her next depot injection on 20 March 2012 in the community. Unfortunately, there was no effective discharge planning for the deceased and there was a misunderstanding about the medication to be used. The deceased did not receive her ongoing depot, nor could she be compelled without consent.

On 21 March 2012 the deceased was assessed as needing medication and was placed on a Community Treatment Order to ensure her compliance with medication. Risperidone was considered the appropriate medication, however, she was not provided with any form of medication pending a scheduled review by her supervising psychiatrist on 30 April 2012. The deceased was reviewed earlier than the scheduled review by her supervising psychiatrist and provided with oral risperidone on 4 April 2012. This was not effective and she was given her first depot risperidone on 30 April 2012. She was extremely distressed the next morning and conveyed a strong wish to die to her private psychiatrist. The Deputy State Coroner found that events of the rest of 1 May 2012 reflected a serious disjunct in communication between the public and private mental health systems.

The Deputy State Coroner was not in a position to say the deceased's supervision, treatment and care was appropriate while subject to the CTO. Nor could she say that optimal supervision, treatment and care would have necessarily prevented her death.

The Deputy State Coroner made three recommendations directed towards appropriate community care plans.

The Finding is on the website of the Coroner's Court of Western Australia.

Jayden Stafford BENNELL
Inquest held in Perth 29 August 2016 to 1 September 2016, investigation finalised 28 February 2017

Jayden Stafford Bennell (the deceased) died on 6 March 2013 at Casuarina Prison. The coroner found the manner of death was suicide. The cause of death was ligature compression of the neck. He was 20 years old.

Immediately before his death the deceased was a "person held in care" under section 3 of the *Coroners Act 1996* because he was a sentenced prisoner and, pursuant to the *Prisons Act 1981,* he was in the custody of the Chief Executive Officer of the Department of Corrective Services. The deceased was serving his sentence at Casuarina Prison.

The deceased had a history of psychiatric illness, which was known to the Department of Corrective Services. While the deceased was on remand at Hakea Prison he was in the care of a Consultant Psychiatrist. After a while the deceased became non-compliant with taking his medications; however, mental health reviews continued and it was noted that although the deceased had refused to take his medications, it appeared his mental state was showing signs of improvement.

On 26 November 2012 the deceased was transferred from Hakea Prison to Casuarina Prison. Upon arrival at Casuarina Prison the deceased maintained his refusal of medication despite those medications being prescribed and offered to him. The deceased continued to be reviewed and agreed to see a psychiatrist to discuss formally ceasing his medications, but that appointment did not eventuate. However, the deceased was reviewed by a mental health nurse on 25 February 2013 who did not note any change in his presentation. This was the deceased's last mental health appointment prior to his death.

On the morning of his death the deceased appeared to be his usual self and attended the morning's Pathways Program. The deceased was subsequently identified as missing from the afternoon muster head count and a second muster was called. It was during this second muster the deceased was located in the cleaning storeroom across the hallway from his cell with a ligature around his neck.

A code red was called and a number of nurses from the health centre attended. Despite all resuscitation attempts by the prison officers, on-site nurses, prison doctor and St John Ambulance paramedics, the deceased was unable to be revived.

The coroner found that the mental health care given to the deceased in Casuarina Prison prior to his death was inadequate. The coroner accepted the evidence of two psychiatrists to the effect that it could not be said that if the deceased had seen a psychiatrist it would necessarily have altered the path of events. However, the coroner accepted that the failure to give the deceased access to a psychiatrist at Casuarina was relevant as it may have enabled the psychiatrist to assess his mental state and associated risk of self-harm.

The coroner also accepted that since the deceased's death, there has been an improvement of the availability of psychiatrists at Casuarina, but noted that on the whole, mental health treatment in WA prisons remains under resourced and underfunded. In this context, the coroner made a recommendation directed towards future resourcing for the purpose of ensuring prisoners are given regular and appropriate access to psychiatrists.

The coroner also acknowledged that unsupervised access to the cleaning storeroom was now limited to a period in the morning.

The Finding is on the website of the Coroner's Court of Western Australia.

Barry Matt STUART
Inquest held in Perth 24 November 2016, investigation finalised 7 March 2017

Barry Matt Stuart (the deceased) died on 16 November 2013 at Hakea Prison. The coroner found the manner of death was suicide. The cause of death was ligature compression of the neck (hanging). He was 49 years old.

Immediately before his death the deceased was a "person held in care" under section 3 of the *Coroners Act 1996* because he was a sentenced prisoner and, pursuant to the *Prisons Act 1981*, he was in the custody of the Chief Executive Officer of the Department of Corrective Services. The deceased was serving his sentence at Casuarina Prison.

The deceased had a known history of depression, drug induced psychosis, hepatitis C and previous attempts of self-harm. He also had a documented history of variable compliance with medications for the treatment of psychosis and depression.

The deceased had been prescribed medication to treat psychotic symptoms he had experienced in the past. It appears a secondary benefit the deceased received from the medication was to assist him to sleep. A concern was raised regarding whether the prescribing of this medication should continue given he had no formal diagnosis of an underlying psychotic disorder at that time. It was an ongoing theme in the deceased's records for his last period of imprisonment. Records also indicated that the deceased should be reviewed by a psychiatrist. Unfortunately, there was a severe shortage of psychiatric appointments at Hakea Prison at that time and as a result the deceased went several months without seeing a psychiatrist.

The coroner concluded that the psychiatric care provided to the deceased in this case was less than the standard one would expect to be provided for a prisoner, and the lack of psychiatric review of the deceased contributed to the deceased's decision to take his own life.

In this context the coroner made a recommendation directed to the future planning of the mental health services within the WA Prison System and addressing regular access to psychiatrists.

The Finding is on the website of the Coroner's Court of Western Australia.

ST (Subject to a Suppression Order)
Inquest held in Perth 30 November 2016, investigation finalised 29 March 2017

ST (the deceased) died on 20 November 2014 at Armadale Kelmscott Hospital. The coroner found the manner of death was natural causes. The cause of death was pneumonia in an infant with a history of surgically repaired congenital heart disease, prematurity and failure to thrive. She was 9½ months old.

Immediately before death the deceased was a "person held in care" under the *Coroners Act 1996* because she was placed in the provisional care of the CEO of the Department of Child Protection and Family Support pursuant to the *Children and Community Services Act 2004*.

The deceased was born prematurely on 29 January 2014 at 29 weeks gestation. She had intrauterine growth restriction and her birth weight was only 738g. She suffered from complications of prematurity. She was also born with congenital heart disease.

The deceased was taken into the care of the CEO of Department of Child Protection and Family Support on 23 September 2014 and on discharge from hospital, was placed with her grandparents at their home. They had the assistance of nurses from Hospital in the Home (HiTH).

On 18 November 2014 a HiTH nurse attended to the deceased who did not appear to be unwell.

On 20 November 2014 at about 7.30 am the deceased's grandmother gave the deceased a sponge bath and set up a feed for her through a nasal gastric tube. She left the house between 10.30 am and 11.00 am and, after she returned, checked on the deceased regularly. The deceased appeared to be sleeping.

At about 1.15 pm the grandmother found the deceased lying on her back with her eyes open, not breathing. The grandmother called for an ambulance and administered CPR. Ambulance officers took the deceased to the Armadale Kelmscott Hospital, but she could not be revived.

The coroner found that those providing care to the deceased had acted reasonably and appropriately. Further, that the care provided by HiTH was appropriate and that there were no problems with the care that the deceased received at both KEMH and PMH.

The coroner did not make any recommendations.

The Finding is on the website of the Coroner's Court of Western Australia.

Ms MANDIJARRA
Inquest held in Broome 22-25 February 2016 and Perth 12 April 2016, investigation finalised 31 March 2017

Ms Mandijarra (the deceased) died on 30 November 2012 at Broome Police Station. The State Coroner found the manner of death was natural causes. The cause of death was unascertained (consistent with Streptococcus dysgalactiae and Staphylococcus aureus septicaemia in a woman with diabetes mellitus). She was 44 years old.

Immediately before death the deceased was a "person held in care" under section 3 of the *Coroners Act 1996* because she under the control, care or custody of members of the Police Force, namely members of the Western Australia Police Service.

The provisions of the *Coroners Act* 1996 require the death of a person while in police custody be examined by way of inquest, and the supervision, treatment and care of the person while in custody be commented upon.

The deceased had been arrested for "street drinking" on the evening of 29 November 2012 at Male Oval in Broome. She was heavily intoxicated when she was admitted into custody, as a result of consuming excessive amounts of alcohol. She was held in a cell at the Broome Police Station overnight, with the intention of being released the following morning after she "slept it off".

The deceased suffered from a range of pre-existing conditions that included poorly controlled diabetes. The severity of those conditions was exacerbated by her alcoholism. At the time of her death she had nowhere to live. Her homelessness exposed her to risks of assault. Her ill health and dysfunction had resulted in repeated cycles of admission to ED, incarceration and attendance at the sobering-up shelter. Her unwillingness to interact with services that may have assisted her compounded these overwhelmingly harmful factors.

The deceased was in the custody of the police at the lock-up from 7.00pm on 29 November 2012 until she was found unresponsive at approximately 4.30am on 30 November 2012. The State Coroner found that the preferred and appropriate course would have been for police to have taken the deceased to hospital for medical assessment on 29 November 2012 and that her supervision, treatment and care at the lock-up was deficient and fell below the standards that should ordinarily be expected of the police.

The inquest highlighted the risks posed by detaining a heavily intoxicated person in a lock-up, without medical assessment, particularly overnight.

The State Coroner made three recommendations directed towards the abolition or reduction of arrest and detention for "street drinking", one recommendation directed towards health assessments for intoxicated detainees, and repeated a number of extant recommendations made in connection with her findings on inquest into the death of Ms Dhu.

The finding is on the website of the Coroner's Court of Western Australia.

Annette SILVER
Inquest held in Perth 19 January 2017, investigation finalised 22 June 2017

Ms Annette Silver (the deceased) died on 2 January 2015 at the train line between Queens Park Station and Welshpool Station in Bentley. The coroner found the manner of death was suicide. The cause of death was multiple injuries.

Immediately before death the deceased was a "person held in care" under the *Coroners Act 1996* because she was an involuntary patient under section 3 of the *Mental Health Act 1996.* The deceased was admitted to the Bentley Hospital at the time of her death.

On 30 November 2014 the deceased had been admitted into an open ward at Bentley Hospital with a diagnosis of depression and anxiety. She was started on a new antidepressant and referred to a psychologist for psychotherapy.

On 2 December 2014 the deceased's psychiatrist formed the impression that she had experienced a major depressive episode with cluster C personality traits and planned to keep her as an inpatient for a short while and then discharge her to stay with a family member with follow up by a private psychiatrist. Over the next three days the deceased's condition appeared to improve.

On 5 December 2014 the deceased was discharged. Her family member attended the hospital and expressed concerns about the deceased's high level of anxiety. The deceased was given weekend leave with her family, with the option to return early if she was not feeling comfortable.

On 8 December 2014 the deceased returned to Bentley Hospital after having expressed suicidal intentions over the weekend. Two days later she was made an involuntary patient until 7 January 2015 and was placed in an open ward, with 15 minute observations.

On 12 December 2014 the deceased appeared pleasant and compliant but then left the hospital and did not return that day. Hospital staff searched for her without success and notified police that she was missing. On 13 December 2014 the deceased returned to Bentley Hospital unassisted. She advised that she had left the hospital to end her life, but realised that she could not do so. She was transferred to the secure ward and placed on 15 minute observations.

The deceased appeared to improve over the next two weeks. On 26 December 2014 she was moved into an open ward. On the evening of 2 January 2015 she left the hospital and police were again notified. In the meantime the deceased had gone to the nearby train line where she stood in the path of an on-coming railcar, which struck her and caused her multiple injuries which caused her death.

The coroner found that the treatment, supervision and care of the deceased was reasonable and generally appropriate.

The coroner did not make any recommendations.

The Finding is on the website of the Coroner's Court of Western Australia.

Ejub MEHINOVIC
Inquest held in Perth 24 January 2017, investigation finalised 29 June 2017

Mr Ejub Mehinovic (the deceased) died on or about 23 November 2015 at Unit 8, 6 Tuart Place, Morley. The Coroner found the manner of death was as a result of natural causes. The cause of death was coronary artery atherosclerosis. He was 50 years old.

Immediately before death the deceased was a "person held in care" under the *Coroners Act 1996* because he was an involuntary patient under the *Mental Health Act 1996.* The deceased had been placed on a Community Treatment Order (CTO).

In 1991 the deceased had been charged and convicted of the offence of murder in relation to the death of his father. He was sentenced to an indefinite term of imprisonment. On 26 May 2006 the deceased was granted parole for five years with conditions related to treatment and management at Graylands. At the end of this period he was placed on a CTO.

On 21 September 2015 the deceased was referred by his case manager at Inner City Mental Health Service to Sir Charles Gairdner Hospital for examination by a psychiatrist because he had not been taking his medication. He was treated as an involuntary patient and then discharged on a CTO on 21 October 2015.

The deceased had an appointment with the treating team at Inner City Mental Health Service on 23 November 2015. On 22 November 2015 one of the deceased's neighbours saw him cleaning his car, as he normally did on a Sunday. In the early hours of the next morning the deceased's neighbour heard a loud bang and a sound like breaking glass coming from the deceased's unit. The neighbour noticed a light coming from the deceased's kitchen window but did not see anything else.

The deceased did not attend his scheduled appointment with his treating team on 23 November 2015. Following a team meeting the next morning, the deceased's case manager went to the deceased's unit, but the deceased did not come to the door. The deceased's case manager and a senior social worker returned to the deceased's unit the following afternoon. They looked through a window and saw the deceased lying on the floor. The doors and windows were locked so they called '000'. Officers forced entry into the unit and confirmed that the deceased was dead.

The deceased had a long history of mental health illness for which he received a considerable amount of ongoing treatment and care. The coroner was satisfied that the care he received in relation to that aspect of his health was of high standard. The coroner was also satisfied that the standard of supervision, treatment and care of the deceased while he was an involuntary patient was reasonable and appropriate in all of the circumstances.

The coroner did not make any recommendations.

The Finding is on the website of the Coroner's Court of Western Australia.

KLD (Subject to a Suppression Order)
Inquest held in Kalgoorlie 12-13 January 2017 and Perth 16-18 January 2017 and 20 January 2017, investigation finalised 30 June 2017

KLD (the deceased) died on 22 August 2012 at Princess Margaret Hospital, Subiaco. The Deputy State Coroner made an open finding as to the manner of death. The cause of death was hypoxic ischaemic encephalopathy following unexplained cardiac arrest. She was 21 months old.

Immediately before death the deceased was a "person held in care" under the *Coroners Act 1996* because she was placed in the provisional care of the CEO of the Department of Child Protection and Family Support pursuant to the *Children and Community Services Act 2004*.

The deceased was placed in the care of carers in Joondalup with supervised access to her biological parents. The deceased initially responded very well while in care but the difficulties with access visits and her biological parents made it preferable for the deceased to be moved to Kalgoorlie where her biological parents had supportive family. DCPFS attempted to find carers in the Kalgoorlie area but were unsuccessful and eventually relative carers on the deceased's mother side were proposed as suitable carers. The deceased moved to Kalgoorlie in March 2012.

The deceased contracted a respiratory infection for which she was initially taken to the doctor but appears to have taken a long time to recover. The deceased suffered some incidents of injury, probably accidental which appear to have gone unnoticed. Her progress stagnated and rather than progressing as a lively, health toddler, she began to show signs of withdrawal which were not picked up or acted upon.

On 16 August 2012 following a supervised access visit at which the deceased was noticeably quiet and withdrawn, she was returned to her foster carers' home in a drowsy condition. At some stage following her return home she was placed on the couch and suffered a fall, the exact parameters of which remained a little unclear. The deceased's foster mother picked her up and she suffered a fit with her eyes rolling back in her head. The deceased's foster mother did not have a telephone to call for help so she gathered the other children and drove the deceased's to hospital as quickly as she could.

The deceased remained in cardiorespiratory arrest until she was stabilised at Kalgoorlie Regional Hospital. She had suffered irreparable brain damage and despite a transfer to Princess Margaret Hospital and the best of care the prognosis for the deceased could not be improved and was declared brain dead.

The Deputy State Coroner found it almost impossible to reconcile the views of the clinicians, including ophthalmology, and the evidence from all the post mortem examinations, particularly neuropathology. All were agreed she suffered hypoxic brain injury but the reasons for the brain injury were never agreed which made the issue of appropriate supervision, treatment and care difficult to elucidate.

The Deputy State Coroner found that on moving to Kalgoorlie the deceased effectively had no case manager while placed on the monitored list in the control of a team leader,

and that this was clearly not appropriate supervision, treatment and care. With appropriate review it would have become increasingly clear that the deceased was not being cared for or supervised appropriately.

The Deputy State Coroner made three recommendations directed to clinical assessment of children in care upon transfer to a new location the allocation of a case worker when a child is transferred from one location to another and for all contact of Department workers with children to be recorded and appropriately assessed. The Deputy State Coroner made a fourth recommendation relating to the resourcing for the State Mortuary to be provided with a CT scanner.

The Finding is on the website of the Coroner's Court of Western Australia.