OFFICE

of the

STATE CORONER

for

WESTERN AUSTRALIA

ANNUAL REPORT

2018-2019

STATE CORONER'S CHAMBERS
CORONER'S COURT OF WESTERN AUSTRALIA
LEVEL 10, 501 HAY STREET
PERTH WESTERN AUSTRALIA 6000
Telephone: (08) 9425 2900
Facsimile: (08) 9425 2920

Our ref: Annual Report

Hon John R Quigley LLB JP MLA
Attorney General
5th floor, Dumas House
2 Havelock Street
WEST PERTH WA 6005

Dear Attorney

ANNUAL REPORT 2018-2019

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, 2019.

Yours sincerely

R V C FOGLIANI
STATE CORONER

1 October 2019

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 2018/19 are outlined below:

- Backlog of cases increased from 368 as at 30 June 2018 to 458 as at 30 June 2019.
    - Of those 458 backlog cases:
        - 100 were backlog inquest cases.
        - 338 were cases where no further finalisations were possible as at 30 June 2019 because the coroner was awaiting completion of aspects of the coronial investigation by external entities (this is approximately 100 more cases than in the previous financial year).
        - 20 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 2293 investigations were finalised in 2018/19:
        - 2231 finalised by administrative finding of which 834 (37%) were backlog cases.
        - 61 finalised by inquest of which 61 (100%) were backlog cases at the time of completion and 30 were mandated inquests.
        - 1397 (61%) of the cases finalised were under 12 months old.
        - 896 (39%) of the cases finalised were over 12 months old.
    - The number of inquests finalised decreased slightly from 63 in 2017/18 to 61 in 2018/19.
    - The total number of administrative findings finalised decreased from 2259 in 2017/18 to 2231 in 2018/19; this is compared to 2366 in 2016/17 compared to 1991 in 2015/16 compared to 1975 in 2014/15.
    - The number of total cases on hand over 24 months old increased to 7.19% in 2018/19 compared to 6.6% in 2017/18 compared to 6.4% in 2016/17 compared to 6.7% in 2015/16 compared to 8.4% 2014/15.
    - Reports of deaths to the coroner increased to 2452 in 2018/19 compared to 2291 in 2017/18 compared to 2422 in 2016/17 compared to 2214 in 2015/16 and 2192 in 2014/15. The number of deaths reported remains high with an increase of 161 from 2017/18.

- The number of cases on hand was 2280 at 30 June 2019 compared to 2127 at 30 June 2018 compared to 2173 at 30 June 2017 compared to 2178 at 30 June 2016 compared to 2027 at 30 June 2015.

- The number of death certificates received in 2018/19 was 1458 compared to 1280 in 2017/18 compared to 1174 in 2016/17 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 decreased from the previous reporting year, however they still remain high at 10239 in 2018/19 compared to 10781 in 2017/18 compared to 11241 2016/17 compared to 10106 in 2015/16 compared to 10753 in 2014/15.

- The number of objections to the performance of post mortem examinations for the purpose of investigating deaths increased to 386 for 2018/19 compared to 320 for 2017/18 compared to 319 in 2016/17 compared to 246 in 2015/16 compared to 279 in 2014/15.

- A procedure for non-invasive post mortem examinations was piloted and introduced in the 2016/17 financial year and continued throughout 2018/19 which resulted in 273 non-invasive post mortem examinations compared to 261 for 2017/18 compared to 227 in 2016/17.

- A procedure for the finalisation of non-narrative natural cause administrative findings by the Principal Registrar was piloted and introduced from January 2017 and continued, resulting in the finalisation of 337 cases in 2018/19 compared to 460 cases in 2017/18 compared to 264 cases from January 2017 by 30 June 2017.

- Law Reform Commission recommendations 55 and 56 were enacted on 21 September 2018, resulting in s 19A enabling a coroner to make an early determination to discontinue an investigation into certain natural cause deaths, and s 25(1A) enabling a coroner to issue early non-narrative findings subject to public interest considerations. This has resulted in 88 findings completed under s 19A and 51 findings completed under s 25(1A) of the Coroners Act, up to 30 June 2019.

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 2019 (2018/19).

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 2231 administrative findings finalised by coroners/principal Registrar in the 2018/19 year comprising approximately 97.3% 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 61 inquests finalised by coroners in the 2018/19 year comprising approximately 2.7% 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 2018/19 year: The Backlog of Coronial Cases and Reform.

Backlog

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 2019 the backlog stood at 458.

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.

Coronial Case Management System

The project to implement an electronic case management system for the Coroner's Court was progressed during 2018/19 with an anticipated commencement date of February 2020.

It is envisaged that the work output of the Coroner's Court 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 public enquiries and statistical reporting purposes, particularly within the context of the coroner's death prevention role.

Reform

On 21 September 2018, recommendations 55 and 56 made by the Law Reform Commission of Western Australia in its *Review of Coronial Practice in Western Australia, project no. 100*, January 2012 were enacted. The Coroners Act was amended to include s 19A, enabling a coroner to make an early determination to discontinue an investigation into certain natural cause deaths and s 25(1A) enabling a coroner to issue early non-narrative findings subject to public interest considerations. The enactment of sections 19A and 25(1A) has increased efficiency, reduced unnecessary delays and delivered more timely responses and outcomes to the families of the deceased. This process commenced in the Perth Coroner's Court 10 December 2018, and after being trialled, it was extended to the Regional Courts on 5 March 2019. Statistics are provided on page 4 of this report.

Further amendments to the Coroners Act are being drafted in accordance with the recommendations made by the Law Reform Commission of Western Australia.

CT Scanner

On 5 June 2019 the Attorney General attended the official inauguration of a long awaited CT scanner at the State Mortuary. Installation of the CT scanner fulfils recommendation 102 of the *Review of Coronial Practice in Western Australia, project no.100*, by lessening the need for full invasive post mortem examinations in certain cases. The CT scanner greatly enhances the scope of forensic pathology, thereby improving the quality of services to the community.

I acknowledge the efforts of Pathwest, the Department of Justice and senior staff of my Office for bringing the CT scanner project to fruition. I would particularly like to thank Dr Jodi White and Dr Dan Moss for their efforts and the Attorney General, Hon Mr John Quigley MLA for his support.

The range of cases that may be more efficaciously progressed under the reform process will be expanded now the dedicated CT scanner is 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.

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 61 investigations finalised by inquest in the past financial year and of those, a total of 31, being approximately 50%, comprised investigations where an inquest was mandated by law.

The 31 mandated inquests were finalised by coroners in the following categories and these are described below:

- 25 mandated inquests in relation to persons held in care immediately before death;
- 2 mandated inquests where it appeared that the death was caused, or contributed to, by an action of the police force; and
- 4 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 2014*.

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

In the past financial year there were 25 investigations of deaths of persons held in care finalised by mandated inquest. Of those:

- Fourteen investigations were finalised by inquest in respect of deaths of persons held in custody under the *Prisons Act* 1981;
- One investigation was 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
- Ten 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 25 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.

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 25 investigations into deaths of persons held in care that were finalised by inquest in the past financial year appears at pages 36-37 of this report. Following that Table, at pages 38 to 65 are the specific reports on the deaths of each person held in care, arranged in the order in which they appear on the Table.

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

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

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

(c) Mandated inquests – suspected deaths

Four investigations into the suspected deaths of missing persons were finalised by mandated 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 four investigations appears at page 34 of this Report.

Long Term Missing Persons Project

This project commenced in the 2019 calendar year, and concerns the assessment by the coroner of the concentrated referral by police of a number of long term missing person's cases, ranging from as far back as the 1960's, for investigation and if possible, finalisation.

For this purpose, the Department of Justice has provided funding for a part-time coroner (0.5 FTE) for a period of 12 months and this role was filled by Coroner Evelyn Vicker (formerly the Deputy State Coroner) commencing as from 9 June 2019.

Coroner Vicker exercised the functions under section 23(1) of the Coroners Act, by assignment, and where she had reasonable cause to suspect that the person had died and that the death was a reportable death, directed that the suspected death be investigated. This first such inquest was heard by Coroner Vicker on 5 August 2019, and further details on this project will be provided in the next Annual Report.

On 9 June 2019, Coroner Barry King was appointed Deputy State Coroner.

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 61 investigations finalised by inquest in the past financial year, a total of 30, being approximately 50%, comprised investigations where the inquest was discretionary.

A Table of all of the investigations that were finalised by inquest appears at pages 29 to 32 of this Report. The mandated inquests are marked as such, leaving the remainder on that Table, a total of 30, 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 6900 telephone contacts and office visits.

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 127 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.

Acknowledgements

I wish to acknowledge the ongoing and assiduous efforts to finalise investigations and reduce the backlog on the part of Deputy State Coroner Barry King, Coroner Evelyn Vicker (who is working part-time on a special project concerning long term missing persons), Coroner Sarah Linton and Coroner Michael Jenkin (who joined the court this year). Their application and dedication reflects their strong commitment to their important service to the community through the coronial system.

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 continued to ably discharge his delegated functions that have included the authorisation 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 and attentive commitment to this task and I acknowledge their ongoing efforts.

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, by 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 continued 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 2018/19 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, two Coroners and as from 9 June 2019 one part-time Coroner (12 months), supported by 23 full time employees (FTE's) as shown Table 'A' below. Office Manager and Coroner's Registrar Ms Susan Wilde continued to capably manage the operations of the Office and was instrumental in the administration of the files and the workflow operations and so as to facilitate the ongoing endeavours to reduce the backlog in the 2018/19 year. Staffing levels were relatively stable over the reporting year.

Table A – Office Structure

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	
Coroner (0.5 FTE)#	Systems Information Officer	
Principal Counsel Assisting	Senior Findings Clerk	
Counsel Assisting	Findings Clerk	
Counsel Assisting	Customer Service Officer	
Listings Manager	Customer Service Officer	
Administrator	Customer Service Officer	
Customer Service Officer	Customer Service Officer	
Customer Service Officer	Customer Service Officer	
Customer Service Officer		

#0.5 FTE commenced on 9 June 2019 for special project for 12m

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 2452 reportable deaths were reported to the coroner for full investigation in the past financial year and 2292 cases were completed representing a clearance rate of just over 93.5%.

With regard to the 2292 cases completed in the past reporting year the breakdown is as follows:

- 2231 – the number of investigations finalised by administrative finding, of which 834 (37%) were backlog cases, and

- 61 - the number of investigations finalised by inquest, of which 61 (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 2280, of which 458 were backlog cases (over 12 months old).

The backlog increased from 368 in 2017/18 to 458 in 2018/19. The number of cases where no further finalisations were possible as at 30 June 2019 because the coroner was awaiting completion of aspects of the coronial investigation by external entities increased from 230 in 2017/18 to 338 in 2018/19.

Of the 458 backlog cases, 100 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 2018/19 year.

Table B – Overview of Work

CASES RECEIVED	*PERTH*	*COUNTRY*	*TOTAL*
Full Investigation	**1779**	**673**	**2452**
Death Certificates	**1458**	**n/a**	**1458**

CASES COMPLETED	*PERTH*	*COUNTRY*	*TOTAL*
Finalised by Inquiry	**1652**	**579**	**2231**
Finalised by Inquest	**42**	**19**	**61**
TOTALS	**1694**	**598**	**2292**

BACKLOG	*PERTH*	*COUNTRY*	*TOTAL*
	326	**132**	**458**

CASES ON HAND	*PERTH*	*COUNTRY*	*TOTAL*
	1678	**602**	**2280**

FINALISATION RATIO		
Finalised by Inquiry	**97.3%**	**2231**
Finalised by Inquest	**2.7%**	**61**

Table C – Cases Closed

Table C below shows the age of a coronial file when closed calculated from the date of death. It will be seen that 61% (1397) of files were closed in under 12 months and 39% (896) of files were over 12 months old at closure (i.e. backlog files).

	INQUIRY		INQUEST	
TIMELINES	***PERTH***	***COUNTRY***	***PERTH***	***COUNTRY***
< 3 mths	**168**	**50**	**0**	**0**
3-6 mths	**161**	**152**	**0**	**0**
6-12 mths	**652**	**214**	**0**	**0**
12-18 mths	**555**	**102**	**1**	**0**
18-24 mths	**75**	**37**	**2**	**0**
>24 mths	**41**	**24**	**39**	**19**
TOTALS	**1652**	**579**	**42**	**19**

Table D – Deaths reported and cases completed

Table D below shows the total number of deaths reported and cases completed during the 2018/19 year for Perth and Regional WA.

TOTAL NUMBER OF DEATHS REPORTED TO THE CORONER			
Death certificates			1458
Metropolitan deaths	1779		
Regional deaths	673		
• **Albany**		109	
• **Broome**		30	
• **Bunbury**		218	
• **Carnarvon**		37	
• **Islands**		0	
• **Geraldton**		73	
• **Kalgoorlie**		85	
• **Kununurra**		19	
• **Northam**		55	
• **Port Hedland**		47	
TOTAL NUMBER OF REPORTABLE DEATHS	2452		1458
CASES COMPLETED	**PERTH**	**COUNTRY**	**TOTAL**
Finalised by Inquiry	1652	579	2231
Finalised by Inquest	42	19	61
TOTALS	1694	598	2292

Table E – Findings on manner of death

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	*2014-2015*	*2015-2016*	*2016-2017*	*2017-2018*	*2018-2019*
Accident	580	635	700	811	830
Misadventure	25	44	61	40	25
Natural Causes	915	851	1039	908	868
No Jurisdiction	5	3	7	4	5
Open Finding	103	105	139	116	81
Self Defence	0	1	3	3	2
Suicide	340	322	420	392	421
Unlawful Homicide	53	88	53	48	61
TOTALS	**2021**	**2049**	**2422**	**2322**	**2293**

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.

With the availability of the dedicated CT scanner at the State Mortuary as from 5 June 2019, the range of cases that are able to be considered for this process is expanded, thereby helping to alleviate some of the stress and anxiety for families who wish to object to full internal post mortem examinations.

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 23 of this Report.

Table F – Reported deaths and outcomes of objections

Table F below shows the number of post mortem examinations and the number of objections received in the 2018/19 year and the outcomes:

REPORTED DEATHS	
Immediate post mortem	**56**
No objection to post mortem	**1915**
Objection to post mortem	**386**
No post mortem conducted (missing person, death certificate originally issued or by order of coroner etc)	**95**
NUMBER OF REPORTED DEATHS	**2452**

OBJECTIONS TO POST MORTEMS	
Objection accepted	**313**
Objection withdrawn	**72**
Objection withdrawn after coroner overruled	**0**
Applications to Supreme Court	**1**
TOTAL OBJECTIONS TO POST MORTEMS	**386**

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, last financial year the State Coroner 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. After a successful implementation in the metropolitan area it was extended to the regional areas, and has now become part of the court's practice.

The process involves 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.

Before the availability of the CT scanner, the types of cases that were able to be considered for this external examination process were more limited to instances of obvious trauma and cases where the deceased had died in hospital, with well documented medical records including pre-mortem imaging. With the availability of the dedicated CT scanner at the State Mortuary as from 5 June 2019, the range of cases that are able to be considered for this process is significantly expanded. They can now include a greater range of trauma cases, and also cases where the deceased has died in circumstances that appear to be natural causes.

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	**282**
PRE approved by Coroner or Principal Registrar	**273**
PRE not approved by Coroner - Full PM	**0**
PRE rejected by next of kin - Full PM	**8**
PRE approved – Partial PM	**1**
TOTAL PATHOLOGIST RECOMMENDED EXTERNAL	**282**

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.

In the 2018/19 year the CCS has been 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 previous 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 largely brought relief to families, who often prefer that no full internal post mortem examination is performed. Following the success of the pilot in the metropolitan area, it was extended to regional areas, and now forms part of the Coroner's Court's ongoing process.

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 – Counselling Statistics and referral types

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	*2014-2015*	*2015-2016*	*2016-2017*	*2017-2018*	*2018-2019*
Phone, Office/Home Visits	**6979**	**6993**	**7274**	**6885**	**6993**
Offers of Service	**1377**	**547**	**577**	**701**	**652**
Mortuary/file viewings	**2397**	**2566**	**3390**	**3195**	**2594**
TOTAL CONTACTS	**10753**	**10106**	**11241**	**10781**	**10239**

For the 2018/19 year the above categories are explained as follows:

- Phone, Office/Home visits refers to all telephone calls (6669) visits to home addresses (15) and attendances at other offices or attendances by others at the Court (309);
- Offers of Service refers to letters offering counselling (652); and
- Mortuary/file viewings refers to emails (998), interoffice liaison (1596) and mortuary contact (0).

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 for the 2018/19 year are as follows:

Professor Alistair Vickery (until March 2019)	Chairperson, Associate Professor, UWA
Dr Jodi White (from April 2019)	Acting Chairperson, Forensic Pathologist, PathWest
Mr Barry King	Deputy State Coroner
Associate Professor Jennet Harvey	Member with relevant research experience
Ms Simone Brand	Member with counselling background
Ms Christine Pitt	Legal Member
Ms Natalie Gately	Lay member
Dr Thomas Hitchcock	Member with relevant research experience
Dr Rosemary Coates	Lay member

In March 2019, Professor Alistair Vickery resigned from the Committee. Professor Vickery had served as Chairperson of the Committee since November 2015. His substantial and valuable contribution to the work of the Committee over such a long period of time is greatly appreciated. Dr Jodi White, who had been serving as Deputy, took over as Acting Chairperson from the April 2019 meeting.

Principal Counsel Assisting Kate Ellson ceased her role as Secretary in December 2018 and remained a member before resigning in May 2019. Ms Ellson's dedication to the work of the Committee over many years is greatly appreciated. The role of Secretary was then filled by Counsel Assisting Alice Barter and Fleur Allen.

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

Table I – Projects and recommendations

Number of Projects Considered	**Number of projects approved**	**Number of projects not approved**	**Deferred**
18	17	1	0
Number of Requests for renewal Considered	**Number of Requests for renewal Approved**	**Number of Requests for renewal Not approved**	**Deferred**
12	12	0	0
Number of Amendments	**Number of amendments approved**	**Number of amendments not approved**	
5	5	0	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. In the 2018/19 year there have been six coroner's registrars at the Coroner's Court in Perth, 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.

It was previously reported that 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 ongoing and timely 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 337 non-narrative natural cause administrative findings and approved 151 pathologist recommended external examinations.

The Principal Registrar also issued 66 Authorisation to Coroner's Investigators pursuant to Section 33(3) of the Coroners Act to seize evidence.

The Principal Registrar deals with incoming notifications and requests to the Coroner's Court 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.

This financial year the Principal Registrar continued to work closely with senior officers of the Department of Justice, and with the staff of PathWest resulting in the acquisition of a CT scanner at the State Mortuary which was officially unveiled by the Attorney General on 5 June 2019.

The Principal Registrar has also provided ongoing and comprehensive assistance in connection with the legislative reform recommendations of the LRCWA in its *Review of coronial practices in Western Australia, project no. 100,* January 2012. As part of the reform process the Principal Registrar assisted with the implementation of the amendments to the Coroners Act, being new sections 19A and 25(1A), which received Royal Assent on 21 September 2018. These amendments were implemented at the Coroner's Court through the creation of a "triage system" for suitable cases. The Principal Registrar played a lead role in devising and implementing the triage system which is proving to be very successful in fast tracking such cases, so that earlier and timelier responses may be provided to families.

Counsel Assisting the Coroner

In the 2018/19 year, there have been three counsel who assist the coroners with the preparation, management and conduct of inquest hearings. Ms Kate Ellson, Principal Counsel Assisting was on secondment during the past year and her duties as Secretary to the Coronial Ethics Committee were shared between the other counsel.

Mr Toby Bishop and Ms Fleur Allen both continued to work diligently to ensure matters in their practices are finalised in a timely way.

Ms Alice Barter was seconded to the Coroner's Court from the Aboriginal Legal Service in September 2018 to work on a special project for one year.

Mr Darren Jones was employed on a one year fixed term contract in October 2018 to take over the practice of Ms Ellson during her secondment.

I am grateful to the Department of Justice for providing temporary additional funding to employ Ms Barter and Mr Jones for those fixed terms

All counsel assisting executed their functions diligently. They continue to focus 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

Police officers attached to the Coroner's Court 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 and serving of summonses etc.

Sergeant Lyle Housiaux is in charge of the police team and also acts as counsel assisting in inquest hearings. He has ably assisted at a number of inquests throughout the year and I am grateful for his diligent and unwavering contribution towards the work of the Coroner's Court.

Since last year's report Senior Constable Eric Langton has retired from the WA Police Force. His many years of service and dedication to his duties at the Coroner's Court are greatly appreciated. Senior Constable Craig Robertson joined the Coroner's Court in August 2018 to work in that role.

In the past year the number of police officers attached to the Coroner's Court has increased from two to four, in order to assist the coroners with the new triage system which commenced operation in December 2018, following the legislative reform. Senior Constable John Turner and Senior Constable Lucy Alexander joined the Coroner's Court towards the end of 2018.

The triage system seeks to fast track certain types of coronial cases pursuant to sections 19A and 25(1A) of the Coroners Act to bring about an early resolution for families.

The police officers are responsible for the sourcing and collation of evidence and preparing briefs for coroners state-wide. With their assistance the triage system has worked very well and has delivered time-saving dividends for the Coroner's Court and Western Australia Police by reducing the need for numbers of longer term investigations, particularly in respect of natural cause deaths, and cases where there is no public interests to be served in making a finding about all of the circumstances attending the death.

All of the police officers attached to the Coroner's Court through their efforts continued to make a valuable contribution to the conduct and/or finalisation of a significant number of coronial investigations.

Table J – Total number of inquests

Table J below shows the total number of inquests **(61)** finalised in the 2018/19. An inquest is finalised when the coroner signs the inquest finding.

NAME OF DECEASED	*DATE OF DEATH*	*DATE OF INQUEST*	*FINDING*	*DATE OF FINDING*
#FLANDERS Shane Christopher	On or about 28/1/2016	10/4/2018	Open Finding	12/7/2018
*KING Stanley	22/5/2015	6-9/3/2018	Natural Causes	16/7/2018
SMITH Jackie-Lee Marama	12/3/2015	14/12/2017 and 27/4/2018	Accident	3/8/2018
#DOYLE Jeffery Thomas	On or about 17/10/2016	11/7/2018	Misadventure	17/8/2018
Baby A (Name Suppressed)	24/1/2015	5-6/2/2018	Accident	23/8/2018
*DICKSON Paul	11/11/2013	16/3/2018	Suicide	29/8/2018
*FRANKER Kim Martin	28/2/2016	1/3/2018	Accident	31/8/2018
*GRIEVE David	1/9/2015	12/3/2018	Natural Causes	6/9/2018
REES Pamella Leslie	30/6/2014	5/4/2018	Natural Causes	20/9/2018
JOHANSEN Theodore Herbert Eric	29/10/2014	22-23/2/2018	Suicide	10/9/2018
*DUDEK Wlodzimierz	7/10/2016	16/7/2018	Accident	19/9/2018
BLANCHARD Scott Andrew	24/7/2015	15-16/8/2018	Suicide	20/9/2018
#POLLARD Dean Anthony	Unknown	19/6/2018	Open Finding	26/9/2018
*HEESTERS Augustinus Clemens Antonius	15/10/2016	18/9/2018	Natural Causes	12/10/2018
SACH Mark Leslie	1/3/2016	18/10/2018	Accident	6/12/2018

NAME OF DECEASED	DATE OF DEATH	DATE OF INQUEST	FINDING	DATE OF FINDING
WOODS Joseph Frederick	29/8/2015	20/11/2018	Misadventure	12/12/2018
NAJAFI Mohammad Nasim	31/7/2015	6/11/2018	Natural Causes	27/12/2018
JAFFARI Ali (aka Talib HOUSSAIN)	16/9/2015	9/10/2018	Suicide	7/1/2019
STRICKLAND Glenn William	21/1/2014	3-6/9/2018	Accident	29/1/2019
THOMAS Torran Jake	8/1/2015	29-31/10/2018 and 21/11/2018	Misadventure	6/2/2019
13 Children and Young Persons in the Kimberley Region	8/1/2013 Between 4-5/4/2015 7/5/2015 6/3/2016 Between 14-15/2/2013 Between 7-8/1/2014 26/9/2014 12/12/2014 24/3/2016 Between 19-20/11/2012 Between 11-12/1/2014 5/1/2015 22/5/2015	26/6/2017-4/7/2017 4-8/9/2017 12-15/9/2017 17-20/7/2017 and 2-4/8/2017, 14-18/8/2017 and 25/8/2017	Suicide (12) Open Finding (1)	7/2/2019
*DAVIS William John	18/10/2016	4/2/2019	Natural Causes	6/2/2019
#OOSTERBAAN Henrick	On or about 9/1/2017	30/11/2018	Open Finding	15/2/2019
*O'NEILL Seanpol Martin Padraig	23/2/2015	18-19/2/2019	Open Finding	8/3/2019
*WOODS Lorna May	10/1/2017	6/3/2019	Natural Causes	12/3/2019
*GIBLETT Ronald Alan	5/11/2016	5/12/2018	Natural Causes	4/4/2019

NAME OF DECEASED	DATE OF DEATH	DATE OF INQUEST	FINDING	DATE OF FINDING
*KUGIS Maris	10/9/2016	22/11/2018	Natural Causes	4/4/2019
CHEGENI NEJAD Fazel	8/11/2015	30/7-10/8/2019	Open Finding	2/5/2019
*JACKAMARRA Khamsani Victor (aka HAJINOOR)	16/12/2015	30-31/10/2018 and 1/11/2018	Suicide	9/5/2019
TONKIN Matthew Neil Hardy	3/7/2014	14 and 16/1/2019	Accident	10/5/2019
^ADWENT Daniel Josef	21/3/2015	19-28/2/2018	Homicide by Self-defence	13/5/2019
*SM (Name Suppressed)	2/8/2014	10 and 21/12/2018	Natural Causes	14/5/2019
*BELL Mervyn Kenneth Douglas *CAMERON Bevan Stanley *HONEYWOOD Brian Robert *JS (Name Suppressed) *WALLAM Aubrey Anthony Shannon	8/9/2015 2/11/2015 16/2/2015 3/8/2015 22/10/2014	26-29/3/2019 and 3-4/4/2019	Suicide	22/5/2019
*HEAVEN Garth Cyril	26/7/2016	10/5/2019	Natural Causes	22/5/2019
*DEBNAM Christopher John	21/11/2014	15-16/10/2018 and 14/11/2018	Natural Causes	22/5/2019
*ASHLEY Pamela Edith	3/2/2016	22-24/10/2018 and 14/11/2018	Natural Causes	22/5/2019
*MACARTNEY Robin David	13/7/2016	14/5/2019	Natural Causes	24/5/2019
TREGONNING Melanie Reanna	Between 12-13/5/2014	22-23/1/2019 and 30/1/2019	Suicide	24/5/2019
*GRAHAM Colin George	24/1/2016	21/8/2018	Natural Causes	31/5/2019
*CRUZ Aurelio Monterlegre	11/12/2016	8/2/2019	Natural Causes	31/5/2019
HARE Ellie Marlene	23/1/2015	31/1/2019	Accident	12/6/2019

NAME OF DECEASED	DATE OF DEATH	DATE OF INQUEST	FINDING	DATE OF FINDING
Child L (Name Suppressed)	27/3/2015	30/4-1/5/2019	Natural Causes	12/6/2019
*O'DRISCOLL Malcolm Patrick	15/4/2017	30/5/2019	Natural Causes	19/6/2019
DUNKEL Gerda Theresia	6/11/2015	27/11/2018	Natural Causes	21/6/2019
^COLLARD Frederick John	18/6/2016	6-7/5/2019	Misadventure	26/6/2019

^ = Death that appeared to be caused or contributed to by any action of a member of the police force (2)
 # = Missing person (4)
*** = Person held in care (25)**
The balance of the matters listed (30) were discretionary inquests
Total Inquests : 61

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 – Deaths caused or contributed to by any action of a member of the police force

Table K below shows the number of inquests **(2)** finalised in 2018/19 year into deaths that appeared to be caused, or contributed to, by any action of a member of the Police Force.

SURNAME OF DECEASED	*DATE OF DEATH*	*DATE OF INQUEST*	*FINDING*	*DATE OF FINDING*
^ADWENT Daniel Josef	21/3/2015	19-28/2/2018	Homicide by Self-defence	13/5/2019
^COLLARD Frederick John	18/6/2016	6-7/5/2019	Misadventure	26/6/2019

One of the investigations (ADWENT, D) concerned the State Coroners scrutiny of a police shooting. The State Coroner was satisfied that within the timeframe of the incident, there were minimal opportunities to de-escalate the situation and the deceased was shot in self-defence. The deceased died as a result of a gunshot wound to the abdomen.

The other investigation (COLLARD, F) concerned the coroner's scrutiny of a death after a police restraint. The coroner was satisfied that it became apparent the deceased needed to be restrained for his safety and the safety of others and the behaviour of police was appropriate. The deceased died as a result of the effect of methylamphetamine in combination with his pre-existing heart disease in combination with his exertion on the roof and his violent struggles against the physical restraint.

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 – Missing Persons

Table L below shows the number of inquests (4) finalised in 2018/19 year into suspected deaths.

SURNAME OF DECEASED	*DATE OF DEATH*	*DATE OF INQUEST*	*FINDING*	*DATE OF FINDING*
#FLANDERS Shane Christopher	On or about 28/1/2016	10/4/2018	Open Finding	12/7/2018
#DOYLE Jeffery Thomas	On or about 17/10/2016	11/7/2018	Misadventure	17/8/2018
#POLLARD Dean Anthony	Unknown	19/6/2018	Open Finding	26/9/2018
#OOSTERBAAN Henrick	On or about 9/1/2017	30/11/2018	Open Finding	15/2/2019

In all of the cases the coroner found that the death of the person had been established beyond all reasonable doubt.

The coroner's 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; or

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

(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 **(25)** finalised in 2018/19 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 – Persons held in care

Deaths of persons held in care finalised in the 2017/18 year:

NAME OF DECEASED	*DATE OF DEATH*	*DATE OF INQUEST*	*FINDING*	*DATE OF FINDING*
*KING Stanley	22/5/2015	6-9/3/2018	Natural Causes	16/7/2018
*DICKSON Paul	11/11/2013	16/3/2018	Suicide	29/8/2018
*FRANKER Kim Martin	28/2/2016	1/3/2018	Accident	31/8/2018
*GRIEVE David	1/9/2015	12/3/2018	Natural Causes	6/9/2018
*DUDEK Wlodzimierz	7/10/2016	16/7/2018	Accident	19/9/2018
*HEESTERS Augustinus Clemens Antonius	15/10/2016	18/9/2018	Natural Causes	12/10/2018
*DAVIS William John	18/10/2016	4/2/2019	Natural Causes	6/2/2019
*O'NEILL Seanpol Martin Padraig	23/2/2015	18-19/2/2019	Open Finding	8/3/2019
*WOODS Lorna May	10/1/2017	6/3/2019	Natural Causes	12/3/2019
*GIBLETT Ronald Alan	5/11/2016	5/12/2018	Natural Causes	4/4/2019
*KUGIS Maris	10/9/2016	22/11/2018	Natural Causes	4/4/2019
*JACKAMARRA Khamsani Victor (aka Hajinoor)	16/12/2015	30-31/10/2018 and 1/11/2018	Suicide	9/5/2019
SM (Name Suppressed)	2/8/2014	10 and 21/12/2018	Natural Causes	14/5/2019

NAME OF DECEASED	DATE OF DEATH	DATE OF INQUEST	FINDING	DATE OF FINDING
*BELL Mervyn Kenneth *CAMERON Bevan Stanley *HONEYWOOD Brian Robert *JM (Name Suppressed) *WALLAM Aubrey Anthony Shannon	8/9/2015 2/11/2015 16/2/2015 3/8/2015 22/10/2014	26-29/3/2019 and 3-4/4/2019	Suicide	22/5/2019
*HEAVEN Garth Cyril	26/7/2016	10/5/2019	Natural Causes	22/5/2019
*DEBNAM Christopher John	21/11/2014	15-16/10/2018 and 14/11/2018	Natural Causes	22/5/2019
*ASHLEY Pamela Edith	3/2/2016	22-24/10/2018 and 14/11/2018	Natural Causes	22/5/2019
*MACARTNEY Robin David	13/7/2016	14/5/2019	Natural Causes	24/5/2019
*GRAHAM Colin George	24/1/2016	21/8/2019	Natural Causes	31/5/2019
*CRUZ Aurelio Monterlegre	11/12/2016	8/2/2019	Natural Causes	31/5/2019
*O'DRISCOLL Malcolm Patrick	15/4/2017	30/5/2019	Natural Causes	19/6/2019

PERSONS HELD IN CARE – specific reports

Stanley KING
Inquest held in Perth 6-9 March 2018, investigation finalised 16 July 2018

Mr Stanley King (the deceased) died on 22 May 2015 at Rockingham General Hospital. The cause of death was coronary artery disease in a man with laryngeal dystonia, severe psychosis (treated) and obesity. The coroner found the manner of death was natural causes. He was 45 years of age.

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.*

On 12 May 2015 the deceased presented at the Rockingham General Hospital with a severe relapse of his paranoid schizophrenia. Following assessment by his psychiatrist on 13 May 2015 the deceased was made an involuntary patient. During his admission the deceased appeared to stablise but experienced periods of breathlessness. It was believed he suffered a dystonic reaction to his antipsychotic medication and he was treated with benztropine. He continued to experience difficulties with breathing and all his antipsychotic medication was withheld while he continued to be treated with benztropine. He was reviewed during the evening of 21 May 2015 and appeared stable.

In the early hours of 22 May 2015 the deceased was noted to be in distress to the extent he became incontinent. He took himself to the shower and the duty medical officer was called. On attendance of the duty medical officer the deceased walked out of his shower towards the duty medical officer who intended to take him to the treatment room. He collapsed and cardiopulmonary resuscitation was commenced and the medical emergency team were called. Unfortunately the deceased could not be revived despite aggressive resuscitation and was declared deceased shortly thereafter.

The Deputy State Coroner made the observation that the occurrence of dystonic laryngeal lingual reactions to antipsychotics to the extent there is a fatal outcome is extremely rare, but considered the case of the deceased should be used as a learning exercise as to the potential for a fatal outcome.

The Deputy State Coroner was satisfied the deceased's supervision, treatment and care was reasonable in all the circumstances and it was difficult to predict whether earlier intervention would have prevented death.

The Deputy State Coroner made a recommendation addressed to the monitoring of breathing difficulties in patients being treated with anti-psychotic medication.

The Finding and response to the recommendation is on the website of the Coroner's Court of Western Australia.

Paul DICKSON
Inquest held in Perth 16 March 2018, investigation finalised 29 August 2018

Mr Paul Dickson (the deceased) died on 11 November 2013 at Sir Charles Gairdner Hospital. The cause of death was from multiple injuries. The Coroner found the manner of death was suicide. He was 34 years of age.

Immediately before his death the deceased was a "person held in care" under the *Coroners Act 1996* because he was subject to a Community Treatment Order made under sections 76 and 79 of the *Mental Health Act 1996.* He had been diagnosed with severe paranoid schizophrenia that required regular medication.

The deceased was single and lived alone in his rental accommodation in Osborne Park. He was unable to work due to his illness and received disability support pension. Throughout his life the deceased had been supported by both his parents. The deceased had first been diagnosed with schizophrenia in 1999. He was trialled on the antipsychotic medication clozapine and various other medications to stabilise his mood. The deceased relapsed repeatedly due to his non-compliance with his medications and required hospitalisation for treatment. Between January 1999 and November 2013 the deceased was admitted to hospital on 18 occasions, usually to Graylands Hospital. He was admitted as an involuntary patient and his admissions could be many months in length.

On 11 November 2013 the deceased recorded what could be described as a 'suicide message' on his mobile telephone. The deceased then walked up to Main Street in Osborne Park, which is a relatively busy road in the area. He was observed to pace up and down on the footpath beside Main Street for approximately 15 minutes while various cars passed by. He appeared to perhaps be waiting for someone.

The deceased was seen to be standing on the side of the road very close to the kerb moving from side to side. Then, without warning, the deceased jumped in front of a passing truck that was travelling south on Main Street. The truck driver swerved but was unable to avoid the deceased and the left hand side of the truck struck the deceased's body. He suffered serious injuries that caused his death.

The Coroner was satisfied that the deceased's sudden decision to end his life was unexpected and he did not show any signs to his treating mental health team prior to doing so. There was nothing to indicate a change in the deceased's presentation that would have warranted a hospital admission at that stage. The Coroner was satisfied his psychiatric treatment, care and supervision both in hospital and in the community was appropriate and of a reasonable standard.

The Coroner did not make any recommendations.

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

Kim Martin FRANKER
Inquest held in Perth 1 March 2018, investigation finalised 31 August 2018

Mr Kim Martin Franker (the deceased) died on 28 February 2016 at Fiona Stanley Hospital. The cause of death was determined as the effects of trihexyphenidyl (Artane, benzhexol) and amphetamine-type stimulants and dehydration with renal impairment in a man with cardiomyopathy and morbid obesity. The Deputy State Coroner found the manner of death was by accident. He was 36 years of age.

Immediately before his death the deceased was a "person held in care" under the *Coroners Act 1996* because he was subject to a Community Treatment Order made under sections 76 and 79 of the *Mental Health Act 1996.*

The deceased had an extensive history of polysubstance abuse including alcohol, intravenous amphetamines, ecstasy, LSD and marijuana dating back to when he was 16 years of age. The deceased was first admitted to a psychiatric hospital in 2001 where he was diagnosed with amphetamine induced psychosis. He had many admissions to psychiatric facilities, predominantly Graylands Hospital and Fremantle Alma Street Centre. He self-reported regular cannabis use and more regular amphetamine use. He was assessed as having limited insight into his illness which caused him to refuse to engage in substance abuse treatment.

The deceased had a number of physical medical conditions in addition to his psychiatric issues and these were generally dealt with by his GP in the community, although it appeared the deceased was also receiving prescriptions from the street doctor and possibly others unbeknown to his GP. While an inpatient the deceased's medications, both psychiatric and physical, were dispensed by the facility in which he was a patient. There was limited interaction by the deceased's GP with his community mental health team.

The Deputy State Coroner concluded the deceased's involvement with illicit drugs and the abuse of prescription medication, which provided him with some effects similar to, or enhanced the effects, of those of illicit drugs while in the community, made it very difficult for those interested in managing his behaviours to ensure he was medication compliant.

The Deputy State Coroner was satisfied the combination of the drugs the deceased had in his system explained his death on 28 February 2016 in combination with his co-morbidities. The Deputy State Coroner was also satisfied it was an intentional abuse of both illicit drugs and prescriptions medications, but there was no evidence the deceased intended to take his life.

The Deputy State Coroner concluded the supervision, treatment and care the deceased received from his CFMHS team while subject to a CTO in the community was of a high standard in all the circumstances with respect to the deceased.

The Deputy State Coroner did not make any recommendations.

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

David GRIEVE
Inquest held in Perth 12 March 2018, investigation finalised 6 September 2018

Mr David Grieve (the deceased) died on 1 September 2015 in Graylands Hospital. The cause of death was coronary atherosclerosis. The Coroner found the manner of death was natural causes. He was 45 years of age.

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 inquest focused primarily on the medical care provided to the deceased in the weeks prior to his death, both physical and mental, as well as the events surrounding his death. The deceased's family had expressed some concern about the failure to diagnose the deceased's heart related issues prior to his death. These concerns were addressed at the inquest hearing by an expert medical witness.

The deceased first began to suffer from psychotic symptoms when he was 17 years old. This led to his first admission to Graylands Hospital in 1987. Between 1987 and 1988 the deceased had more than 20 admissions to Graylands Hospital. He was initially diagnosed with schizophreniform psychosis but in 1988 his diagnosis was changed to schizophrenia. The deceased's admissions to Graylands for his psychotic relapses were often precipitated by alcohol and marijuana abuse or non-compliance with his medications. Due to his non-compliance with oral medications he was managed with depot injections for many years.

Prior to his death the deceased was living with some others in a rental property. All of them had mental health issues. They were very supportive of each other and were generally self-sufficient and received good family support. The deceased usually attended the Odin Road Medical Centre in Innaloo for his regular medical care and was in the care of the Osborne Park Community Mental Health Service with regard to his mental health issues.

In the days prior to his death the deceased spoke to his mother and told her he had been in hospital to get his heart checked as he was experiencing breathlessness. He advised her that he had an appointment to see a heart specialist. It became apparent to the deceased's mother that he was deteriorating mentally around this time and she felt that he seemed more aggressive towards her and his friend, which was not his nature.

A little less than a fortnight before his death the deceased was reviewed at SCGH for some symptoms that were thought to possibly be cardiac related, but after investigation and consultation with cardiac specialists were attributed to the deceased's psychiatric illness. In the following days his mental state continued to deteriorate.

On 25 August 2015 the deceased's mother contacted the Mental Health Emergency Response Line with concerns that the deceased was not well. In response the deceased was assessed that afternoon and found to be hostile, over inclusive and pressured in speech. He admitted to hearing voices on a regular basis but denied that they were causing him distress. The deceased was reviewed again the following day and it was not felt that there were enough

grounds to admit him as an involuntary patient. On 29 August 2015 the deceased refused to allow Hospital in the Home staff to visit. Osborne Clinic staff assessed the deceased on 31 August 2015 and he was reported to be hostile and threatening. He was transferred to Graylands with the assistance of police under the Mental Health Act so that he could be psychiatrically assessed.

On 1 September 2015 the deceased was noted to be restless and disorganised during the night and his sleep chart indicated he had been awake from 1.00 am, despite having been given a sleeping tablet. A nursing entry at 11.20am reported the deceased had been elevated and inappropriate towards female staff. The deceased was reviewed by a Consultant Psychiatrist who made the deceased an involuntary patient. The deceased was transferred to a segregated secure ward just after 1.00 pm, where he remained psychotic and agitated. At 10.00 pm the deceased was noted to be sleeping in a chair in the common lounge area of the ward, with his breath being regular, deep and snoring. At 10.45 pm the deceased's breathing was reported to become slower and he was seen to slide from the chair.

A medical emergency was activated and when the Duty Medical Officer arrived the deceased appeared to be pale and cyanotic. Resuscitation attempts were unsuccessful and he died. A post mortem examination found the cause of death was coronary atherosclerosis in the context of the deceased's obesity and known systemic hypertension.

The Coroner concluded the medical care leading up to the deceased's death was reasonable and appropriate in the circumstances.

The Coroner did not make any recommendations.

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

Wlodzimierz DUDEK
Inquest held in Perth 16 July 2018, investigation finalised 19 September 2018

Mr Wlodzimierz Dudek (the deceased) died on 7 October 2016 at Sir Charles Gairdner Hospital. The cause of death was bronchopneumonia and hypoxic brain injury following aspiration of food (choking). The Coroner found the manner of death was accident. He was 35 years of age.

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 2014.*

The deceased had been diagnosed with bipolar affective disorder. He suffered predominantly manic relapses with psychosis, often prolonged, and had been admitted to several mental health hospitals.

While in the mental health unit at Joondalup Health Campus in December 2015, the deceased developed pneumonia, possibly due to ischaemic heart disease. His condition deteriorated suddenly on 9 December 2015, with elevated and irregular pulse rate and elevated blood pressure. He recovered from the pneumonia, but on 14 December 2015 a speech pathologist noted mild to moderate oropharyngeal dysphagia (difficulty swallowing) likely to related to delirium and recommended a soft food diet. There had been no previous reports of dysphagia.

The deceased was transferred to Graylands Hospital on 5 April 2016. By that time, his respiratory symptoms had resolved completely and his medical problems had been stable for months. The discharge summary from Joondalup Health Campus had not mentioned dysphagia. In mid-July 2016, he was struck in the face by another patient and was moved to a ward, which catered for patients with significant physical co-morbidities. In August 2016 another patient struck the deceased in the face, so the deceased was placed on a 2:1 special, whereby he was monitored by two staff members for his and other patients' protection.

On 4 October 2016 the deceased was eating breakfast on his own when he choked on bread. He became unconscious and his heart arrested. Hospital staff at Graylands Hospital administered CPR and ambulance officers took him to Sir Charles Gairdner Hospital, where he was admitted into the intensive care unit with a suspected hypoxic brain injury. His condition deteriorated and on 7 October 2016, following meetings between ICU medical staff and the deceased's family, and a subsequent discussion between staff and the Public Guardian, he was extubated and provided with palliative care until he died shortly thereafter.

The Coroner was satisfied that the supervision, treatment and care provided to the deceased was reasonable and appropriate. The deceased's choking episode appeared to have effectively been a one off incident that was accidental and unpredictable.

The Coroner did not make any recommendations.

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

Augustinus Clemens Antonius HEESTERS
Inquest held in Perth 18 September 2018, investigation finalised 12 October 2018

Mr Augustinus Clemens Antonius Heesters (the deceased) died on 15 October 2016 at Fiona Stanley Hospital, Murdoch. The cause of death was acute myocardial infarct in association with coronary artery atherosclerosis. The Deputy State Coroner found the manner of death was by natural causes. He was 70 years of age.

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 Bunbury Regional Prison.

The deceased had a long history of ischaemic heart disease with two prior myocardial infarctions. His medical history recorded lumbar back pain, cuff tear repair surgery to the right shoulder, skin cancer, bipolar effective disorder, hyperlipidemia, gastro-oesophageal respiratory disease, right inguinal hernia and depression. He was prescribed multiple medications for his various ailments. Indications were the deceased was not always compliant with his medication.

On 5 October 2016 the deceased was transferred to Bunbury Regional Hospital from Bunbury Regional Prison after becoming ill. The deceased was assessed, stabilised and transferred to Fiona Stanley Hospital via the Royal Flying Doctor Service for further management. At Fiona Stanley Hospital the deceased was admitted to the coronary care unit.

On 12 October 2016 the deceased's MRI indicated his heart showed severe systolic dysfunction and on 14 October 2016 he received a stent into the right coronary artery and appeared to recover after the procedure. Later that evening he developed ventricular tachycardia and arrested. As a result the deceased required increasing amounts of support, but declined further resuscitation. The deceased had a telephone discussion with his partner as he deteriorated and he passed away in the morning of 15 October 2016.

The Deputy State Coroner was satisfied that the deceased's supervision, treatment and care while in custody was of a good standard.

The Deputy State Coroner did not make any recommendations.

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

William John DAVIS
Inquest held in Perth 4 February 2019, investigation finalised 6 February 2019

Mr William John Davis (the deceased) died on 18 October 2016 at Karnet Prison Farm. The cause of death was subarachnoid haemorrhage caused by a ruptured berry aneurysm. The Coroner found the manner of death was by natural causes. He was 37 years of age.

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 Karnet Prison Farm.

The deceased had been diagnosed with Ehlers Danlos Syndrome (EDS), an inherited connective tissue disorder. He had a significant history of drug and alcohol abuse, and struggled with depression. His adoptive parents provided him with a loving and supportive environment. He undertook a number of drug rehabilitation programs. Following the death of his adoptive mother in 2011, he attempted to take his life and engaged in self-harming behaviours.

In 2012, the deceased was sentenced to imprisonment for 6 years. He was made eligible for parole, which was granted and he was due to be released on 28 October 2016.

On 18 October 2016, the deceased carried out his normal morning routine and was given his usual medication at the prison's medical centre. He returned to his cell and spoke to several prisoners and appeared to be his usual self. Later in the morning, the deceased was found sitting in a chair outside his cell block. He was slumped over and cool to the touch. Prison authorities were altered and CPR was commenced immediately. Ambulance officers arrived at the prison and continued resuscitation attempts but were unable to revive the deceased and he was pronounced dead.

The Coroner noted that the rate of occurrence of intracranial berry aneurysms for people diagnosed with a sub-type of EDS (vascular EDS) appears to be higher but there is no consensus in the literature. There was no evidence about which form of EDS the deceased had been diagnosed with, nor evidence that routine screening would have been appropriate for him.

The Coroner found the care provided to the deceased was reasonable and appropriate while he was incarcerated.

The Coroner did not make any recommendations.

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

Seanpol Martin Padraig O'NEILL
Inquest held in Perth 18-19 February 2019, investigation finalised 8 March 2019

Mr Seanpol Martin Padraig O'Neill (the deceased) died on 23 February 2015 at Armadale Kelmscott District Memorial Hospital. The cause of death was methadone toxicity. The Coroner made an open finding as to the manner of death. He was 30 years of age.

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.*

As an adolescent, the deceased was treated by several mental health services for anxiety, depression and panic attacks. In 2005, the deceased was diagnosed with narcolepsy.

On 3 February 2012, the deceased was admitted to the high dependency unit of the Armadale Mental Health Service and diagnosed with paranoid schizophrenia. Following his discharge his care was transferred to the Gosnells Community Mental Health Team which managed his schizophrenia until his death. In November 2012, the deceased was prescribed Physeptone (methadone) tablets for chronic pain. Physeptone has a known sedating effect.

On 16 February 2015, the deceased had an appointment with his GP. He became angry when his doctor refused to prescribe additional medication and made threats towards her and clinic staff and expressed a range of delusional beliefs. After consulting the deceased's mental health team, his GP completed forms under the *Mental Health Act 1996 (WA)* requiring the deceased to be examined by a psychiatrist. The deceased was taken to the Armadale Kelmscott Memorial Hospital and admitted to an open ward under the care of the Armadale Mental Health Service. He was found to be floridly psychotic and had grandiose delusions. He was given Acuphase, a fast acting anti-psychotic medication used to treat acute psychosis. Acuphase has a known sedating effect.

From the time of his admission, the deceased was placed on 15-minute observations, the results of which were recorded in a visual observation record (VOR). On 23 February 2015, the deceased's VOR indicated he was asleep from 12.15 am onwards. At 7.55 am, a nurse entered the deceased's room to wake him for breakfast. The deceased did not respond when called, was not breathing and was cold to the touch. The medical emergency team was called and following discussions between clinical staff, it was decided that CPR would be inappropriate because the deceased had clearly been dead for some time.

The Coroner concluded that the deceased died on 23 February 2015 as a result of methadone toxicity but was unable to determine how the deceased came to have a lethal amount of methadone in his system.

The Coroner observed that there were two broad areas where the deceased's supervision, treatment and care could have been improved, in connection with observation of the deceased's vital signs and observations with respect to risk of absconding. With the exception of those issues, the Coroner was satisfied that the supervision, treatment and care provided to the deceased was adequate.

The Coroner made three recommendations addressed towards improving the monitoring of patients who appear to be asleep, and documenting the reasons and outcomes.

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

Lorna May WOODS
Inquest held in Perth 6 March 2019, investigation finalised 12 March 2019

Ms Lorna May Woods (the deceased) died on 10 January 2017 at Joondalup Health Campus. The cause of death was pulmonary thromboembolism due to deep vein thrombosis and sepsis due to pyelonephritis on a background of metastatic ovarian cancer. The Coroner found the manner of death was by natural causes. She was 39 years of age.

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* 2014.

In 1997, the deceased was diagnosed with disorganised schizophrenia and found to have an IQ of 64, which is generally regarded as a mild intellectual impairment. She had an extensive history of minor public order type offences and in 2013, she spent 100 days at the Frankland Centre, Graylands Hospital pursuant to a hospital order issued under the *Criminal Law (Mentally Impaired Accused) Act 1996* for assaulting a public officer and stealing offences.

The deceased had a history of presenting at hospital for treatment, often following alleged assaults, and either leaving before she was seen, or discharging herself against medical advice. In April 2015, she presented to hospital with a serious kidney infection and discharged herself despite being told she risked serious illness or death if her condition was not treated.

On 7 January 2017, the deceased complained of nausea and stomach pain and was taken to the emergency department at Joondalup Health Campus. She was diagnosed with sepsis and found to have metastatic ovarian cancer. Scans identified her shrunken left kidney as the possible source of her sepsis. The deceased was reviewed by the gynaecology team and found to be agitated and thought disordered and a psychiatric review was requested.

On 9 January 2017, a psychiatrist found the deceased to be thought disordered and suffering from a psychotic illness made worse by delirium. She was placed on an inpatient treatment order under the *Mental Health Act 2014 (WA)* on the basis that she was unable to make decisions for herself and required urgent medical treatment.

In the afternoon of 9 January 2017, the deceased's condition deteriorated and despite the efforts of clinical staff, she developed septic shock from which she was unable to recover. Her family were at the deceased's bedside when she died in the early hours of 10 January 2017.

The Coroner noted that the deceased had a complex medical and mental health history and that on numerous occasions, the deceased had not taken up offers of treatment and support. The deceased lacked insight into her health issues and had a limited understanding of the need for treatment and follow-up.

Having regard to all of the evidence, the Coroner found that the supervision, treatment and care provided to the deceased while she was an involuntary patient at Joondalup Health Campus was both reasonable and appropriate.

The Coroner did not make any recommendations.

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

Ronald Alan GIBLETT
Inquest held in Perth 5 December 2018, investigation finalised 4 April 2019

Mr Ronald Alan Giblett (the deceased) died on 5 November 2016 at Karnet Prison Farm, Serpentine. The cause of death was valvular ischaemic heart disease in association with coronary arteriosclerosis. The Deputy State Coroner found the manner of death was by natural causes. He was 79 years of age.

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 Karnet Prison Farm.

The deceased had an extensive medical history which included a family history of heart disease on both his parents' sides. The deceased attended the Mead Medical Centre until his imprisonment in December 2013. He had suffered ischaemic heart disease with previous myocardial infarctions, and had undergone stents and coronary artery bypass surgery. He had hypertension, high cholesterol, kidney disease, had a parathyroidectomy, appendectomy, right knee replacement with arthritis in his right hip, gout, osteomyelitis, he had suffered a hernia, he had gastroesophageal reflux disease, coeliac disease and benign prostatic hypertrophy.

The deceased appeared well once located at Karnet Prison Farm and was able to continue with his hobbies. The deceased's prison medical record indicated he had regular annual reviews and six monthly cardiovascular care plan reviews. There were few concerns with respect to his cardiac disease. The Deputy State Coroner was satisfied the deceased exhibited no warning signs when observed by prison staff at unlock on 5 November 2016. He was observed by fellow prisons to be in a jovial mood. He suffered a fatal cardiac arrest sometime between 8.00 am and 9.30 am after returning to his room. He was located unresponsive and did not recover despite medical intervention.

On 6 February 2017 the forensic pathologist completed all investigations which included histology and confirmed changes to the heart muscle. The nodules in the spleen showed features of B-cell malignant lymphoma. Neuropathology indicated no significant abnormalities, microbiology showed the presence of some bacterial organisms not considered to be of significance to the death, while toxicology indicated the presence of medications consistent with the deceased's known medical care. Following assessment of those investigations the forensic pathologist was of the opinion the cause of death for the deceased was best described as valvular and ischaemic heart disease in association with coronary arteriosclerosis.

The Deputy State Coroner was satisfied the deceased's naturally occurring coronary arteriosclerosis was appropriately dealt with during his incarceration and that he died without warning as the result of a fatal cardiac arrest, the effects of which could not be reversed.

The Deputy State Coroner was satisfied the deceased's supervision, treatment and care while in custody were of a good standard.

The Deputy State Coroner did not make any recommendations.

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

Maris KUGIS
Inquest held in Perth 22 November 2018, investigation finalised 4 April 2019

Mr Maris Kugis (the deceased) died on 10 September 2016 at Sir Charles Gairdner Hospital. The cause of death was bronchoprenumonia in a man with chronic obstructive pulmonary disease. The Deputy State Coroner found the manner of death was by natural causes. He was 68 years of age.

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* 2014.

The deceased at the time of his death had been a long term involuntary inpatient of Graylands Hospital due to his multiple medical and mental health issues. The deceased's welfare was supervised through the Public Advocate and his finances managed by the Public Trustee as ordered on 25 January 2012. The deceased's continuing involuntary status under the Mental Health Act was reviewed three monthly. He was assessed as never being able to live in the community and was unsuited to aged care living. The deceased remained in the care of the Graylands Hospital until his death.

In September 2016 the deceased was admitted to Sir Charles Gairdner Hospital as a result of his seriously declining health with increasing shortness of breath and persistently low oxygen saturations. He was diagnosed with acute on chronic type 2 respiratory failure due to chronic obstructive airway disease, congestive cardiac failure and malignant pleural effusion. He was discharged back to Graylands Hospital with a plan for follow up and the probability he would require palliative care in the future. Within hours of the deceased returning to Graylands Hospital his oxygen saturation dropped to less than 80% on room air and he was returned to Sir Charles Gairdner Hospital. Following discussions with the deceased's relevant carers it was determined he should be treated palliatively and he died on 10 September 2016.

The Deputy State Coroner was satisfied with the supervision, treatment and care of the deceased while an involuntary patient under the care of Graylands Hospital which was reasonable and appropriate.

The Deputy State Coroner did not make any recommendations.

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

Khamsani Victor JACKAMARRA (aka Hajinoor)
Inquest held in Broome 30, 31 October and 1 November 2018, investigation finalised 9 May 2019

Mr Khamsani Victor Jackamarra (aka Hajinoor) (the deceased) died on 16 December 2015 at Broome Regional Prison. The cause of death was ligature compression of the neck (hanging). The Deputy State Coroner found the manner of death was by suicide. He was 36 years of age.

Immediately before death the deceased was a "person held in care" under section 3 of the *Coroners Act 1996* because he was a 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 required to remain in custody awaiting his surety papers to be signed.

The deceased had a significant criminal history with offences of considerable violence. The majority of his offending reflected his use of alcohol and illicit substances, and when not intoxicated he expressed a desire not to be violent. His substance misuse coincided with a significant history of mental health issues in the form of personality disorders for which he was prescribed medication but with which he was not always compliant. The deceased had been a long term client of the mental health services in the Kimberley.

On 16 December 2015 the deceased, who had not made prior arrangements for his surety to be available at his court appearance that morning, was remanded by the court for sentence with bail and a surety. Significant attempts were made by various people during the course of the morning to enable the deceased's surety to be signed, but these attempts were unsuccessful. Once the deceased realised he would remain in custody he became withdrawn and then frustrated.

The deceased was transferred from the Broome Magistrates Court to the Broome Regional Prison and into the prison system without effective communication of his behaviour pending transfer. He was assessed and prison officers had no concerns regarding the deceased's welfare or state of mind. The deceased spoke with a prison support officer and while he appeared to be upset initially, by the time they finished speaking the prison support officer had no concerns for his welfare. After this meeting a prison officer met with the deceased and they went through the orientation check list. The deceased was seen to interact with other prisoners and he had chosen the cell in which he wished to stay. Another prisoner wished to say hello to the deceased and was told he was in the shower block. He did not go and find him.

The deceased was subsequently found by a fellow prisoner in the shower block, which was old and with accessible hanging points. The deceased had used a shirt to hang himself in the shower sometime during the 40 minutes since he had spoken with the prison officer, about having a telephone assisted call to his family when he was ready.

The Deputy State Coroner found that even with proper communication of the deceased's behaviour while at the Broome Court House, and knowledge of his prior attempts at self-harm while in custody, the conditions and systems in place in Broome Prison at that time would not have made a difference to how the deceased was dealt with in the two and half hours he was

present in the prison. The Deputy State Coroner was satisfied that the individuals involved in the whole custody issue did the best they could with the system they had.

The Deputy State Coroner made six recommendations aimed at improving prisoner welfare and enhancing the security of Broome Regional Prison.

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

SM (Name Subject to Suppression Order)
Inquest held in Perth 10 and 21 December 2018, investigation finalised 14 May 2019

SM (the deceased) died on 2 August 2014 at Princess Margaret Hospital. The cause of death was complications following cardio respiratory arrest in association with a seizure in a young boy with bronchopneumonia on a background of cerebral palsy and chronic seizure disorder. The manner of death was natural causes. He was seven years of age.

Immediately before death the deceased was a "person held in care" under the *Coroners Act 1996* because he 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 with a carer family on 28 April 2014. Multiple agencies were involved in the provision of care to the deceased and it was noted the deceased's health had been deteriorating since the placement into the family care by way of increased seizure activity and respiratory infection, however, the deceased increased in weight and appeared to enjoy being part of a family unit.

The deceased was admitted on 1 August 2014 to Joondalup Health Campus with excessive amounts of seizures. These seizures had increased since the deceased had returned home from a previous hospital admission, 27 July to 31 July 2014. The deceased was transferred to Princess Margaret Hospital but, unfortunately, the deceased's condition deteriorated and he became unresponsive on the morning of 2 August 2014. The deceased was resuscitated and placed in paediatric ICU while unsuccessful attempts were made to locate his biological mother. The deceased's life support was removed and he died at 6.15 pm on 2 August 2014.

The Deputy State Coroner concluded the deceased's supervision, treatment and care were appropriate while in the care of the Department of Communities.

The Deputy State Coroner did not make any recommendations.

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

Mervyn Kenneth BELL and Bevan Stanley CAMERON and Brian Robert HONEYWOOD and JM (Subject to Suppression Order) and Aubrey Antony WALLAM
Inquest held in Perth 26-29 March 2019 and 3-4 April 2019, investigation finalised 22 May 2019

Mervyn Kenneth BELL (the deceased) died on 8 September 2015; Bevan Stanley CAMERON (the deceased) died on 2 November 2015; Brian Robert HONEYWOOD (the deceased) died on 16 February 2015; JM (Subject to Suppression Order) (the deceased) died on 3 August 2015; Aubrey Antony WALLAM (the deceased) died on 22 October 2014. All five deaths occurred at Casuarina Prison, and with the exception of Mr Bell, the cause of each death was ligature compression of the neck (hanging). In Mr Bell's case, the cause of death was incised injury to elbow region veins. In each case, the Coroner found the manner of death was suicide.

Immediately before their deaths, each of the deceased persons was a "person held in care" under section 3 of the *Coroners Act 1996* because they were sentenced prisoners, and pursuant to the *Prisons Act 1981* in the custody of the Chief Executive Officer of the Department of Corrective Services. The deceased persons were serving their sentences at Casuarina Prison.

Pursuant to a direction by the State Coroner on 25 February 2019, all five deaths were investigated at one inquest. That inquest focused on the supervision, treatment and care provided to each of the deceased persons while they were prisoners, as well as the circumstances of their respective deaths.

The Coroner found that that each of the deceased persons had died at Casuarina Prison and that the manner of death in each case was suicide. The Coroner heard evidence about the management of at risk prisoners, some of the risk factors impacting on prisoner management and the strategies and tools employed to address those factors.

Four of the five deceased persons had varying levels of involvement with counsellors the Prison Counselling Service (PCS). One of the deceased persons had no involvement at all. The Coroner heard that at a time when the muster at Casuarina Prison was rising, staffing levels within PCS had fallen. This meant that PCS counsellors were unable to carry out any proactive work aimed at addressing the psychological issues some of the deceased persons presented with. Because of staffing levels at the relevant time, PCS counsellors were only able to deal with crisis situations and conduct risk assessments with respect to prisoners.

The Coroner also heard that in the past PCS staff had access to the medical records of prisoners, stored in an electronic system called EcHO and clinical staff were able to access information stored by PCS staff. However, at some time prior to the deaths of the deceased persons, this reciprocal access had been removed and this had led to inefficiencies and had the potential to impact on prisoner welfare.

The Coroner heard that an increasing number of prisoners have personality disorders and other mental health conditions which impact on their management whilst incarcerated. The Coroner

heard that additional training for custodial staff and that a model of prisoner management called trauma informed custodial care may help to better manage prisoners with these issues.

The Coroner made eight recommendations aimed at improving prisoner welfare and enhancing the security of Casuarina Prison.

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

Garth Cyril HEAVEN
Inquest held in Perth 10 May 2019, investigation finalised 22 May 2019

Mr Garth Cyril Heaven (the deceased) died on 26 July 2016 at Bethesda Hospital. The cause of death was bronchopneumonia complicating a metastatic and locally advanced primary adenocarcinoma of the right lung in a man under palliative care. The Coroner found the manner of death was by natural causes. He was 57 years of age.

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 served his sentence at Hakea Prison, Casuarina Prison and Acacia Prison.

The inquest focused on the care provided to the deceased while he was a prisoner, as well as on the circumstances of his death.

While in prison the deceased was noted to be quiet, polite and respectful. The deceased was employed in prison metal shops and later as a gardener. He remained employed until he could no longer work because of his medical condition.

Following blood tests in December 2015 which showed he had anaemia, the deceased was referred for a colonoscopy to check for gastro-intestinal bleeding. He declined to have the colonoscopy but a chest x-ray in January 2016 identified a lesion in his right lung and he was referred for further tests. In February 2016 the deceased was diagnosed with metastatic lung cancer and he received radiotherapy. On 23 March 2016, the deceased was registered as Stage 3 terminally ill under the departmental policy dealing with prisoners with terminal illnesses.

On 27 May 2016 the deceased complained of back pain and was taken to Fiona Stanley Hospital by ambulance. He was noted to have bony metastases which had been seen during a PET scan on 11 February 2016. After treatment for pain by the palliative team, the deceased was discharged to the infirmary at Casuarina Prison. On 17 July 2016, the deceased's condition deteriorated and he was again taken to Fiona Stanley Hospital by ambulance. The deceased remained at Fiona Stanley Hospital until 25 July 2016, when he was transferred to the hospice at Bethesda Hospital for end-of-life care. The deceased died on 26 July 2016.

Having regard to all of the circumstances of the deceased's case, the Coroner found that the supervision, treatment and care provided to the deceased during his incarceration was reasonable and appropriate.

The Coroner did not make any recommendations.

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

Christopher John DEBNAM
Inquest held in Perth 15-16 October and 14 November 2018, investigation finalised on 22 May 2019

Mr Christopher John Debnam (the deceased) died on 21 November 2014 at Graylands Hospital. The cause of death was consistent with cardiomyopathy with early pneumonia in a man with reported sleep apnoea and a high body mass index. The Deputy State Coroner found the manner of death was by natural causes. He was 40 years of age.

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 was an obese male originally diagnosed with chronic paranoid schizophrenia, later refined to suffering bipolar affective disorder with psychotic features, who was prone to a high degree of arousal when he became unwell. Past history indicated he could become very aggressive and violent when unwell. He had been released from Graylands on 12 November 2014 without including his community mental health team in discharge planning. On 20 November 2014 the deceased, who had been recently discharged as a voluntary patient into the care of his family, was exhibiting elevated levels of agitation. The deceased's parents, while wanting him home, were unable to care for him and asked for assistance. The deceased was admitted to Graylands Hospital pending assessment and provided with a bed with a primary focus being a reduction in his agitation for both his own and other persons' safety. He was reviewed and provided with medication he had tolerated well over his prior two months while at Graylands.

Observations of the deceased were within normal levels apart from a slightly elevated blood pressure. Due to his level of agitation a comprehensive medical assessment was not possible. There was nothing from the assessment for the deceased on his admission, nor his admission to the ward, which indicated elevated monitoring or observations were necessary. His history recorded he had sleep apnoea and was obese. There was nothing recently to indicate he needed more frequent monitoring than the usual respirations hourly.

The Deputy State Coroner accepted it was a priority to reduce the deceased's level of agitation, which was usually successfully done via sedation, and that due to the same sedation having been used successfully in the prior two months, it was not considered the deceased was at risk of respiratory arrest such as to warrant transfer to an acute clinical setting. The Deputy State Coroner was satisfied the deceased died as the result of his combined undiagnosed cardiomyopathy and reported obstructive sleep apnoea following a cardiorespiratory arrest. There was no evidence the sedation with which the deceased been provided on the evening of the 20 November 2014 was still providing sedation on the morning of 21 November 2014. Rather it was considered possible developing hypoventilation caused respiratory depression then arrest on the background of his naturally occurring cardiac disease, sleep apnoea, developing pneumonia and obesity.

The Deputy State Coroner found there was no effective discharge planning for the deceased's return home to his parents on 12 November 2014, on the same day his status was changed from involuntary to voluntary. However, the Deputy State Coroner did not believe any level

of appropriate discharge planning would have prevented his deterioration. He was in touch with his CMHS and appropriately medicated. He was not on a Community Treatment Order due to his reported compliance with medication and the fact his parents were supervising his medication.

The Deputy State Coroner was satisfied that overnight on 20 to 21 November 2014, the deceased's supervision, treatment and care while on forms pending involuntary patient status appears to have been reasonable. The Deputy State Coroner was concerned the lack of prior investigation of the risks to his clinical state when an involuntary patient, put the clinicians dealing with those circumstances at disadvantage in appreciating the extent of the clinical risks faced by the deceased.

The Deputy State Coroner made four recommendations directed to ensuring appropriate clinical investigation of patients with physical conditions which would predict a risk with the necessary treatment when highly unwell, and the development of more acute care units for highly aroused mental health patients with high clinical risk factors for cardio respiratory arrest.

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

Pamela Edith ASHLEY
Inquest held in Perth 22-24 October 2018 and 14 November 2018, investigation finalised on 22 May 2019

Mrs Pamela Edith Ashley (the deceased) died on 3 February 2016 at Armadale Kelmscott District Memorial Hospital. The cause of death was a fatal cardiac arrhythmia in a lady with obstructive sleep apnoea, obesity and suffering an acute psychotic episode to the extent sedation was necessary in an attempt to reduce her level of agitation. The Deputy State Coroner found the manner of death was by natural causes. She was 64 years of age.

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 a medical history of well controlled diabetes mellitus, high cholesterol and bilateral leg swelling, apparently without cardiac cause, obesity and obstructive sleep apnoea. She also had a long history of bipolar affective disorder.

On the evening of 2 February 2016 the deceased arrived at the emergency department of the Armadale Kelmscott District Memorial Hospital by ambulance due to her deteriorating mental health. She was assessed as requiring admission to an acute secure ward which was not immediately available. The deceased remained in the emergency department overnight. The next morning the deceased was still agitated and distressed and there were fears for both her safety and possibly others due to her very distressed behaviour. It was decided to move the deceased to an older adult mental health ward, which was secure, in an attempt to provide her with a more therapeutic environment.

In the days preceding the deceased's admission to hospital she was sleep deprived and not drinking or eating adequately, while stressed over her dissatisfaction with the outcome of their recent move and her perceived inability to make things neat and tidy. This had continued for a number of days and would have depleted her ability to compensate for ongoing stressors to her system. Despite sedation in the emergency department which provided her some relief by way of sleep, the deceased remained resistant to intervention on the ward and a decision was made to confirm her involuntary status and provide her with intramuscular injection of medication. This required the combined efforts of all nursing staff available on the ward in the presence of a medical registrar.

While close physical observations were not practical or safe on the ward for someone with the deceased's presentation the deceased was visually observed until it was considered she was asleep and physical observations could be safely conducted. The deceased was found to be unresponsive and a medical emergency was called. The MET arrived and commenced aggressive resuscitation, unsuccessfully.

Expert evidence was heard in an attempt to clarify contributors to the deceased's death. Overall it was considered toxicology did not contribute to her death, there being almost no sedating drugs in her system at the time of her death. A respiratory physician did not believe hypoventilation had contributed to the death due to the deceased's biochemistry at the time

of her arrest, but did consider her sleep apnoea predisposed her to sudden cardiac death. This related to all the physiological factors surrounding the deceased's presentation leading up to her death. The Deputy State Coroner was satisfied that the deceased was experiencing a prolonged period of extreme mental unwellness which depleted her physiological reserves, and was satisfied the deceased experienced a sudden malignant arrhythmia due to all the circumstances, both clinical and psychiatric, and died.

The Deputy State Coroner was satisfied that the deceased was at risk of sudden cardiac death regardless of the level of monitoring applied, and that it was more likely the death of the deceased was a sudden acute event, rather than a prolonged deterioration.

The Deputy State Coroner made one recommendation addressed to the provision of mental health observation units for appropriate transition of mental health patients with high clinical risk factors for sudden death.

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

Robin David MACARTNEY
Inquest held in Perth 14 May 2019, investigation finalised 24 May 2019

Mr Robin David Macartney (the deceased) died on 13 July 2016 at Bethesda Hospital. The cause of death was bronchopneumonia in a man receiving terminal palliative care for metastatic carcinoma of the colon. The Coroner found the manner of death was by natural causes. He was 62 years of age.

Immediately before death the deceased was a "person held in care" under section 3 of the *Coroners Act 1996* because he was a 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 inquest focused on the care provided to the deceased while he was a prisoner, as well as on the circumstances of his death.

On 12 December 2006 following a colonoscopy at Royal Perth Hospital, the deceased was diagnosed with metastatic sigmoid colon cancer. Surgery was recommended, but the deceased refused, believing that God would cure him. On 19 February 2007, the deceased signed a medical escort waiver declining to attend an appointment at Royal Perth Hospital. Despite reviews by the medical officers at Casuarina Prison, the deceased continued to refuse surgery.

On 4 April 2007 the deceased was reviewed by a psychiatrist who determined the deceased was competent to make decisions about his medical treatment and the deceased did not have a mental illness or cognitive impairment. By the end of 2008 the deceased's cancer had progressed. After being assured that he would not be required to wear leg restraints during any hospital admission, the deceased agreed to have surgery to address his cancer. Following surgery, the deceased was seen by numerous specialists and in 2010, secondary tumours (metastases) were detected in his lungs. These were treated with good effect by radiotherapy. A lesion was found in the deceased's liver and this was treated successfully by chemotherapy in July 2015.

On 5 January 2016, the deceased was admitted to Royal Perth Hospital with a history of falls and confusion. Tests showed he had metastases in his brain. The deceased underwent brain surgery to remove the tumours. On 25 May 2016 the deceased was admitted to Fiona Stanley Hospital and a CT scan of his brain showed further metastases. After treatment he was transferred to St John of God Murdoch Community Hospice on 3 June 2016. After a few days he was assessed as not requiring hospice care and was returned to the infirmary at Casuarina Prison on 9 June 2016. The deceased had falls in the infirmary on the 15 and 27 June 2016, despite being provided with various aids and a commode.

On 1 July 2016 the deceased was found in the corner of his room in the infirmary and was taken to Fiona Stanley Hospital. On admission he was found to have fractured his right upper arm bone (humerus) and after treatment he was admitted to the hospice at Bethesda Hospital. He remained in the hospice until his death on 13 July 2016.

Having regard to all of the circumstances of the deceased's case, the Coroner found that the supervision, treatment and care provided to the deceased during his incarceration was reasonable and appropriate.

The Coroner did not make any recommendation.

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

Colin George GRAHAM
Inquest held in Perth 21 August 2018, investigation finalised 31 May 2019

Mr Colin George Graham (the deceased) died on 24 January 2016 at St John of God Hospice, Murdoch Drive, Murdoch. The cause of death was disseminated malignancy – known non-small cell carcinoma of lung. The State Coroner found the manner of death was by natural causes. He was 56 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 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 was a heavy smoker and had developed severe emphysema and chronic obstructive pulmonary disease. In 2012 he was diagnosed with lung cancer.

The deceased had regular medical assessments during his incarceration and on 6 November 2014, while still at Acacia Prison, he was assessed as no longer being fit for work, and he was identified as a terminally ill prisoner due to his severe underlying lung disease and carcinoma of the right lung.

On 7 May 2015 the deceased was transferred to Casuarina Prison infirmary due to his compromised health, and he continued to reside at the infirmary for additional treatment and care. By November 2015 following regular assessments, it was noted following a CT scan at Fiona Stanley Hospital that the deceased displayed new symptoms suggestive of brain metastases. He was offered admission for consideration of radiotherapy or chemotherapy palliative treatment, but he declined admission expressing a wish for hospice care and palliation only. He accepted steroid medication for symptomatic treatment and was medically assessed as having capacity to refuse treatment.

In early January 2016, the deceased was diagnosed with renal metastases. Over this period he was frequently transferred from Casuarina infirmary to Fiona Stanley Hospital for treatment, then returned to the infirmary. On 11 January 2016 the deceased was re-admitted to Fiona Stanley Hospital for palliative care. Permission for removal of his restraints was granted on 12 January 2016. On 20 January 2016 the deceased was conveyed to St John of God Murdoch Community Hospice for terminal palliative care where his deterioration continued and he died.

The State Coroner found the deceased's mental and physical health needs were managed and treated to a high standard while in the care and custody of the Department of Justice.

The State Coroner did not make any recommendations.

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

Aurelio Monterlegre CRUZ
Inquest held in Perth 8 February 2019, investigation finalised 31 May 2019

Mr Aurelio Monterlegre Cruz (the deceased) died on 11 December 2016 at Fiona Stanley Hospital. The cause of death was bronchopneumonia complicating terminal palliative care in an elderly man with chronic renal failure, ischaemic heart disease and cerebral atrophy. The Coroner found the manner of death was by natural causes. He was 81 years of age.

Immediately before death the deceased was a "person held in care" under section 3 of the *Coroners Act 1996* because he was a 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 Hakea Prison.

The deceased was first sentenced on 17 January 2003 to a term of 4 years' immediate imprisonment with eligibility for parole. While serving this term of imprisonment the deceased was seen at the prison medical centre predominantly for monitoring of his diabetes, blood pressure and asthma. Some testing suggested his diabetes was poorly controlled and his renal function was slightly impaired. He also underwent surgery in September 2003 for a disc extrusion in his neck. He was released after two years in prison on parole and attended his local medical facilities. His renal function remained impaired and his diabetic control and blood pressure fluctuated. In January 2008 he developed congestive heart failure. By the end of June 2014 the deceased's renal function had deteriorated further.

In 2015 the deceased was convicted for a second time and returned to custody. He was eventually moved to the Casuarina Prison Infirmary due to his multiple health conditions. The deceased was treated for various medical complaints from February 2015 until he presented at Fiona Stanley Hospital Emergency Department on 7 December 2016 under the care of the Nephrology Dialysis Department. The deceased was diagnosed with end stage renal failure, uraemic encephalopathy, hypercalcaemia and urinary retention. The deceased declined dialysis treatment and was given palliative care until his death. The deceased died in the early hours of 11 December 2016.

The Coroner found the deceased's treatment, supervision and care were of an appropriate standard.

The Coroner did not make any recommendation.

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

Malcolm Patrick O'DRISCOLL
Inquest held in Perth 30 May 2019, investigation finalised 19 June 2019

Mr Malcolm Patrick O'Driscoll (the deceased) died on 15 April 2017 at Acacia Prison. The cause of death was from acute myocardial infarction on a background of atherosclerotic cardiovascular disease. The Coroner found the manner of death was by natural causes. He was 66 years of age.

Immediately before death the deceased was a "person held in care" under section 3 of the *Coroners Act 1996* because he was a 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.

The deceased had a complex medical history including heart disease and vascular disease and he attended numerous medical and specialist appointments with respect to his conditions. The deceased was housed in the assisted care unit at Acacia Prison which is designed to provide additional help to prisoners unable to cope in mainstream cells. Prisoners in the unit are subject to regular checks. The deceased was last seen at 4.15 am on 15 April 2017 and seemed fine. At about 6.25 am, the deceased was found unresponsive in his cell. A medical emergency was called but despite the efforts of custodial and nursing staff, the deceased could not be revived. The deceased was declared dead by St John Ambulance officers at 7.03 am.

The Coroner heard evidence that the deceased had multiple and serious health conditions that predisposed him to a premature death. During his incarceration he was seen by prison medical staff and an external specialist on numerous occasions with respect to his complex medical issues, and was surgically treated for his conditions. He was seen by the prison doctor on 10 April 2017 when he reported feeling well. There was no evidence that in the days leading up to his death, the deceased had complained of feeling unwell and his death appeared to have been unexpected.

Having regard to all of the circumstances of the deceased's incarceration, the Coroner was satisfied that the supervision, treatment and care provided to the deceased was reasonable and appropriate.

The Coroner did not make any recommendation.

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