OFFICE

of the

STATE CORONER

for

WESTERN AUSTRALIA

ANNUAL REPORT

2020-2021

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
11th floor, Dumas House
2 Havelock Street
WEST PERTH WA 6005

Dear Attorney

ANNUAL REPORT 2020-2021

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, 2021.

Yours sincerely

R V C FOGLIANI
STATE CORONER

30 September 2021

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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 2020/21 are outlined below:

- Backlog of cases increased from 483 as at 30 June 2020 to 810 as at 30 June 2021.
    - Of those 810 backlog cases:
        - 81 were backlog inquest cases.
        - 627 were cases where no further finalisations were possible at the Coroner's Court as at 30 June 2021 because the coroner was awaiting completion of aspects of the coronial investigation by external entities.
        - 102 cases were pending analysis at the Coroner's Court before finalisation.
    - 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 1994 investigations were finalised in 2020/21:
        - 1937 finalised by administrative finding of which 704 (36%) were backlog cases.
        - 57 finalised by inquest of which 55 (96%) were backlog cases at the time of completion and 47 were mandated inquests.
        - 1235 (62%) of the cases finalised were under 12 months old.
        - 759 (38%) of the cases finalised were over 12 months old.
    - The number of inquests finalised decreased from 100 in 2019/20 to 57 in 2020/21. Some inquests were vacated and needed to be re-listed during 2020/21 due to COVID-19. Further, the higher figure of 100 was due in large part to the finalisation of 44 Long Term Missing Persons inquests in 2019/20 made possible by the allocation of an additional coroner (0.5 FTE) to address the concentrated referral of these matters.
    - The total number of administrative findings finalised decreased from 2637 in 2019/20 to 1937 in 2020/21; this is compared to 2231 in 2018/19 compared to 2259 in 2017/18 compared to 2366 in 2016/17. A contributor to the decrease in administrative findings finalisations was a reduction in the number of completed investigation reports submitted to the coroner.
    - The number of total cases on hand over 24 months old decreased slightly to 7.6% in 2020/21, compared to 7.9% in 2019/20 compared to 7.19% in 2018/19, compared to 6.6% in 2017/18, compared to 6.4% in 2016/17.

- Reports of deaths to the coroner increased to 2942 in 2020/21 compared to 2573 in 2019/20, compared to 2452 in 2018/19, compared to 2291 in 2017/18, compared to 2422 in 2016/17. The number of deaths reported remains high with an increase of 369 from 2019/20 or 14%.

- The number of cases on hand was 3117 at 30 June 2021 compared to, 2067 at 30 June 2020 compared to 2280 at 30 June 2019 compared to 2127 at 30 June 2018, compared to 2173 at 30 June 2017.

- The number of death certificates received in 2020/21 was 1425 compared to 1129 in 2019/20, compared to 1458 in 2018/19 compared to 1280 in 2017/18 compared to 1174 in 2016/17. 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, at 5856 in 2020/21, compared to 10304 in 2019/20, compared to 10239 in 2018/19, compared to 10781 in 2017/18, compared to 11241 in 2016/17. An outline of the reasons for this change appears later in this report at pages 22 to 24.

- The number of objections received to the performance of post mortem examinations for the purpose of investigating deaths increased to 475 in 2020/21 compared to 447 for 2019/20 compared to 386 for 2018/19 compared to 320 in 2017/18 compared to 319 in 2016/17.

- The number of non-invasive post mortem examinations was 787, compared to 247 in 2019/20, compared to 273 in 2018/19, compared to 261 for 2017/18 and 227 in 2016/17.

- 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. With the benefit of two full financial years, this has resulted in 600 findings being completed under s 19A in 2020/21, compared with 647 findings completed in 2019/20. There were 242 findings completed under s 25(1A) in 2020/21, compared with 267 findings in 2019/20.

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 2021 (2020/21).

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 s 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 s 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 1937 administrative findings finalised by coroners in the 2020/21 year comprising 97% 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 57 inquests finalised by coroners in the 2020/21 year comprising approximately 3% 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 2020/21 year: The Backlog of coronial cases, Coronial Case Management System, Reform, Restructure and CT Scanner.

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 2021 the overall backlog stood at 810. The backlog for which the Coroner's Court remained responsible stood at 183 (being 81 inquest cases and 102 cases pending analysis at the court).

A total of 627 backlog cases were not able to be progressed by the Coroner's Court because the Coroner's Court was awaiting the completion of investigations by external entities.

The older cases are not necessarily 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

Following the implementation of the Integrated Court Management System (ICMS) on 10 February 2020 at the Coroner's Court, with the benefit of a full financial year, the court was able to continue its progress towards a fully electronic case management file.

This has allowed the court at Perth to provide expedited assistance to regional locations through real-time file transfers and the subsequent completion of coronial investigations.

The next phase of electronic case management will involve the expanded use of electronic documents, orders and authorisations that have been enabled through amendments to the *Coroners Regulations 1997*.

The court is also working towards facilitating the electronic receipt of documents from a number of external entities that provide investigation services early in 2022 calendar year, through the enhancement of the eCourts Portal.

This is part of a process of continual improvement. The ICMS allows for a broader access to file records, so that multiple functions may be carried out on the one matter. It also enhances search capabilities to assist with retrieval of records and responses to queries.

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 ss 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. With the benefit of two full financial years, this has resulted in 600 findings being completed under s 19A and 242 findings under s 25 (1A) for 2020/21, compared with 647 findings completed under s 19A and 242 findings under s 25(1A) for 2019/20.

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

Internal Restructure

An internal review into the structure of the Coroner's Court was completed in 2019 and resulted in an adapted structure being implemented in stages including throughout this reporting year.

The adapted structure aims to ensure that there is better utilisation of existing resources and reduction in the duplication of functions. It is expected that it will lead to officers undertaking duties that are comparable with their classification level.

CT Scanner

On 5 June 2019 the Attorney General, Hon Mr John Quigley MLA attended the official inauguration of the 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 and I thank the Attorney General for his support.

The range of cases that may be more efficaciously progressed under the reform process has been 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.

I acknowledge the efforts of PathWest in supporting the usage of the CT scanner, developing processes and their continued expertise in this area.

The number of CT scans performed over the course of the financial year followed the general trend of reportable deaths, averaging 247 scans being performed per month.

For the financial year ended 30 June 2021, a total of 2960 CT scans were performed which is an increase of 819 CT scans from the previous year, or 38%. This increase may be attributed to an

increase in the number of reportable deaths, and greater experience and familiarity in utilising the CT scanner to support non-invasive post mortem examinations.

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

Under s 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 57 investigations finalised by inquest in the past financial year and of those, a total of 47, being 82%, comprised investigations where an inquest was mandated by law.

The 47 mandated inquests were finalised by coroners in the following categories and these are described below:

- 19 mandated inquests in relation to persons held in care immediately before death;
- 9 mandated inquests in relation to the suspected deaths of missing persons;
- 17 mandated inquests where it appeared that the death was caused, or contributed to, by an action of the police force;
- 1 mandated inquest in relation to a person held in care immediately before death and also where it appeared that the death was caused or contributed to by an action of the police force; and
- 1 mandated inquest directed by the State Coroner under s 22(1)(e) *Coroners Act 1996*.

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

In the past financial year there were 20 investigations of deaths of persons held in care finalised by mandated inquest. Of those:

- 7 investigations were finalised by inquest in respect of deaths of persons held in custody under the *Prisons Act* 1981;
- 9 investigations were finalised by inquest in respect of a child who was the subject of a protection order under the *Children and Community Services Act 2004*;
- 3 investigations were finalised by inquest in respect of the death of an involuntary patient within the meaning of the *Mental Health Act* 1996;
- 1 investigation was finalised by inquest in respect of the death of a person who was the subject of a custody order under the *Criminal Law (Mentally Impaired Accused Act 1996).*

In respect of all of the 20 investigations of deaths of persons held in care finalised by mandated inquest this past reporting year, the coroner was required under s 25(3) of the Coroners Act to comment on the quality of the supervision, treatment and care of the person while in that care. In 4 cases, the coroner expressed concern about aspects of supervision, treatment and/or care (Child RM; Child LDW; Anderson, J and Dugan, S).

Under s 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. Tables of the 20 investigations into deaths of persons held in care that were finalised by inquest in the past financial year (Tables L and O) appear at pages 34 and 38 to 39 of this report. Following those Tables, at pages 40 to 69 are the specific reports on the deaths of each person held in care.

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

There were a total of 18 inquests in this category :

- 17 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; and
- One investigation was 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 and where the deceased was a child who was the subject of a protection order under the *Children and Community Services Act 2004.*

In 14 instances, the coroner found that the police did not cause or contribute to the death. In 2 instances, the coroner found the police in effect caused the death but were acting lawfully and/or reasonably or their actions were justified by the circumstances (Stacey, H and Kneale, J). In 2 instances the coroner found actions or omissions by police contributed to the death (Green, D and Thorsager, J).

The Tables of the 18 investigations (Tables K and L) appear at pages 33 to 34 of this Report.

(c) Mandated inquests – suspected deaths

There were 9 investigations into the suspected deaths of missing persons 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 s 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 9 investigations (Table N) appears at page 36 of this Report.

(d) Mandated inquests – s 22(1)(e)

An inquest becomes mandated when the State Coroner so directs under s 22(1)(e) of the Coroners Act.

During this reporting year, 1 inquest (FINN, S) that was the subject of a s 22(1)(e) direction, was finalised.

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

Under s 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 s 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 s 24(1) of the Coroners Act. Of the 57 investigations finalised by inquest in the past financial year, a total of 10, being approximately 18%, comprised investigations where the inquest was discretionary.

A Table of all of the investigations that were finalised by inquest appears at pages 29 to 34 of this Report. The mandated inquests are marked as such, leaving the remainder on that Table, a total of 10, as the discretionary inquests.

The Coronial Counselling Service

Under s 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 range of services provided by the Coronial Counselling Service and statistical information on work output is set out at page 22 to 24 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 4% 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 selected 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 112 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 25 to 26 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 Sarah Linton, Coroner Michael Jenkin and Coroner Philip Urquhart. Their application and dedication reflects their strong commitment to their important service to the community through the coronial system.

This reporting year saw the retirement of Deputy State Coroner Barry King. I thank him for his dedicated service to the Western Australian coronial system over many years.

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

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, neuropathologists 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 2020/21 Annual Report of the Office of the State Coroner.

R V C FOGLIANI
STATE CORONER

Office Structure

An internal review into the structure of the Coroner's Court was completed in 2019 and resulted in an adapted structure being implemented in 2020/21. The new structure continues to operate with 23 full time employees. The restructure aims to ensure that there is better utilisation of existing resources and reduction of duplication of functions, and will lead to officers undertaking duties that are comparable with their classification level.

The Coroner's Court of WA comprises the State Coroner, Deputy State Coroner, two Coroners and 23 FTE.

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 x 2
Coroner x 2	Registry Manager	
Counsel Assisting x 3	Assistant Registry Officer	
Listings Manager	Resource and Administration Officer	
Chambers Administrator	Findings Clerk x 2	
Customer Service Officer x 3	Customer Service Officer x 5	

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 s 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 s 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 s 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 the Registry Manager (Coroner's Registrar), 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 2942 reportable deaths were reported to the coroner for full investigation in the past financial year and 1994 cases were completed representing a clearance rate of 68%.

With regard to the 1994 cases completed in the past reporting year the breakdown is as follows:

- 1937 – the number of investigations finalised by administrative finding, of which 704 (36%) were backlog cases, and

- 57 - the number of investigations finalised by inquest, of which 55 (96%) 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 3117, of which 810 were backlog cases (over 12 months old).

The backlog increased from 483 in 2019/20 to 810 in 2020/21. The number of cases where no further finalisations were possible as at 30 June 2021 because the coroner was awaiting completion of aspects of the coronial investigation by external entities increased from 297 in 2019/20 to 627 in 2020/21.

Of the 810 backlog cases, 81 were backlog inquest cases.

The increase in the number of cases where no further finalisations were possible was contributed to by :

- Other resourcing commitments in policing due to COVID-19; and

- The need to await completion of reports from external agencies.

The following Tables provide an overview of the work of the Coroner's Court in the 20120/21 year.

Table B – Overview of Work

CASES RECEIVED	*PERTH*	*COUNTRY*	*TOTAL*
Full Investigation	**2160**	**782**	**2942**
Death Certificates	**1425**	**n/a**	**1425**

CASES COMPLETED	*PERTH*	*COUNTRY*	*TOTAL*
Finalised by Inquiry	**1321**	**616**	**1937**
Finalised by Inquest	**45**	**12**	**57**
TOTALS	**1366**	**678**	**1994**

BACKLOG	*PERTH*	*COUNTRY*	*TOTAL*
	671	**139**	**810**

CASES ON HAND	*PERTH*	*COUNTRY*	*TOTAL*
	2447	**670**	**3117**

FINALISATION RATIO		
Finalised by Inquiry	**97%**	**1937**
Finalised by Inquest	**3%**	**57**

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% (1235) of files were closed in under 12 months and 38% (759) of files were over 12 months old at closure (i.e. backlog files).

	INQUIRY		INQUEST	
TIMELINES	***PERTH***	***COUNTRY***	***PERTH***	***COUNTRY***
< 3 mths	**73**	**122**	**0**	**0**
3-6 mths	**343**	**147**	**1**	**0**
6-12 mths	**385**	**163**	**1**	**0**
12-18 mths	**338**	**105**	**1**	**0**
18-24 mths	**119**	**37**	**5**	**1**
>24 mths	**63**	**42**	**37**	**11**
TOTALS	**1321**	**616**	**45**	**12**

Table D – Deaths reported and cases completed

Table D below shows the total number of deaths reported and cases completed during the 2020/21 year for Perth and Regional WA.

TOTAL NUMBER OF DEATHS REPORTED TO THE CORONER			
Death certificates			1425
Metropolitan deaths	2160		
Regional deaths	782		
• **Albany**		128	
• **Broome**		49	
• **Bunbury**		263	
• **Carnarvon**		36	
• **Islands**		0	
• **Geraldton**		82	
• **Kalgoorlie**		79	
• **Kununurra**		15	
• **Northam**		71	
• **Port Hedland**		59	
TOTAL NUMBER OF REPORTABLE DEATHS	2942		
CASES COMPLETED	**PERTH**	**COUNTRY**	**TOTAL**
Finalised by Inquiry	1321	616	1937
Finalised by Inquest	45	12	57
TOTALS	1366	628	1994

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	*2016-2017*	*2017-2018*	*2018-2019*	*2019-2020*	*2020-21*
Accident	700	811	830	663	455
Misadventure	61	40	25	33	19
Natural Causes	1039	908	868	506	298
No Jurisdiction	7	4	5	6	7
Open Finding	139	116	81	124	69
Self Defence	3	3	2	2	1
Suicide	420	392	421	434	252
Unlawful Homicide	53	48	61	55	51
Section 19A (Natural Causes)	N/A	N/A	N/A	647(a)	600 (a)
Section 25 (1A)	N/A	N/A	N/A	267(b)	242 (b)
TOTALS	**2422**	**2322**	**2293**	**2737**	**1994**

Section 19A and s 25 (1A) findings were only in effect for a full financial year as from 2019/20, and continue to be separately accounted for in 2020/21.

(a) These are findings where the coroner determines under s 19A that the death is due to natural causes and therefore is not required to continue to investigate.

(b) These are findings where the coroner determines under s 25(1A) that there is no public interest in finding how death occurred.

Post Mortem Examinations

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

Under s 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 s 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 s 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 s 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 Coronial Investigation Squad of the Western Australia Police, seven days a week from 7 am to midnight, or directly with the 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 internal 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 over-ruling the objection to the senior next of kin. Also, under s 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 objection 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. In the 2019/20 year, 2141 CT scans were performed, and in the 2020/21 year 2960 CT scans, were performed.

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 22 to 24 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 2020/21 year and the outcomes:

REPORTED DEATHS	
Immediate post mortem	**56**
No objection to post mortem	**2365**
Objection to post mortem	**475**
No post mortem conducted (missing person, death certificate originally issued or by order of coroner etc)	**46**
NUMBER OF REPORTED DEATHS	**2942**

OBJECTIONS TO POST MORTEMS	
Objection accepted	**417**
Objection withdrawn	**47**
Objection Overruled	**11**
TOTAL OBJECTIONS TO POST MORTEMS	**475**

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, the State Coroner has implemented the scheme to support the forensic pathologist's use of the least invasive procedures that are available and appropriate in the conduct of post mortem examinations.

The process 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	**828**
PRE approved by Coroner	**787**
PRE not approved by Coroner - Full PM	**37**
PRE rejected by next of kin - Full PM	**4**
PRE approved – Partial PM	**0**
TOTAL PATHOLOGIST RECOMMENDED EXTERNAL	**828**

Coronial Counselling Service Functions

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

The CCS provides information, counselling, and liaison to those affected by sudden death and to numerous government and non-government agencies. The CCS is available Monday to Friday during normal court business hours.

During the 2020/21 year, CCS was staffed by a Senior Coronial Counsellor and two Coronial counsellors. There were some staffing challenges during the 2020/21 year with various coverage and backfilling strategies explored but not always achieved. The result has been an average of two staff for the majority of the year and a focus on priority work.

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 and 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 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 have been able to attend at the State Mortuary to support next of kin if they require that support when viewing their loved one. It is envisaged that the support for the next of kin when viewing a loved one will in future be undertaken by the PathWest Bereavement Liaison Officer located at the State Mortuary.

The Perth based CCS provides its services in a variety of ways including in person and by telephone. In addition CCS has continued to maintain productive links with counselling services available in regional and/or remote areas to ensure locally based services are available. At any time that WA has been in lockdown due to COVID-19, CCS has continued to provide service delivery to its clients, with the majority of work undertaken by telephone contact.

During the 2020/21 year, it became apparent that CCS was providing a number of client services which were not necessarily counselling specific. It also became apparent that the majority of contacts coming into the Coroner's Court were referred to CCS in the first instance, even for routine client queries. This process identified that many of the client contacts could be

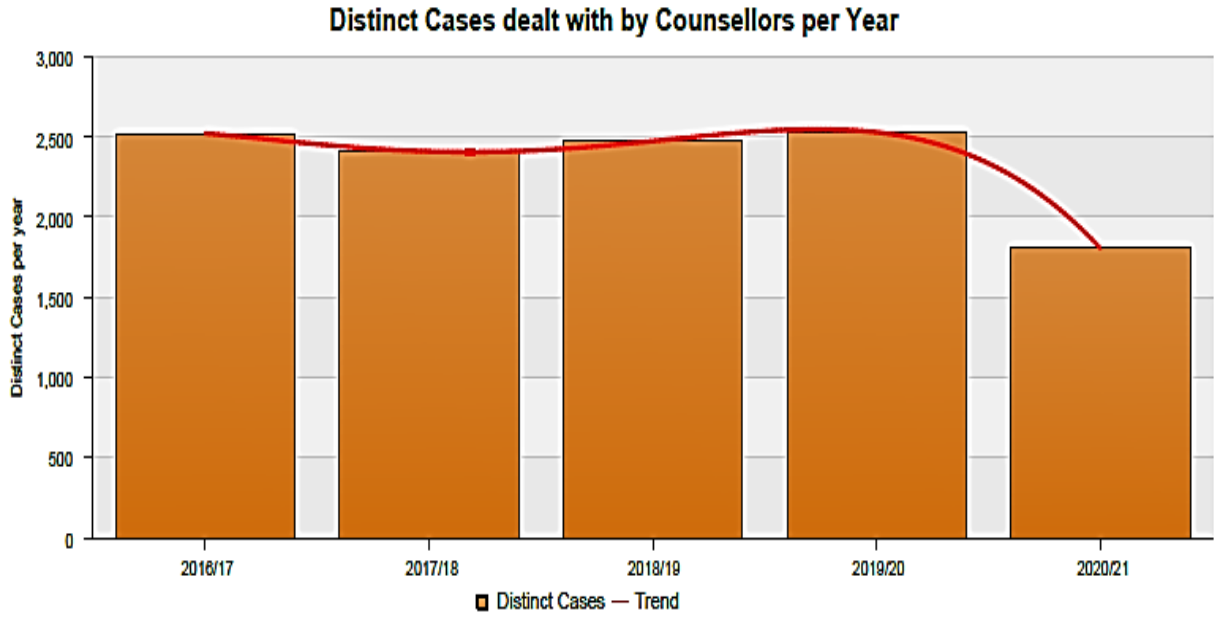
addressed by other staff in the Coroner's Court, especially when a client does not specifically seek the assistance of the counselling service. Following some consultation within the broader Coroner's Court context, a number of client contacts were redirected to other business areas in the Registry based on the nature of the query.

This change awaits review and reporting back to the State Coroner.

Table H – Counselling Statistics

The following two graphs show the total number of individual cases that CCS has been involved in where the number of cases worked on per year has been counted only once over the entire year.

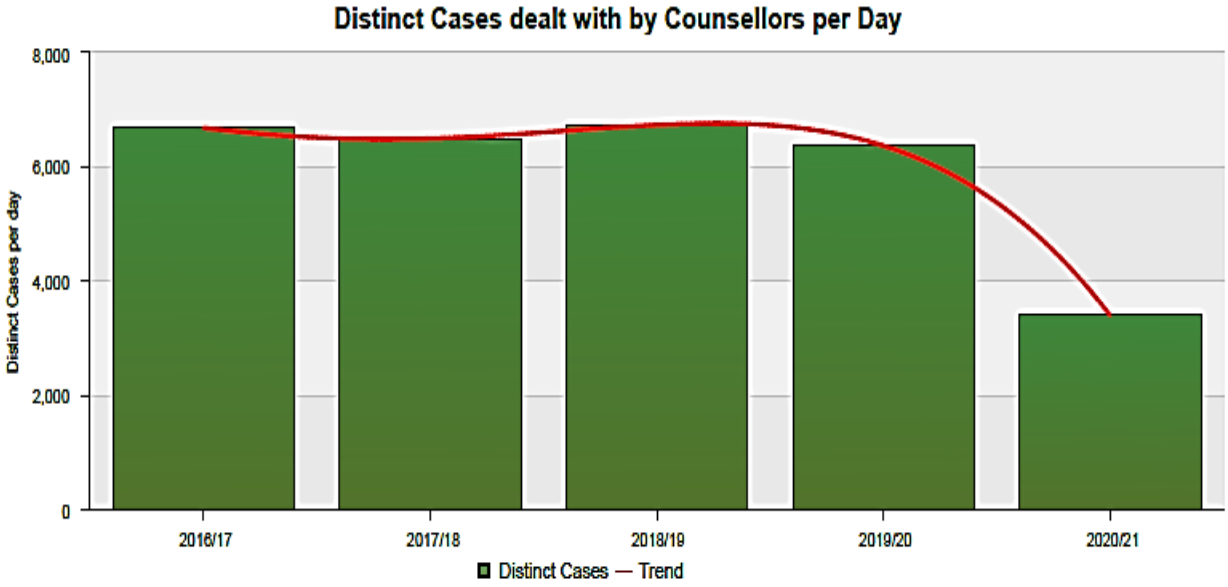
The Coroner's Court has had 2942 reportable deaths over 2020/21. The CCS have had contact with next of kin in respect of 1804 distinct cases over the year though not necessarily all related to the 2942 reportable deaths within 2021.



Cases dealt with by Counsellors

	2016/17	2017/18	2018/19	2019/20	2020/21	% Change
Distinct cases dealt with by counsellors per year	2,519	2,407	2,471	2,526	1,804	-28.6%

As CCS service delivery would usually involve more than one contact per case, the following graph demonstrates the total number of cases when each case is counted per working day rather than per year. This figure better demonstrates the volume of client contacts that is undertaken by CCS, and indicates that for each case there is at least more than one contact.



	2016/17	2017/18	2018/19	2019/20	2020/21	% Change
Distinct cases dealt with by counsellors per day	6,675	6,489	6,724	6,361	3,401	-46.5%

The difference in the figures relating to contact type and distinct cases is not unexpected due the staffing challenges that CCS experienced over 2021/21, and the redirection of activities from CCS to other business areas in the Registry of the Coroner's Court.

Coronial Ethics Committee Functions

The Coronial Ethics Committee was established pursuant to s 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 2020/21 year are as follows:

Dr Jodi White	Chairperson, Forensic Pathologist, PathWest
Mr Michael Jenkin	Coroner (Until 4 February 2021)
Mr Philip Urquhart	Coroner (From 4 February 2021 to Current)
Associate Professor Jennet Harvey	Member with relevant research experience
Ms Simone Brand	Member with counselling background
Ms Christine Pittman	Member with counselling background
Ms Natalie Gately	Member with relevant research experience
Dr Thomas Hitchcock	Member with relevant research experience
Dr Rosemary Coates	Member with relevant research experience

Upon rotation, one of the counsel assisting acts as Secretary to the Committee who is supported administratively by one support officer.

Owing to the effects of COVID-19 and lockdown restrictions, the April 2021 meeting was conducted remotely via Microsoft Teams so the work of the Committee was not interrupted.

This past reporting year, the Coronial Ethics Committee met five times in person and one time remotely 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	15	0	3
Number of Requests for renewal Considered	**Number of Requests for renewal Approved**	**Number of Requests for renewal Not approved**	**Deferred**
6	6	0	0
Number of Amendments	**Number of amendments approved**	**Number of amendments not approved**	
54	54	0	0

Principal Registrar and Coroner's Registrars

Coroner's registrars are appointed under s 12 of the Coroners Act and one of the registrars performs the functions of the Principal Registrar. All registrars have statutory functions under s 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 s 10 of the Coroners Act. Over the 2020/21 year there have been 13 coroner's registrars at the Coroner's Court in Perth, all of whom exercise a range of specific delegated functions under s 10 of the Coroners Act. 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 s 10 and statutory functions under s 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 coroner's registrars also 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 is the coroner's registrar who 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 represents the State Coroner at a variety of internal and external forums/meetings. On behalf of the State Coroner, the Principal Registrar liaises with members of the Western Australia Police Force, officers from the Department of Health, the Western Australian Ombudsman, and numerous other government and non-government agencies. The Principal Registrar also provides education and information sessions to health and legal professionals and other organisations as part of a community education strategy.

Counsel Assisting the Coroner

The Coroner's Court has three counsel who assist the coroners in the conduct of their inquests. They are legal practitioners, and they appear in court as counsel assisting the coroner. They present the evidence and examine and cross examine witnesses. They prepare the matters for inquest, compile the coroner's brief, and they liaise with family members and interested persons in the lead up to the inquest, to ensure that all relevant material is placed before the coroner at

the inquest, in order to assist the coroner in making the findings under s 25(1) of the Coroners Act. They also assist the coroner in formulating recommendations to prevent deaths arising in similar circumstances. Where necessary or desirable, they are involved in the gathering of further evidence for the coroner.

The counsel assisting also provide advice and recommendation to the State Coroner upon statutory requests for inquests (under s 24 of the Coroners Act), that may be made by any person.

On rotation, one of the counsel assisting acts as the Secretary to the Ethics Committee.

Police Assisting the Coroner

The four police officers attached to the Coroner's Court serve as a critical link between the Coroner's Court and the Coronial Investigation Squad of the Western Australia Police Force.

There is one sergeant, and a senior constable who carry out the dual roles of appearing as assistant to the coroner at inquests and providing assistance to the coroners in the preparation of matters for inquest, including the gathering of evidence where necessary and serving of summonses.

There are two constables, one senior constable and one first class constable, who continue to operate the triage system, that supports the making of determinations by the coroner under s 19A and s 25(1A) of the Coroners Act. One officer is responsible for the metropolitan area and one for regional Western Australia. This system seeks to fast track certain types of cases, to bring about an early resolution for the families. It is noted that a total of 842 such findings were completed by the coroners over this reporting year.

Together the police officers attached to the court assist the coroners in the exercise of the statutory functions under the Coroners Act, including the gathering of further evidence (including under compulsion), the provision of supplemental information from governmental departments and medical and technical experts, assistance to coroners in other jurisdictions at the direction of the State Coroner, liaison with inquest witnesses, and quality assurance on the more complicated reports to the coroner. They provide assistance to all police officers state-wide, in relation to advice and guidance on matters of coronial procedure, jurisdiction and authority, to generate consistency in approach to coronial investigations.

Table J – Total number of inquests

Table J below shows the total number of inquests **(57)** finalised in the 2020/21. An inquest is finalised when the coroner signs the inquest finding.

Name of Deceased	*Date of Death*	*Inquest Date*	*Finding*	*Date of finding*
***CHILD SJC**	20/11/2017	18/6/2020	Natural Causes	1/7/2020
***CHILD RM**	16/4/2017	8/6/2020	Suicide	16/7/2020
^KICKETT Desmond Richard	29/6/2018	10/7/2020	Accident	31/7/2020
<FINN Shirley June	On or about 22/6/1975	29/8/2017 11, 13, 14/9/2017 18, 19, 20/9/2017 20 to 24/11/2017 27 to 30/11/2017 11 to 14/12/2017 20/12/2017 23 to 27/7/2018 1, 3 4/4/2019	Unlawful Homicide	4/8/2020
***KELL** Stephen Michael	26/4/2015	21 to 22/8/2019	Natural Causes	6/82020
^ARMSTRONG Amy-Lee **^EADES** Kyrone Terrance **^DE AGRELA** Ashley Scott	2/12/2015	3/4/2019	Unlawful Homicide	7/8/2020
WINDIE Susan Jessica Elsie	29/10/2016	23/10/2019	Natural Causes	13/8/2020
^STACEY Hyden Paul	27/5/2018	22/7/2020	Homicide by way of self defence	18/8/2020
JACKSON Jessica Lesley	14/11/2017	10 to 13/3/2020	Misadventure	18/8/2020
***JACOVIC** Dragan	22/6/2018	30/6/2020	Natural Causes	3/9/2020
PARAONE Malakai Matiu Ward	26/8/2016	5 to 7/11/2019	Natural Causes	4/9/2020
#TITTUMS Carlton Scott	On or about 27/7/2011	3/9/2020	Open Finding	10/9/2020

Name of Deceased	*Date of Death*	*Inquest Date*	*Finding*	*Date of finding*
***PT**	27/1/2016	9 to 11/9/2019	Natural Causes	23/9/2020
#JENSEN Jorn Jesper	On or about 25/6/2017	23 to 24/9/2020	Open Finding	2/10/2020
***JM**	9/7/2015	11/12/2019	Natural Causes	7/10/2020
***LEESE** Wayne Frederick	20/5/2018	8/9/2020	Natural Causes	8/10/2020
^POLO Joshua David	23/3/2017	26, 28/11/2019	Unlawful Homicide	8/10/2020
^DEMEZA Bradley Ronald Andrew	9/5/2018	5/2/2020	Misadventure	8/10/2020
RUYZING Renee Desiree	14/6/2015	20/9/2018 28/2/2020	Natural Causes	19/10/2020
^KOSTOVSKI Jordana	29/7/2017	11 to 12/8/2020	Suicide	22/10/2020
^KEY Andrew John	11/8/2015	17 to 18/9/2019	Suicide	4/11/2020
***PURNELL** Damien	20/8/2018	15 to 16/9/2020	Natural Causes	4/11/2020
#YORK Paul Clifford	On or about 10/11/2011	4/2/2020	Open Finding	5/11/2020
^CONGDON Levi Shane Clement	13/11/2017	19/5/2020	Misadventure	19/11/2020
^ROBERTSON Trent Nathaniel	27/5/2018	22/11/2019	Accident	20/11/2020
#JOHNSON Gary Lance	5/1/2020	17/11/2020	Misadventure	20/11/2020
^GRAHAM Jamie Alan	On or about 11/4/2019	27 to 28/10/2020	Accident	25/11/2020
BEMBRIDGE Tahlia Rose	2/10/2015	5 to 6/8/2019 2/9/2019 19/2/2020	Natural Causes	1/12/2020
***SHARPE** Simon John	30/6/2017	14/10/2020	Natural Causes	2/12/2020
***DINAH** Macker Joseph	1/10/2018	29/10/2020	Natural Causes	3/12/2020

Name of Deceased	*Date of Death*	*Inquest Date*	*Finding*	*Date of finding*
***ANDERSON** Jordan Robert	23/3/2017	26 to 28/8/2020	Suicide	22/12/2020
***^CHILD JM**	1/4/2017	9 TO 11/12/2019	Unlawful Homicide	30/12/2020
^GREEN Dennis Michael	7/12/2017	15 to 16/6/2020	Accident	30/12/2020
***BABY JDU**	5/3/2018	12/10/2020	Natural Causes	4/1/2021
^KNEALE Jamie Douglas	30/3/2016	10/12/2020	Accident	13/1/2021
***DUGAN** Stuart William	4/5/2017	22/9/2020	Natural Causes	15/1/2021
BABY H	28/5/2017	19 TO 21/10/2020	Unlawful Homicide	9/2/2021
***CHILD T**	13/7/2019	4/2/2021	Natural Causes	11/2/2021
#MPANZA Conrad Thon	7/1/1978	5/2/2021	Open Finding	15/2/2021
***SOLLY** Stephen Craig	11/3/2018	4/3/2021	Natural Causes	8/3/3021
#LAWSON Jason Marcus	On or about 11/12/2003	23/3/2021	Open Finding	25/3/2021
CHURCHILL Cyril	13/11/2017	17 to 18/2/2021	Misadventure	26/3/2021
FJ	13/11/2016	8 to 10/9/2020	Suicide	25/3/2021
#POULSON Sebastian	On or about 19/10/2014	9/4/2021	Open Finding	13/4/2021
^CANDELORO Davide	3/7/2019	16/12/2020	Accident	20/4/2021
***CHILD LDW**	14/8/2017	12 to 13/1/2021	Open Finding	16/4/2021
***BOND** Andre Walter	14/5/2019	6/5/2021	Acident	10/5/2021
#KEHLET Jennie Anne **KEHLET** Raymond Keith	On or about 22/3/2015	6 to 10/1/2020 13-17/1/2020 11/2/2020	Open Finding Homicide	10/5/2021
^CROFT Janice Ann	21/1/2019	10 to 12/11/2020	Suicide	11/5/2021
#McGOWAN Glenyce Rae	On or about 10/12/1975	11/5/2021	Open Finding	28/5/2021
***CHILD AM**	4/9/2015	26 to 27/11/2020	Natural Causes	22/6/2021

Name of Deceased	*Date of Death*	*Inquest Date*	*Finding*	*Date of finding*
BABY AM	14/9/2017	24 to 25/11/2020	Natural Causes	10/6/2021
^THORSAGER Jordan Alexander	14/2/2019	14 to 15/4/2021	Unlawful Homicide	27/6/2021
***WALSH** Samuel Mark	Between 5 and 12/10/2014	12/5/2021	Suicide	29/6/2021

 # = Missing person (9)

*** = Person held in care (19)**

^ = Death that appeared to be caused or contributed to by any action of a member of the police force (17)

^* = Person held in care and death that appeared to be caused or contributed to by any action of a member of the police force (1)

< = Directed by the State Coroner under s 22(1)(e) Coroners Act 1996 (1)

The balance of the matters listed (10) were discretionary inquests

Total Inquests : 57

I acknowledge the considerable assistance rendered by the Coroner's Court's Listing Manager and my Administrator 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, M, N and O) 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 s 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 **(17)** finalised in 2020/21 year into deaths that appeared to be caused, or contributed to, by any action of a member of the Police Force.

Name of Deceased	*Date of Death*	*Inquest Date*	*Finding*	*Date of finding*
KICKETT Desmond Richard	29/6/2018	10/7/2020	Accident [Police Pursuit}	31/7/2020
ARMSTRONG Amy-Lee **EADES** Kyrone Terrance **DE AGRELA** Ashley Scott	2/12/2015	3/4/2019	Unlawful Homicide [Police Pursuit}	7/8/2020
STACEY Hyden Paul	27/5/2018	22/7/2020	Homicide by way of self defence [Police Shooting]	18/8/2020
POLO Joshua David	23/3/2017	26, 28/11/2019	Unlawful Homicide [Police Pursuit]	8/10/2020
DEMEZA Bradley Ronald Andrew	9/5/2018	5/2/2020	Misadventure [Police Pursuit]	8/10/2020
KOSTOVSKI Jordana	29/7/2017	11 to 12/8/2020	Suicide [Police Pursuit]	22/10/2020
KEY Andrew John	11/8/2015	17 to 18/9/2019	Suicide [Police Response]	4/11/2020
CONGDON Levi Shane Clement	13/11/2017	19/5/2020	Misadventure [Police Response]	19/11/2020
ROBERTSON Trent Nathaniel	27/5/2018	22/11/2019	Accident [Police Pursuit]	20/11/2020
GRAHAM Jamie Alan	On or about 11/4/2019	27 to 28/10/2020	Accident [Police Response]	25/11/2020
GREEN Dennis Michael	7/12/2017	15 to 16/6/2020	Accident	30/12/2020

Name of Deceased	*Date of Death*	*Inquest Date*	*Finding*	*Date of finding*
KNEALE Jamie Douglas	30/3/2016	10/12/2020	Accident [Police Pursuit]	13/1/2021
CANDELORO Davide	3/7/2019	16/12/2020	Accident [Police Pursuit]	20/4/2021
CROFT Janice Ann	21/1/2019	10 to 12/11/2020	Suicide [Police Response]	11/5/2021
THORSAGER Jordan Alexander	14/2/2019	14 to 15/4/2021	Unlawful Homicide [Police Pursuit}	27/6/2021

In 14 instances, the coroner found that the police did not cause or contribute to the death. In 2 instances, the coroner found the police in effect caused the death but were acting lawfully and reasonably or their actions were justified by the circumstances (Stacey, H and Kneale, J).

In 2 instances the coroner found actions or omissions by police contributed to the death (Green, D and Thorsager, J).

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

Table L – Death of a child immediately before death was held in care in circumstances where it appeared that death was caused or contributed to by any action of a member of the police force

In 1 case, the coroner held an inquest into the death of a child who immediately before death was held in care (within the meaning of s 22(1)(a) of the Coroners Act), in circumstances where it appeared that the death was caused, or contributed to, by any action of a member of the Police Force

Table L below shows this inquest.

Name of Deceased	*Date of Death*	*Inquest Date*	*Finding*	*Date of finding*
CHILD JM	1/4/2017	9 to 11/12/2019	Unlawful Homicide [Police Pursuit]	30/12/2020

The coroner found that police did not cause or contribute to the death.

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

INQUEST DIRECTED BY STATE CORONER

Under s 22(1)(e) of the Coroners Act, an inquest becomes mandated where the State Coroner so directs.

Table M – Inquest directed by State Coroner

Table M below shows the inquest directed by the State Coroner.

Name of Deceased	*Date of Death*	*Inquest Date*	*Finding*	*Date of finding*
FINN Shirley June	On or about 22/6/1975	29/8/2017 11, 13, 14/9/2017 18, 19, 20/9/2017 20 to 24/11/2017 27 to 30/11/2017 11 to 14/12/2017 20/12/2017 23 to 27/7/2018 1, 3 4/4/2019	Unlawful Homicide [Police Response}	4/8/2020

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

SUSPECTED DEATHS

Under s 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 N – Missing Persons

Table N below shows the number of inquests (**9**) finalised in 2020/21 year into suspected deaths.

Name of Deceased	*Date of Death*	*Inquest Date*	*Finding*	*Date of finding*
TITTUMS Carlton Scott	On or about 27/7/2011	3/9/2020	Open Finding	10/9/2020
JENSEN Jorn Jesper	On or about 25/6/2017	23 to 24/9/2020	Open Finding	2/10/2020
YORK Paul Clifford	On or about 10/11/2011	4/2/2020	Open Finding	5/11/2020
JOHNSON Gary Lance	5/1/2020	17/11/2020	Misadventure	20/11/2020
MPANZA Conrad Thon	7/1/1978	5/2/2021	Open Finding	15/2/2021
LAWSON Jason Marcus	On or about 11/12/2003	23/3/2021	Open Finding	25/3/2021
POULSON Sebastian	On or about 19/10/2014	9/4/2021	Open Finding	13/4/2021
KEHLET Jennie Anne	On or about 22/3/2015	6 to 10/1/2020 13-17/1/2020 11/2/2020	Open Finding Homicide	10/5/2021
McGOWAN Glenyce Rae	On or about 10/12/1975	11/5/2021	Open Finding	28/5/2021

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

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

PERSONS HELD IN CARE

Under s 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 s 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 ss 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* s 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 O overleaf shows the number of inquests **(19)** finalised in 2020/21 into deaths of persons held in care.

In accordance with s 27(1) of the Coroners Act, the specific report on the death of each person held in care appears after Table O, together with the report into the death of Child JM, at Table L, making a total of 20 case reports.

Table O – Persons held in care

Table O below shows the number of inquests (**19**) finalised in 2020/21 year into Deaths of persons held in care.

Name of Deceased	*Date of Death*	*Inquest Date*	*Finding*	*Date of finding*
CHILD SJC	20/11/2017	18/6/2020	Natural Causes	1/7/2020
CHILD RM	16/4/2017	8/6/2020	Suicide	16/7/2020
KELL Stephen Michael	26/4/2015	21 to 22/8/2019	Natural Causes	6/82020
JACOVIC Dragan	22/6/2018	30/6/2020	Natural Causes	3/9/2020
PT	27/1/2016	9 to 11/9/2019	Natural Causes	23/9/2020
JM	9/7/2015	11/12/2019	Natural Causes	7/10/2020
LEESE Wayne Frederick	20/5/2018	8/9/2020	Natural Causes	8/10/2020
PURNELL Damien	20/8/2018	15 to 16/9/2020	Natural Causes	4/11/2020
SHARPE Simon John	30/6/2017	14/10/2020	Natural Causes	2/12/2020
DINAH Macker Joseph	1/10/2018	29/10/2020	Natural Causes	3/12/2020
ANDERSON Jordan Robert	23/3/2017	26 to 28/8/2020	Suicide	22/12/2020
BABY JDU	5/3/2018	12/10/2020	Natural Causes	4/1/2021
DUGAN Stuart William	4/5/2017	22/9/2020	Natural Causes	15/1/2021
***CHILD T**	13/7/2019	4/2/2021	Natural Causes	11/2/2021
***SOLLY** Stephen Craig	11/3/2018	4/3/2021	Natural Causes	8/3/3021
***CHILD LDW**	14/8/2017	12 to 13/1/2021	Open Finding	16/4/2021
***BOND** Andre Walter	14/5/2019	6/5/2021	Accident	10/5/2021

Name of Deceased	*Date of Death*	*Inquest Date*	*Finding*	*Date of finding*
***CHILD AM**	4/9/2015	26 to 27/11/2020	Natural Causes	22/6/2021
***WALSH** Samuel Mark	Between 5 and 12/10/2014	12/5/2021	Suicide	29/6/2021

In 4 cases, the coroner expressed concern about aspects of supervision, treatment and/or care (Child AM, Child LDW, Anderson, J and Dugan, S).

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

The individual cases summaries follow.

Child SJC (Name Subject to Suppression Order)
Inquest held in Perth 18 June 2020, investigation finalised 1 July 2020

Child SJC died on 20 November 2017 at 201 Hay Street, Perth. She was 2 years and 5 months old. The Coroner found that the cause of death was complications relating to metastatic neuroblastoma. The Coroner found the manner of death was natural causes.

Immediately before her death, Child SJC was a "person held in care" under the *Coroners Act 1996* because she had been taken into care by the Director General of the Department of Communities, pursuant to the *Children and Community Services Act 2004*.

Child SJC was diagnosed with Stage IV high-risk neuroblastoma, an aggressive form of cancer that predominantly affects young children. The primary tumour was located in her right adrenal gland with secondary tumours identified in her liver and skull and limbs.

Child SJC was treated with chemotherapy, radiotherapy and biotherapy. Initially, she appeared to respond well to treatment and was discharged home on 10 January 2017. However, on 7 August 2017, a routine scan detected a right-sided pelvic mass along with secondary tumours in her right groin, the back of her right knee and in her the lymph system, skeletal bones and bone marrow.

Child SJC was treated with chemotherapy and immunotherapy, using Dinutuximab Beta, but scans on 6 October 2017, showed that she was not responding and her tumours continued to progress. She underwent palliative radiotherapy, primarily to control pain.

On 7 November 2017, new tumours were discovered in Child SJC's jaw and below her ear and on 15 November 2017, tumour deposits were also identified at her jaw and knee.

On 17 November 2017 a Silver Chain nurse felt that Child SJC's condition had deteriorated significantly, and that death was imminent. Child SJC died, surrounded by family, on 20 November 2017.

The Coroner found that the supervision, treatment and care provided by the Department of Communities to Child SJC was of an acceptable standard.

The Coroner made one recommendation directed towards the availability and placement of the monoclonal antibody Dinutuximab on the Pharmaceutical Benefits Scheme.

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

Child RM (Name Subject to Suppression Order)
Inquest held in Perth 9 June 2020, investigation finalised 16 July 2020

Child RM died on 16 April 2017 at Sir Charles Gairdner Hospital. The cause of death was ligature compression of the neck (hanging). The Coroner found the manner of death was suicide. She was 17 years old.

Immediately before her death, Child RM was a "person held in care" under the *Coroners Act 1996* because she had been taken into care by the Director General of the Department of Communities, pursuant to the *Children and Community Services Act 2004*.

Child RM first came to the attention of the Department of Communities (Department) in 2000 when she was 12 months old. In 2001, following an assessment by the Department, Child RM was placed in foster care for two weeks before being returned to her parents. In 2007 the Department was concerned about the inability of either of Child RM's parents to provide her with a safe environment, and Child RM was removed from her parent's care on 8 September 2008. On 4 March 2009, a Protection Order (until age 18 years) was made in the Children's Court of WA.

Between 2008 and 2011, Child RM was the subject of numerous out-of-home placements organised by the Department, including general carers, family carers and residential homes. When there placements broke down, largely as a result of her increasingly challenging behaviours, Child RM would "self-select" placements and return to live with one of other of her parents, neither of whom were approved carers.

Between late 2011 and early 2012, the Department investigated allegations of harm with respect to Child RM including historical sexual abuse and emotional and physical harm.

Between 2012 and January 2017, Child RM was admitted to the Kath French Secure Care Centre (Centre)on four separate occasions. Secure care is a placement of last resort used in exceptional circumstances where a child is at imminent and substantial risk of harm and there are no other suitable alternative placements. The Centre operates as a therapeutic, trauma-informed facility and offers a time limited "circuit breaker" designed to stablise the child's behaviours.

During the time she was in secure care, Child RM abstained from drinking alcohol and attended medical appointments as well as education sessions about self-care and safety. After leaving the Centre for the last time, Child RM was referred to an agency in Midland, that services young people at significant risk of homelessness. Although Child RM briefly engaged with the services she was offered for a few days, in February 2017, she absconded and went to live with her father.

During the evening of 15 April 2017, Child RM was in Northbridge with her boyfriend, mother and others. Child RM had been drinking alcohol with some other girls and she and her boyfriend had been arguing. Child RM's boyfriend was arrested for disorderly conduct and after his release, he and Child RM caught a bus that was heading in the direction of her father's home.

At about 10.30 pm, Child RM and her boyfriend were on the bus when they began fighting. The driver stopped the bus and called Transperth security. As Child RM's boyfriend got off, he spat into the driver's face and was subsequently arrested by police who attended the scene.

Child RM was initially agitated when her boyfriend was arrested but she later appeared to calm down and seemed happy. She declined repeated offers from police to take her to her father's home, saying she had lived on the streets before and preferred to walk. When police left the scene at about 11.15 pm, they had no concerns for her welfare.

At about 11.35 pm, on 15 April 2017, two men in the front garden of a home on Ravenswood Drive Mirrabooka, noticed a silhouette, in a tree near the corner of Arun Place and Ravenswood Drive. The men approached the figure and realised it was a female with a ligature around her neck, hanging from the tree. One of the men called emergency services and shortly afterwards, police arrived at the scene.

Police removed the ligature from around her neck and started CPR. Ambulance officers arrived and took over resuscitation efforts. Child RM was taken to Sir Charles Gairdner Hospital, but she could not be revived.

The Coroner was satisfied that the Department of Communities did what it could to address Child RM's complex needs but found that they missed opportunities where additional support from the Department may have altered Child RM's life. The Coroner made three recommendations directed towards improving placements for young persons with complex needs.

The Finding and responses to those recommendations are on the website of the Coroner's Court of Western Australia.

Stephen Michael KELL
Inquest held in Perth 21-22 August 2019, investigation finalised 6 August 2020

Mr Stephen Michael Kell (Mr Kell) died on 26 April 2015 at Graylands Hospital. The cause of death was acute vomit aspiration in a man with acute large intestine obstruction (severe megacolon) and clozapine-induced intestinal hypomotility. The State Coroner found the manner of death was misadventure. He was 35 years old.

Immediately before his death Mr Kell was a "person held in care" under the *Coroners Act 1996* because he was subject to an Involuntary Patient Order made under the *Mental Health Act 2014* (WA). Mr Kell had a history of chronic paranoid schizophrenia. He responded poorly to clinical treatments and his condition was exacerbated by his ongoing abuse of illicit substances. When unwell he could become aggressive.

Mr Kell's first contact with mental health services was in 2001 when he was 22 years old. By the time of his death he had been a long term involuntary patient at Graylands Hospital, due to the difficulties of managing his mental illness in the community. One of the medications which had been prescribed to Mr Kell over his years of treatment was the antipsychotic medication clozapine. During his June 2012 admission to Graylands Hospital it was noted that his clozapine had been ceased due to a low white blood cell count which is a known side-effect that is monitored. However, his mental health deteriorated from the time of cessation.

In May 2013 after consultation with him, his family, and compliance with the manufacturer's processes, Mr Kell was recommenced on clozapine, together with medication to boost his white blood cell count. Improvement in his mental state was subsequently noted.

Mr Kell's involuntary patient status was last reviewed in March 2015, and it was continued for a further three months. In the month leading up to his death his behaviour and mental state were noted to fluctuate, and he appeared to be responding to unseen stimuli. It was thought his behaviour was consistent with varying levels of psychosis, possibly as a result of substance abuse. He was restricted to escorted ground access due to these concerns.

On 24 April 2015, two days before his death Mr Kell was granted a day's leave in the company of his father. They spent the day together and his father returned Mr Kell to Graylands Hospital in the afternoon. Later that evening a psychiatric review was done. Mr Kell appeared drowsy and he was not able to speak coherently. He denied using drugs.

The next day Mr Kell was recorded as displaying bizarre behaviour and it was posited amongst his clinicians that he had smoked synthetic cannabis. Later that evening when approached for his medications, he was unable to communicate, he had a tremor and an elevated heart rate. His tremor and heart rate subsequently settled, but later that night his condition rapidly deteriorated. He became unresponsive, and despite resuscitation attempts he remained in asystole and died in the early hours of 26 April 2015.

The State Coroner found the supervision, treatment and care that Mr Kell received was appropriate to his needs, and that reasonable efforts were made to balance ethe need for his detention under the Mental Health Act for his safety and the importance of fostering interaction with his family and the community.

The State Coroner concluded that Mr Kell's deterioration immediately before death was sudden and unexpected and that he did not display symptoms consistent with intestine obstruction or mobility issues. The State Coroner found that the effects of the clozapine contributed to Mr Kell's death. The State Coroner found Mr Kell died by way of misadventure.

The State Coroner made two recommendations directed towards highlighting the potentially fatal risk of clozapine-induced gastrointestinal hypomobility on the boxed warnings for this medication.

The Finding and responses to those recommendations are on the website of the Coroner's Court of Western Australia

Dragan JACOVIC
Inquest held in Perth 30 June 2020, investigation finalised 3 September 2020

Mr Dragan Jacovic (Mr Jacovic) died on 22 June 2018 in Acacia Prison. The cause of death was ischaemic heart disease. The Deputy State Coroner found the manner of death was natural causes. He was 63 years old.

Immediately before death Mr Jacovic 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.

Mr Jacovic had been incarcerated for a lengthy period. Over the years, Mr Jacovic received medical treatment for various physical and mental health issues, including severe cardiac disease. From 12 to 21 June 2018 Mr Jacovic received treatment in hospital for heart failure with acute pulmonary oedema, a heart attack, community acquired pneumonia and acute on chronic renal failure. He was not suitable for surgery.

After he was stabilised, Mr Jacovic was discharged from hospital back to prison on 21 June 2018 with a plan for further cardiology follow-up as an outpatient and management of his heart failure with medication and fluid restriction.

On his return to prison, Mr Jacovic was admitted to the medical ward of Acacia Prison, where he appeared settled overnight and the following morning.

At about midday on 22 June 2018, Mr Jacovic was found unresponsive in his cell. Despite resuscitation attempts by nursing and medical staff, he could not be revived.

The Deputy State Coroner was satisfied that the supervision, treatment and care provided to Mr Jacovic while he was incarcerated was of a high level.

The Deputy State Coroner did not make any recommendations.

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

PT (Name Subject to Suppression Order)
Inquest held in Perth 9-11 September 2019, investigation finalised 23 September 2020

PT died on 27 January 2016 at St John of God Hospital, Midland. The cause of death was aspiration of vomit, with microscopic early pneumonia, in a child with a history of cerebral palsy and epilepsy. The State Coroner found the manner of death was by natural causes. PT was 5 years old.

Immediately before death PT was a "person held in care" under the *Coroners Act 1996* because she was in the care of the Director General of the Department of Communities, under a Protection Order pursuant to the *Children and Community Services Act 2004*.

PT had been taken into care when she was five months old afters suffering catastrophic injuries that were considered to be non-accidental.

On 17 November 2015, approximately two months prior to her death, PT had her last appointment at PMH with her usual paediatrician. She had received Botox injections in her legs two months previously for spasticity of her leg muscles. The consultation documented the need for additional equipment for school and home including standing frames, shower chairs, hoist sling and hospital bed. The next scheduled appointment was planned for April 2016.

PT had been medically stable in the two months prior to her death. Over the 72 hours prior to her death, PT's foster carers had noted that she had been a little more lethargic, and that she was sleeping more than usual.

On 26 January 2016 at approximately 8.00 pm, PT's foster carer put her to bed, positioned lying on her side. She had been sleeping in a new bed, which included a change from sleeping on her right shoulder to sleeping on her left shoulder. Just before 10.30 pm that night PT was found by her foster carer lying with her face down onto the pillow. She was not breathing and a pulse could not be found. CPR was commenced and SJA was called.

PT's foster carers continued with CPR for approximately 25 minutes prior to the arrival of SJA, which was staffed by volunteer ambulance officers. The volunteer ambulance officers continued CPR for a further 20 minutes before ceasing. Two minutes after CPR was ceased the Community Paramedic arrived who advised that CPR should be re-started as a defibrillator had not been attached and without analysis of PT's cardiac rhythm, they did not meet the criteria for termination of CPR.

CPR was continued along with an insertion of a largyngeal mask and interosseous access. Adrenalin and fluid resuscitation was given. Cardiac rhythm remained in asystole. SJA conveyed PT to St John of God Hospital, Midland arriving at 12.14 am on 27 January 2016. Further resuscitation efforts were continued without success.

The State Coroner was satisfied that DCP made decisions in respect of PT's supervision, treatment and care that were appropriate and reasonable, based upon the information they had at the material time. The State Coroner was also satisfied that PT's foster parents diligently attended to her numerous medical and allied health appointments, and that during her period in care, clinicians appropriately reported back to DCP.

The State Coroner made one recommendation directed towards the inclusion of a duty to report injuries in a non-ambulant child.

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

JM (Name Subject to Suppression Order)
Inquest held in Perth 11 December 2019, investigation finalised 7 October 2020

JM died on 9 July 2015 at Fitzroy Crossing Hospital. The cause of death was dehydration complicating diarrhoea (aetiology unknown). The Deputy State Coroner found the manner of death was natural causes. JM was 10 weeks old.

Immediately before death JM was a "person held in care" under the *Coroners Act 1996* because he was placed in the care of the Director General of the Department of Communities, pursuant to the *Children and Community Services Act 2004*.

JM lived with family carers (foster parents) in a community out from Fitzroy Crossing. He was developing well with no health or care concerns. JM received his first immunisations on 1 July 2015. On 8 July 2015, he became unwell with fever and diarrhoea. His foster parents provided paracetamol, fluids and constant care overnight, but his condition deteriorated.

At 5.00 am on 9 July 2015, JM's foster father stated that JM was crying and his hands were cold, but his chest felt normal. He could not settle, so his foster father woke up JM's foster mother and called the Fitzroy Crossing Hospital. He was told to bring JM to the hospital, but JM's foster father said that he could not get to the hospital any time soon. He was then told that JM could see a doctor who would be visiting the community at about 8.00 am.

At about 7.30 am, JM's foster father noticed that JM was not breathing properly and not responding to him, so he called the hospital again. He was told that an ambulance would be sent and asked to drive JM towards Fitzroy Crossing to meet the ambulance part-way.

JM's foster parents got into their car with JM and had travelled about 3 km when they noticed that JM was not breathing. They then administered CPR as they continued to travel to meet the ambulance. At 8.25 am they met up with the ambulance. JM was non-responsive.

JM was placed in the back of the ambulance and CPR was administered for the journey to the Fitzroy Crossing Hospital. Upon arrival at the hospital, JM was taken straight into the resuscitation room where doctors and nurses were waiting and a paediatrician was on video link from Broome, but JM could not be revived.

The Deputy State Coroner found the quality of the supervision, treatment and care that JM received while in care was reasonable and appropriate in the circumstances and was satisfied that the improvements have been implemented in the community in which JM lived (including education on signs and symptoms of dehydration) will reduce the likelihood of another child dying in similar circumstances.

The Deputy State Coroner made no recommendations.

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

Wayne Frederick LEESE
Inquest held in Perth 8 September 2019, investigation finalised 8 October 2019

Mr Wayne Frederick Leese (Mr Leese) died on 20 May 2018 at St John of God Hospital, Midland. The cause of death was from complications, including hepatic encephalopathy, pneumonia and multi-organ failure, of hepatitis C and hepatocellular carcinoma. The Coroner found the manner of death was natural causes. He was 54 years old.

Immediately before his death Mr Leese 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. Mr Leese was in custody at Acacia Prison.

At about 3.00 pm on 4 May 2018, Mr Leese was attending a class in the prison education centre at Acacia Prison. After getting up from his chair, he appeared unsteady. He then fell and bumped his head on a wall and began having a seizure for approximately 20 seconds. Mr Lees was assisted to a chair and a Code Blue was called over the prison's radio.

Prison medical staff attended and he was taken to the prison's medical centre. Mr Leese appeared disorientated and his abdomen was distended. A decision was made to convey him to hospital and an ambulance arrived at 3.48 pm and transferred him to St John of God Hospital Midland at 4.10 pm.

Mr Leese arrived at the emergency department and was subsequently diagnosed with encephalopathy, secondary to decompensated liver disease, ascites due to liver failure, urinary retention, chest infection and sepsis. Blood tests showed a very low sodium level and a CT scan showed early cerebral oedema. He was intubated and admitted to the intensive care unit in an induced coma. A nasogastric tube was inserted and he was administered intravenous sodium chloride, antibiotics, enemas to treat encephalopathy, albumin and diuretics to manage his ascites.

On 6 May 2018, a further diagnosis of a right-lower lobe chest infection was made and this was treated with intravenous antibiotics. The following day Mr Leese's left-lower lobe collapsed and on 8 May 2018, following a review by a hepatologist, Mr Leese's poor prognosis was confirmed.

On 11 May 2018, Mr Leese was reviewed by surgeons who diagnosed ileus and it was recommended that conservative treatment should commence due to his comorbidities. Mr Leese was commenced on total parenteral nutrition. On 15 May 2018, Mr Leese developed signs of left-sided pneumonia and his condition was upgraded to critical.

On 18 May 2018, a CT scan showed an occlusive thrombosis of the superior mesenteric and portal veins and ascites thickening of the small bowel. Mr Leese had developed clinical illness myopathy with peripheral wasting of muscles and mutli-organ failure. The decision was taken, in conjunction with his family, to move Mr Leese into the palliative care unit where he died on 20 May 2018.

The Coroner was satisfied Mr Leese's supervision, treatment and care which he received whilst in custody was reasonable

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

Damien PURNELL
Inquest held in Perth 15-16 September 2020, investigation finalised 4 November 2020

Mr Damien Purnell (Mr Purnell) died on 20 August 2018 at Bunbury Regional Prison. The cause of death was organ failure following cardiorespiratory impairment, in a man with arteriosclerotic heart disease and recent use of drugs. The Coroner found the manner of death was natural causes. He was 37 years old.

Immediately before death Mr Purnell 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. Mr Purnell was in custody at Bunbury Regional Prison.

Mr Purnell had been housed in a self-care unit cell, with another prisoner for three weeks before his death. On Friday 17 August 2018 Mr Purnell was released from his cell at 7.30 am. He received his usual morning dose of methadone and ate breakfast before being locked back into his cell due to prison staff training commitments. Sometime around 11.00 am, prison staff found Mr Purnell collapsed on his bunk in his cell. He was not breathing, so they commenced CPR and called for an ambulance to attend.

Ambulance paramedics arrived on the scene and took over resuscitation attempts. They managed to get Mr Purnell's circulation back. Once he was stable, he was taken by ambulance to Bunbury Regional Hospital. He remained in hospital thereafter.

On 19 August 2018 Mr Purnell was added to the prison's Terminally Ill Module as a Stage 4 prisoner, indicating his death was considered imminent. On 20 August 2018 Mr Purnell was examined and brain death was confirmed. His death was declared and organ donation was completed with his family's consent.

Evidence indicated Mr Purnell had consumed the synthetic cannabinoid Kronic shortly before his death, and expert evidence supported the conclusion the synthetic cannabinoid played a role in his sudden cardiac event.

Mr Purnell had a long history of polysubstance abuse and had overdosed on several occasions in the past. Although he had a complex mental health history, he received regular mental health reviews while in custody and there was no evidence Mr Purnell had any intention to self-harm during his last prison admission at any time. He had admitted to prison health staff that he had been purchasing medications from other prisoners and had been counselled against it. Mr Purnell managed to access illicit drugs within the prison by an unknown means, in particular the synthetic cannabinoid Kronic.

The Deputy State Coroner found that while locked in his cell on 17 August 2018, Mr Purnell smoked Kronic after taking his prescribed methadone and suffered a cardiac event.

The Deputy State Coroner was satisfied Mr Purnell received a high standard of supervision, treatment and care while being held in the Bunbury Regional Prison.

The Deputy State Coroner did not make any recommendations.

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

Simon John SHARPE
Inquest held in Perth 14 October 2020, investigation finalised 2 December 2020

Mr Simon John Sharpe (Mr Sharpe) died on 30 June 2017 at Fiona Stanley Hospital. The cause of death was non-specific interstitial pneumonia. The Deputy State Coroner found the manner of death was natural causes. He was 45 years old.

Immediately before death Mr Sharpe 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. Mr Sharpe was in custody at Casuarina Prison.

Prior to Mr Sharpe being sentenced and admitted to prison, he was already suffering from a chronic incurable lung condition, known as idiopathic nonspecific interstitial pneumonia. It reduced the capacity of his lungs and reduced his life expectancy. Mr Sharpe took daily medications and required 24 hour oxygen therapy, to help the body overcome the deficiency in the lungs to maintain oxygen levels, and a CPAP machine at night. He had been suffering from the respiratory illness since 2012 and had been receiving a disability pension.

Mr Sharpe was admitted to Casuarina Prison and was initially housed in the infirmary and was reviewed daily by nursing staff. He was given permission to bring in some of his own equipment from home. An oxygen concentrator was installed in his cell for use with a medium sized oxygen cylinder left in his cell, in case the concentrator failed overnight, and small oxygen cylinders were available for use when mobilising.

On 8 February 2016 Mr Sharpe was registered as a terminally ill prisoner, Stage 1, given his reduced life expectancy.

On 27 June 2017 prison nursing staff responded to a cell call and found Mr Sharpe in respiratory distress in his cell with very low oxygen levels, despite being on 8L/min oxygen. He was transferred to Fiona Stanley Hospital by ambulance. Mr Sharpe's condition continued to deteriorate. His resuscitation status was noted as not for resuscitation in the event of sudden deterioration.

On 30 June 2017, Mr Sharpe's treating doctor decided observations should be ceased and the aim would be to keep Mr Sharpe comfortable. At 6.40 pm Mr Sharpe was found not to be breathing and his death was confirmed.

The Deputy State Coroner was satisfied that Mr Sharpe received an appropriate standard of supervision, treatment and care while in prison. His death was due to the progression of his known respiratory condition and was not preventable.

The Deputy State Coroner did not make any recommendations.

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

Macker Joseph DINAH
Inquest held in Perth 29 October 2020, investigation finalised 3 December 2020

Mr Macker Joseph Dinah (Mr Dinah) died on 1 October 2018 at Casuarina Prison. The cause of death was atherosclerotic heart disease in a man with diabetes mellitus. The Deputy State Coroner found the manner of death was natural causes. He was 57 years old.

Immediately before death Mr Dinah 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. Mr Dinah was in custody at Casuarina Prison.

Mr Dinah was born in Wagin on 30 May 1961 and was a victim of the Stolen Generation. Despite being taken away from his family when he was a child, he still retained close ties to his family for the rest of his life and his siblings remained a close support for him.

Mr Dinah was known to have been suffering significant health issues, including poorly controlled diabetes and complex chronic heart disease. He was generally frail and unwell prior to his death, but at his request he had been moved from the prison infirmary to the mainstream prison population.

Mr Dinah's cell mate woke up around 7.30 to 8.00 am on the morning of 1 October 2018 and made Mr Dinah a cup of tea. Mr Dinah's relative, who was also a prisoner housed in the same unit block, brought Mr Dinah his breakfast. After breakfast, Mr Dinah was pushed in his wheelchair to the medication parade and Mr Dinah visited some other relatives who were also prisoners at Casuarina.

At lunchtime Mr Dinah ate food in his cell with his cell mate. He was reported to be talking for a while and seemed in good spirits before he told his cell mate that he wanted to have a sleep. Mr Dinah was picked up and placed into the bed in the bottom bunk. Mr Dinah's cell mate then left the cell. He returned to wake Mr Dinah up for the afternoon muster at approximately 3.00 pm. He found Mr Dinah still lying in his bunk but he could not be roused. He called for help, prison officers and medical staff attended and Mr Dinah's death was confirmed.

The Deputy State Coroner was satisfied that Mr Dinah received a high standard of care. Unfortunately, due to his severe heart disease, Mr Dinah remained at risk of a sudden cardiac event at any time and, that is what occurred on 1 October 2018.

The Deputy State Coroner did not make any recommendations.

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

Jordan Robert ANDERSON
Inquest held in Perth 26-28 August 2020, investigation finalised 22 December 2020

Mr Jordan Robert Anderson (Mr Anderson) died on 23 March 2017 at Fiona Stanley Hospital. The cause of death was hypoxic brain injury and bronchopneumonia complicating ligature compression of the neck. The Coroner found the manner of death was suicide. He was 23 years old.

Immediately before his death Mr Anderson was a "person held in care" under section 3 of the *Coroners Act 1996* because he was on remand, and pursuant to the *Prisons Act 1981* he was in the custody of the Chief Executive Officer of the Department of Corrective Services. Mr Anderson was in custody at Hakea Prison.

At the time of his death, Mr Anderson had been placed in a specialised unit for disciplinary reasons.

As at 4 March 2017, Mr Anderson was not coping with his confinement. He refused to leave one of the exercise yards in Unit 1 and was verbally abusive towards prison officers. At one point he lit a small fire. He was eventually compliant and was taken to his cell without incident after he was advised his request to be transferred to Casuarina would be considered. He was calm when he was locked in his single cell at approximately 6.30 pm.

A fellow prisoner in the cell opposite Mr Anderson spoke to him on the evening of 4 March 2017 in which Mr Anderson told him about an upsetting phone call and a visit he was expecting which did not take place. Mr Anderson did not indicate he may self-harm.

At a cell check at 10.00 am that night, Mr Anderson was in his cell on his bed and appeared to be asleep. The next check was after midnight on 5 March 2017 and Mr Anderson was observed not to be on his bed. A torch was used to scan the cell and a sheet tied to the single tap located on the right hand side of the cell's basin was seen. After unlocking the medical hatch of the cell door, Mr Anderson was observed sitting on the floor near the basin with the sheet tied around his neck. Mr Anderson did not respond to the prison officer and was not moving.

There was a time lapse from when Mr Anderson was first found to be unresponsive by the prison offer to when his cell door was unlocked. There were further delays before CPR was commenced by prison staff. Though attending ambulance officers were able to achieve a return of circulation and a pulse, Mr Anderson remained in a critical condition and he died at Fiona Stanley Hospital on 23 March 2017.

The Coroner noted that since Mr Anderson's death, steps have been taken by the Department of Justice to prevent the delays in unlocking a cell door and commencing CPR following a self-harm incident by hanging within a prisoner's cell. However, the Coroner noted that more could be done to improve the involvement of prison mental health staff following a prisoner's participation in a critical incident involving violent behaviour or when a prisoner is sent to a specialised unit for disciplinary purposes.

The supervision, treatment and care provided to Mr Anderson by the Department of Justice was reasonable throughout his periods of incarceration, except for the failure by prison staff to unlock his door and then commence CPR within a reasonable time frame on 5 March 2017.

The Coroner made four recommendations directed towards enhancing safety and security and supporting mental health assessments.

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

CHILD JM (Name Subject to Suppression Order)
Inquest held in Perth 9-11 December 2019, investigation finalised 30 December 2020

Child JM (Child JM) died on 1 April 2017 at Royal Perth Hospital. The State Coroner found the cause of death was multiple injuries. The manner of death was unlawful homicide. He was 16 years old.

Immediately before death Child JM was a "person held in care" under the *Coroners Act 1996* because he was in the care of the CEO of the Department of Communities.

In 2010 Child JM had been diagnosed with Attention Deficit Hyperactivity Disorder, Oppositional Defiant Disorder, Unsocialised Conduct Disorder, Post-Traumatic Stress Disorder and specific development disorder of scholastic skills. He was a troubled child with complex emotional and medical needs. Regrettably his conditions were exacerbated by his use of cannabis, alcohol, tobacco and inhalants. As he grew older, his behaviour became increasingly difficult to manage. Concerns were elevated when he began to display self-harming behaviour. The Department of Communities made sustained efforts to provide Child JM with stable and secure environment, but this proved difficult.

On 10 March 2017 the Department of Communities prepared a Care Plan for Child JM in anticipation of his return to live with his mother on a short-term basis pending the exploration of alternative youth accommodation options. Before Child JM died, he was waiting to start full-time employment as an apprentice brick layer, and he appeared to have achieved a measure of stability and purpose in his life. It was noted that numerous department officers, family members and extended family members had over the years tried to help Child JM.

On 1 April 2017, Child JM was a passenger in a motor vehicle that had been stolen during a burglary the day before. The vehicle was being driven by his friend. Police tried to stop the vehicle, and it became involved in a series of Evade Police Intercept Driving incidents. Child JM was in the rear passenger side of the vehicle when it collided with another vehicle resulting in him receiving fatal injuries.

The State Coroner after reviewing the evidence concerning the actions of the involved police officers in all the intercepts was satisfied that police did not cause or contribute to Child JM's death.

The State Coroner was satisfied that the quality of Child JM's supervision, treatment and care while in the care of the Department of Communities was appropriate, though of necessity the outcomes were limited by Child JM's reluctance to engage and his pattern of absconding behaviour. The department made reasonable inquiries and efforts to achieve suitable and stable placements for Child JM, and appropriately took into account his safety and welfare and the desirability of fostering the relationship with his family, in particular his mother.

The State Coroner did not make any recommendations.

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

Baby JDU (Name Subject to Suppression Order)
Inquest held in Perth 12 October 2020, investigation finalised 4 January 2021

Baby JDU (Baby JDU) died on 5 March 2018 at Princess Margaret Hospital. The Coroner found the cause of death was Scimitar syndrome. The manner of death was natural causes. He was 11 weeks old.

Immediately before death, Baby JDU was a "person held in care" under the *Coroners Act 1996* because he was placed in the provisional care and protection of the CEO of the Department of Communities, pursuant to the *Children and Community Services Act 2004.*

The application for provisional protection and care for Baby JDU was made by the Department before his birth, to take effect after his birth. The Coroner considered this was appropriate under the circumstances.

Baby JDU was born on 17 December 2017 at Geraldton Regional Hospital. He was 38 weeks plus 5 days gestation which was considered to be term. Shortly after his birth, he developed respiratory distress and his oxygen levels dropped significantly. A chest X-ray showed that Baby JDU's heart was on the right rather than left side of the chest cavity, which suggested dextrocardia (a rare congenital heart condition in which the heart points to the right). When his respiratory distress continued to deteriorate, Baby JDU was transferred to Princess Margaret Hospital on 18 December 2017.

Despite a range of treatments, including surgery, Baby JDU succumbed to his complications and he died on the morning of 5 March 2018 at the age of 11 weeks.

The Coroner having reviewed all of the evidence, was satisfied that the standard of, supervision, treatment and care that Baby JDU received from the Department was appropriate.

The Coroner did not make any recommendations.

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

Stuart William DUGAN
Inquest held in Perth 22 September 2020, investigation finalised 15 January 2021

Mr Stuart William Dugan (Mr Dugan) died on 22 September 2020 at Kalamunda Hospital Hospice. The cause of death was carcinoma of the lung. The Deputy State Coroner found the manner of death was natural causes. He was 67 years old.

Immediately before death Mr Dugan 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. Mr Dugan was in custody at Acacia Prison prior to being transferred to hospital. He had commenced his sentence on 1 February2010.

Mr Dugan became unwell in early 2017. Following medical investigations, he was diagnosed with advanced inoperable lung cancer in late February 2017. His prognosis was poor and it was estimated he only had weeks to live. Mr Dugan accepted the medical advice to commence palliative management only. The inquest focussed primarily on the late diagnosis of Mr Dugan's terminal condition.

On 9 December 2016 Mr Dugan was reviewed by a prison medical officer after complaining of an intermittent cough with sputum. Mr Dugan had ceased smoking six months earlier. He was prescribed antibiotics, routine blood tests were ordered and a review was planned for four weeks. Mr Dugan was not seen again by health services staff until 31 January 2017, when he was reviewed by a prison nurse. At the time he reported that he had been coughing up blood for the last couple of weeks and was experiencing chest pain. His observations were normal apart from a raised pulse. Mr Dugan undertook various tests but he had not undergone an urgent chest x-ray before his condition seriously deteriorated.

On 19 February 2016, as a result of Mr Dugan being unable to breathe properly and coughing up thick blood stained sputum, it was decided by prison medical staff that Mr Dugan should be transferred by ambulance to hospital. Mr Dugan was diagnosed at St John of God Hospital, Midland with locally advanced inoperable left upper lobe cancer of the lung. He was considered to be a poor surgical candidate given his functional status, his tumour was too big for radiotherapy and medical staff felt he was at that time too weak for chemotherapy. Palliative radiotherapy was considered but was deemed not suitable due to potential damage to lung tissue.

Mr Dugan was discharged from hospital back to Casuarina Prison on 2 March 2017, where he was cared for by nursing staff in the Casuarina Infirmary. The nursing staff expressed concerns that they were not able to manage his care safely there. His welfare was assessed by a prison medical officer who then made arrangements for Mr Dugan to be transferred by ambulance to St John of God Midland Hospice. On 7 March 2017, St John of God Hospice staff wished to discharge Mr Dugan back to the Casuarina Prison Infirmary as they believed he was doing well and was self-caring. When Mr Dugan returned to Casuarina Prison Infirmary, it became immediately apparent to the prison nursing staff

that they did not have the ability to manage his care in the prison and he was not self-caring.

A decision was made to return Mr Dugan to hospital.

On 11 March 2017, Mr Dugan was admitted to Fiona Stanley Hospital. Later arrangements were made to transfer Mr Dugan to Kalamunda Hospice on 6 April 2017 for end of life care. Mr Dugan remained at the hospice and received palliative care until his death on the morning of 4 May 2017.

The Deputy State Coroner found that there were signs that could have alerted health staff to the seriousness of Mr Dugan's medical condition at an earlier stage, and certainly by 31 January 2017. The Deputy State Coroner found the late recognition of the seriousness of Mr Dugan's health situation, did not ultimately affect the outcome, but did adversely affect his level of comfort.

The Deputy State Coroner noted that significant changes had been made at Acacia Prison to its processes and procedures in its health services since Mr Dugan's death. Acacia Prison has implemented a more proactive approach to monitoring "at risk" prisoner's health to ensure that they are monitored and their care escalated quickly when required. There was also more effort to improve monitoring of referrals to specialist services to identify and follow-up delays, and improvements to access to dental services.

The Deputy State Coroner was satisfied that Mr Dugan's death was unlikely to have been preventable even if diagnosed earlier, and accepted that his supervision, treatment and care while in prison was satisfactory.

The Deputy State Coroner made no recommendations.

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

Child T (Name Subject to Suppression Order)
Inquest held in Perth 4 February 2021, investigation finalised 11 February 2021

Child T (Child T) was 2 years old when he died on or about 13 July 2019 in Port Kennedy. The cause of death was pneumonia in association with bronchiolitis. The Coroner found the manner of death was natural causes.

Immediately before death Child T was a "person held in care" under the *Coroners Act 1996* because he had been taken into care by the Director General of the Department of Communities, pursuant to the *Children and Community Services Act 2004*.

Concerns about the welfare of Child T and his sibling were first reported to the Department of Communities in May 2018. A departmental caseworker investigated the concerns, but the case was closed because Child T's paternal grandmother had agreed to provide support. Further concerns about the welfare of the children were reported in July and August 2018, and on 22 August 2018, Child T and his sibling were placed in a refuge with their mother.

After Child T's mother left the refuge on 23 August 2018, and returned to her partner, the Department apprehended Child T and his sibling. They were placed with an experienced foster carer who had an older child of her own and on 12 March 2019, the Children's Court of WA made a Protection Order with respect to the children.

Child T's carer was proactive in attending to his medical needs and Child T was regularly seen by a doctor for standard childhood ailments including gastroenteritis and minor chest infections. When it was realised that there had been an eight-month delay in Child T receiving his 12-month old childhood vaccinations, this was remedied. Child T's doctor did not consider that this delay had placed Child T at any additional risk, nor that the lapse had played any role in Child T's death.

On 12 July 2019, Child T attended day-care centre as usual. During the day, he seemed fine, but when his carer collected him at about 5.30 pm, staff told her that Child T had just started coughing badly. That evening, Child T ate some of his dinner but seemed tired and was still coughing. His carer gave him a standard dose of Children's Panadol and he appeared to settle. She placed Child T on his back in his cot just after 7.30 pm but he rolled onto his stomach, which was his preferred sleeping position.

When the carer woke at about 7.00 am on Saturday 13 July 2019, Child T and his sibling appeared to be asleep. As it was the weekend and Child T had not been well, the carer decided to let the children have a sleep-in. Her former husband arrived at the home at about 11.00 am and sometime later, Child T's sibling woke up. When the carer went to wake Child T just before midday, she found him deceased in his cot.

The Coroner found that Child T received adequate care while in the care of the Department.

The Coroner did not make any recommendation.

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

Stephen Craig SOLLY
Inquest held in Perth 4 March 2021, investigation finalised 8 March 2021

Mr Stephen Craig Solly (Mr Solly) died at Graylands Hospital on 11 March 2018. The cause of death was respiratory failure in a man with lung cancer, chronic obstructive pulmonary disease and pulmonary fibrosis. The Coroner found the manner of death was natural causes. He was 63 years old.

Immediately before death he was a "person held in care" under the *Coroners Act 1996* because he was an involuntary patient who was the subject of an Inpatient Treatment Order made under the *Mental Health Act 2014* (WA).

Mr Solly had been diagnosed with paranoid schizophrenia and organic personality disorder, and more recently with cognitive impairment that was assessed as early onset dementia.

Mr Solly was a heavy smoker and in 2015, he was diagnosed with emphysema and pulmonary fibrosis. A CT scan of Mr Solly's chest in late 2016, showed a new lesion in his lower right lung, widespread emphysema, stable interstitial lung disease and nodules in both lungs. Although he had severely limited lung function, Mr Solly continued to smoke heavily and steadfastly refused to quit, despite frequent episodes of respiratory failure.

It was extremely difficult for Mr Solly's respiratory team to engage him in meaningful discussions about treatment options because of his psychiatric and cognitive issues. Oxygen therapy, which may have helped his symptoms, was not a viable option in Mr Solly case, because he refused to stop smoking. In addition, Mr Solly's aggressive behaviour meant that having an oxygen cylinder on a closed psychiatric ward was an unacceptable risk.

As Mr Solly's physical condition declined, his behaviour became more challenging and he assaulted patients and staff in February and March of 2018. Following discussions with his family, a series of "Not for CPR" forms were prepared.

After he woke up on the morning of 11 March 2018, Mr Solly began shouting and then threw milk at the nursing station on his ward. Although he allowed his vital signs to be recorded at about 9.00 am, he declined a subsequent request to do so. Mr Solly then lay in front of the nursing station and demanded cigarettes, but at about 10.00 am, he allowed himself to be helped into a wheelchair. It was noted that his breathing was laboured and as a nurse was assessing his vital signs, Mr Solly suddenly lost consciousness. He was declared deceased at 10.20 am.

The Coroner found that Mr Solly had received a very good standard of care.

The Coroner did not make any recommendations.

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

CHILD LDW (Name Subject to Suppression Order)
Inquest held in Perth 12-13 January 2021, investigation finalised 16 April 2021

Child LDW (Child LDW) died on 14 August 2017 at Wongan Hills. The Deputy State Coroner found the cause of death was tramadol toxicity. The Deputy State Coroner made an open finding on the manner of death. She was 3 years old.

Immediately before death Child LDW a "person held in care" under the *Coroners Act 1996* because she was placed under the care of the CEO of the Department of Communities, pursuant to the *Children and Community Services Act 2004*.

Child LDW was taken by the Department from her mother's care for safety reasons and was temporarily living with her step-father and siblings. Planning was undertaken to return her to her mother's care at the time of her death.

Child LDW was sighted by her case manager on 20 January 2017, 3 March 2017 and 17 March 2017 for her Quarterly Case Reports and there were no concerns recorded while she was in her step-father's care. Her step-father appeared to be doing the best that he could to care for the children by himself with little support or respite.

In May 2017 Child LDW's step-father had broken his wrist. He also had a pre-existing back injury that was causing him chronic pain. He was prescribed opioid pain relief medications in the form of tramadol capsules to assist with pain management for his wrist and back injury.

On the Saturday of the weekend before her death, Child LDW and her siblings were collected by their maternal grandmother and taken to see their mother for a home visit. Child LDW's step-father asked if the children could stay with their grandmother for a sleepover. She declined as she was concerned they would get into trouble if the Department found out and they might stop allowing the children to visit.

After their contact visit the children returned to their home arriving in the early hours of Sunday morning. Child LDW and one of her siblings appeared to be coming down with a cold. On the Sunday morning Child LDW had breakfast and slept in the lounge on and off throughout the day in front of the heater. Child LDW ate her dinner and then lay on a mattress in the lounge room. At about 7.00 pm Child LDW vomited a small amount and she looked unwell, like she had the flu. Child LDW went back to sleep, but at about 8.30 pm she vomited again. Child LDW then got up and was noticed to be a staggering a little. She then went to the toilet and then to bed.

Child LDW and one of her siblings still appeared to be sick the next morning so it was decided to keep them home for the day and they were left in bed. At 2.00 pm one of the children got up to watch television and Child LDW's step-father went to check on Child LDW. She was wet and floppy when picked up. Child LDW's step-father immediately took her to the hospital, where her death was confirmed shortly after her arrival.

The death was not initially treated as suspicious by the police. However, after the cause of death was determined to be tramadol toxicity, the death prompted the WA Police Homicide Squad to launch a full criminal investigation into the circumstances of Child LDW's death. Child LDW's step-father was interviewed as a suspect as part of that

investigation. At the end of the investigation the police could not exclude the possibility that Child LDW had found the tramadol and taken it herself.

The Deputy State Coroner noted that after a review by the Department it had implemented a range of practice improvements since the Child LDW's death.

The Deputy State Coroner concluded the supervision and care by the Department was below the appropriate standard expected. There were missed red flags that should have prompted a more proactive approach to assessing the step-father's ongoing suitability to care for the children. As a result, there was a missed opportunity to intervene and possibly prevent the death.

The Deputy State Coroner did not make any recommendations.

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

Andre Walter BOND
Inquest held in Perth 6 May 2021, investigation finalised 10 May 2021

Mr Andre Walter Bond (Mr Bond) died at Fiona Stanley Hospital on 14 May 2019. His cause of death was upper airway obsruction (choking) in an obese man with atherosclerotic heart disease and schizophrenia. The Coroner found the manner of death was accident. He was 42 years old.

Immediately before his death, Mr Bond was a "person held in care" under the *Coroners Act 1996* because he was the subject of a Community Treatment Order (CTO) made under the *Mental Health Act 2014.*

Mr Bond had been diagnosed with schizophrenia, schizoaffective disorder, Asperger's syndrome, and bipolar affective disorder. He also had high blood pressure and asthma and was severely obese. He had been in contact with mental health services since 1994.

On 19 February 2019, Mr Bond presented to Fiona Stanley Hospital having been referred there by a community mental health service following inappropriate behaviour towards his GP and threats of arson. He was transferred to the Alma Street Centre as an involuntary patient and on admission, he disclosed that he had recently stopped taking his anti-psychotic medication. Following treatment, Mr Bond was discharged on a CTO into the care of his parents on 17 April 2019.

In Mr Bond's case, the CTO was considered necessary because he had previously been non-compliant with his medication regime and because it was felt that he lacked the capacity to make treatment decisions with respect to his mental health. The CTO was due to expire on 15 July 2019, but was varied on 9 May 2019 when a different supervising psychiatrist was appointed.

Shortly before 7.30 pm on 14 May 2019, Mr Bond was having dinner at home when he made a choking noise and leant forward placing his fingers in his mouth. Mr Bond then said that he was choking before he collapsed, unresponsive to the floor. Mr Bond's father called emergency services and started CPR. Ambulance officers arrived and took over resuscitation efforts and took Mr Bond to Fiona Stanley Hospital, but he could not be revived.

The Coroner was satisfied that the decision to place Mr Bond on a CTO was justified and that the treatment that Mr Bond received whilst he was the subject of the CTO was appropriate.

The Coroner did not make any recommendation.

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

Child AM (Name Subject to Suppression Order)
Inquest held in Perth 26-27 November 2020, investigation finalised 22 June 2021

Child AM (Child AM) died on 4 September 2015 at Joondalup Health Campus. The cause of death was bronchopneumonia in an infant with obstructive sleep apnoea. The Coroner found the manner of death was natural causes. She was 3 years 11 months old.

Immediately before death Child AM was a "person held in care" under the *Coroners Act 1996* because she was placed into provisional protection and care of the CEO of the Department of Communities, pursuant to the *Children and Community Services Act 2004*.

Child AM was born in a remote community in the East Kimberley and her birth weight was regarded as low. However between 17 November 2011 and 22 March 2014, Child AM was evacuated from her remote East Kimberley community on 12 occasions due to obesity related issues. She was mainly admitted to the Broome Hospital but also spent time in Royal Darwin Hospital and Halls Creek Hospital. Child AM was also a patient at Princess Margaret Hospital on several occasions from December 2013.

Child AM suffered from rapid excessive weight gain, global development delay, obstructive sleep apnoea, asthma, and on occasion periods of loss of consciousness. The health consequences of Child AM's significant obesity were substantial and included obstructive-hypoventilation syndrome requiring supportive ventilation, right heart ventricular hypertrophy, severe pulmonary hupertension, hyperinsulinemia and hypercholesterolemia. Due to her age, Child AM's obesity was considered a threat to her life based on the complications then of severe asthma and her obstructive sleep apnoea.

Child AM was placed into provisional protection and care of the Department from 8 May 2014 until 17 August 2014 and again from 30 January 2015 until her death on 4 September 2015. On 29 June 2015, Child AM was placed in the care of a new foster carer. Her weight had been reduced significantly and she had switched from a CPAP machine to a BiPAP machine to manage her sleeping.

On 1 September 2015, Child AM had a respiratory clinic appointment where she was examined by a doctor specialising in endocrinology. It was noted her weight was stable and she was more active. She also had improved sleep and could be distracted from food-seeking behaviours. She had a chest infection and was treated with antibiotics. The plan was to continue on the BiPAP machine and the melatonin to assist with her sleeping.

On 3 September 2015, Child AM woke up with diarrhoea, but otherwise appeared normal. She had follow-up appointments with an occupational therapist and physiotherapist and did not appear unwell. She ate her dinner that evening and then laid down on the floor to watch television. She then fell asleep. Her carer was unable to lift her and so she waited until her partner came home at 11.00 pm. On attempting to lift Child AM she was found to be unresponsive. Attempts were made to commence CPR but Child AM's jaw was locked. Paramedics found Child AM had no output and no respiratory effort and was cold to touch. Paramedics were unable to intubate due to the spasm of the jaw. An

oropharyngeal airway was inserted with some difficulty. Child AM was conveyed to the Joondalup Hospital and despite all efforts, Child AM was certified as having died.

The Coroner was satisfied as to the adequacy of the supervision, treatment and care provided to Child AM by the Department.

The Coroner made two recommendations.

The Coroner's finding can be found on the website of the Coroner's Court of Western Australia.

Samuel Mark WALSH
Inquest held in Perth 12 May 2021, investigation finalised 29 June 2021

Mr Samuel Mark Walsh (Mr Walsh) died between 5 October 2014 and 12 October 2014 near Karalee Rocks Pumping Station, Yellowdine Nature Reserve. The cause of death was carbon monoxide toxicity. The Coroner found the manner of death was suicide. He was 38 years old.

Immediately before death Mr Walsh was a "person held in care" under the *Coroners Act 1996* because he was subject to a custody order made under the *Criminal Law (Mentally Impaired Accused) Act 1996.*

Mr Walsh was charged with the wilful murder of his mother and was remanded in custody at Eastern Goldfields Regional Prison. On 18 October 2005, he was refused bail and transferred on a hospital order to the Frankland Centre at Graylands Hospital. He was assessed as floridly psychotic. He expressed bizarre, grandiose and religious delusions, describing a multi-national conspiracy directed against him which involved the police. His thought form was rambling and over-inclusive with looseness of association. Mr Walsh had no insight into his legal situation and his judgement was assessed as impaired.

Mr Walsh showed signs of improvement when he was commenced on the anti-psychotic medication, clozapine. Later he was also prescribed the anti-depressant, mirtazapine.

On 26 March 2007, Mr Walsh pleaded not guilty in the Supreme Court on account of unsoundness of mind at the time of doing the act that killed his mother. On 30 March 2007, Mr Walsh was found not guilty on account of unsoundness of mind and placed on a custody order.

On 5 April 2007, Mr Walsh was transferred from Hakea Prison to the Frankland Centre at Graylands Hospital. Records indicate that Mr Walsh continued to make a very good recovery. By 2010, his paranoid schizophrenia was considered to have been in remission with the treatment he had received for many years. As his progress was so significant, Mr Walsh was granted a leave of absence from the Frankland Centre. He gradually increased his leave of absence periods from the Frankland Centre from one night per week to three nights per week in February 2011 to six nights per week in August 2011, and eventually for 13 days per fortnight following a Leave of Absence Order dated 1 May 2012.

At about 8.30 am on 5 October 2014, Mr Walsh was spoken to by the Duty Supervisor at Romily House who described him as being happy that morning. Mr Walsh then left for the day in his car which was his normal practice on a Sunday. Mr Walsh's car was recorded as driving on Great Eastern Highway in Hines Hill and at 12.09 pm Mr Walsh and his car were observed on CCTV camera footage at the BP service station on Great Eastern Highway in Merredin. Mr Walsh refuelled his car, went to the toilet and purchased a chocolate bar with cash. He then drove away in an easterly direction on Great Eastern Highway towards Southern Cross. This is the last confirmed sighting of Mr Walsh.

On 11 January 2017, his body was found in his car in remote bushland 400 km east of Perth.

The Coroner was satisfied that the supervision, treatment and care of Mr Walsh by police, prison staff and mental health clinicians from the time of his arrest on 17 October 2005 was appropriate.

The Coroner did not make any recommendation.

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