OFFICE

of the

STATE CORONER

for

WESTERN AUSTRALIA

ANNUAL REPORT

2017-2018

State Coroner Western Australia

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

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

Our Ref : Annual Report

27 September 2018

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

Dear Attorney

ANNUAL REPORT 2017-2018

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, 2018.

Yours sincerely

R V C FOGLIANI
STATE CORONER

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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 2017/18 are outlined below:

- Backlog of cases increased from 347 as at 30 June 2017 to 368 as at 30 June 2018.

- Of those 368 backlog cases:

    - 128 were backlog inquest cases.
    - 230 were cases where no further finalisations were possible as at 30 June 2018 because the coroner was awaiting completion of aspects of the coronial investigation by external entities.
    - 10 cases were with Counsel Assisting for review or advice as directed by the State Coroner.

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

- A total of 2322 investigations were finalised in 2017/18:

    - 2259 finalised by administrative finding of which 1161 (51%) were backlog cases.
    - 63 finalised by inquest of which 58 (92%) were backlog cases at the time of completion and 39 were mandated inquests.
    - 1103 (48%) of the cases finalised were under 12 months old.
    - 1219 (52%) of the cases finalised were over 12 months old.

- The number of inquests finalised increased from 53 in 2016/17 to 63 in 2017/18. This reflects a focus on finalisation by coroners of inquest matters, assisted by the delegation to the Principal Registrar to authorise him to finalise more routine investigations by way of administrative finding.

- The total number of administrative findings finalised decreased from 2366 in 2016/17 to 2259 in 2017/18; this is compared to 1991 in 2015/16 compared to 1975 in 2014/15 compared to 1959 in 2013/14.

- The number of total cases on hand over 24 months old increased marginally to 6.6% in 2017/18 compared to 6.4% in 2016/17; this is compared to 6.7% in 2015/16 compared to 8.4% 2014/15 compared to 10% in 2013/14.

- Reports of deaths to the coroner decreased to 2291 in 2017/18 compared to 2422 in 2016/17; this is compared to 2214 in 2015/16 compared to 2192 in 2014/15 and 2009 in 2013/14. Whilst there was a reduction of 131 deaths reported as compared to 2016/17, the number of deaths reported remains high.

- The number of cases on hand was 2127 at 30 June 2018 compared to 2173 at 30 June 2017 compared to 2178 at 30 June 2016, compared to 2027 at 30 June 2015 compared to 1891 at 30 June 2014.

- The number of death certificates received in 2017/18 was 1280 compared to 1174 in 2016/17 compared to 1198 in 2015/16 compared to 908 in 2014/15 compared to 683 in 2013/14. These are cases where the coroner has determined that the reported death does not require further investigation and the doctor's death certificate is accepted.

- Counselling Service contacts and referrals decreased from the previous reporting year, however they still remain high at 10781 in 2017/18 compared to 11241 in 2016/17 compared to 10106 in 2015/16 compared to 10753 in 2014/15 compared to 9750 in 2013/14.

- The number of objections to the performance of post mortem examinations for the purpose of investigating deaths remains relatively stable, at 320 for 2017/18 compared to 319 in 2016/17 compared to 246 in 2015/16 compared to 279 in 2014/15 compared to 256 in 2013/14.

- A procedure for non-invasive post mortem examinations was piloted and introduced in the 2016/17 financial year and implemented throughout the 2017/18 year. This resulted in coroners accepting 261 recommendations by pathologists for external only post mortem examinations for 2017/18 compared to 227 in 2016/17.

- A procedure for the finalisation of non-narrative natural cause administrative findings by the Principal Registrar was piloted and introduced from January 2017 and implemented throughout the 2017/18 year. This resulted in the finalisation by the Principal Registrar of 460 cases in 2017/18 compared to 264 cases for the half year from January 2017 to 30 June 2017.

Structure of the Report

The first part of this Report provides statistical and other information on the operations of the Office of the State Coroner in the past financial year ended 30 June 2018 (2017/18).

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

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

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

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

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

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

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

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

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

There were 2259 administrative findings finalised by coroners in the 2017/18 year comprising approximately 97.3% of all reportable deaths investigated for this year. For these matters the coroner makes findings on the evidence before him or her, in chambers. They are not public proceedings. These findings are provided to the deceased's next of kin and they are not published on the Coroner's Court website.

There were 63 inquests finalised by coroners in the 2017/18 year comprising approximately 2.7% of all reportable deaths investigated for this year. As inquests are public proceedings, the coroner takes evidence in open court (unless otherwise ordered). The coroner's written findings are published on the Coroner's Court website. Where the coroner has made a recommendation, the written response by the Minister or responsible entity is also published on the website.

The focus over the 2017/18 year: The Backlog of Coronial Cases and Reform

Backlog

As with the previous reporting years, much of the effort across all levels at the Office of the 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 2018 the backlog stood at 368.

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

Coronial Case Management System

The project to implement an electronic case management system for the Coroner's Court was significantly progressed during 2017/18 with an anticipated completion date of July 2019.

It is envisaged that the work output of the Coroner's Court would be optimised with the introduction of an electronic case management system. Full implementation will ultimately facilitate the allocation of caseloads to coroners from the time the death is reported, for case management by the same coroner, until completion.

Another benefit includes the efficient retrieval of information for public enquiries and statistical reporting purposes, particularly within the context of the coroner's death prevention role.

Reform

As outlined in previous year's annual reports, I have completed my input into the Department of Justice's Briefing Note to the Attorney General in respect of the 113 recommendations made by the Law Reform Commission of Western Australia in its *Review of Coronial Practice in Western Australia, project no. 100*, January 2012. The Department of Justice has presented its position on each of the recommendations to the Attorney General who has endorsed the Department of Justice's position. The Department of Justice is currently finalising key stakeholder consultation, prior to finalising its submission to government.

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

These two recommendations are part of a reform process that is aimed at reducing unnecessary delays and facilitating a more timely response to families of the deceased. The two recommendations have found expression in ss 19A and 25(1A) of the Coroners Act.

CT Scanner

The deployment of a dedicated computed tomography (CT) Scanner for the forensic pathologists at the State Mortuary will improve the range of cases that could be more efficaciously progressed due to the depth and quality of information afforded by this medium at an early stage.

At the time of writing this report, PathWest are in negotiations with a preferred vendor, prior to awarding the contract for the CT Scanner. With a 16 week build and delivery schedule for the CT Scanner, a deployment date of February 2019 has been set. PathWest are also running the upgrade and refurbishment of a room to house the CT Scanner in parallel to this process.

In addition to facilitating the earlier finalisation of coronial cases, a CT Scanner will also support the intent of recommendation 102 of the *Review of Coronial Practice in Western Australia, project no. 100*, to the effect that a forensic pathologist conducting a post mortem examination should use the lease invasive procedure that is available and appropriate in the circumstances.

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

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

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

Overall there were 63 investigations finalised by inquest in the past financial year and of those, a total of 39, being approximately 62%, comprised investigations where an inquest was mandated by law.

The 39 mandated inquests were finalised by coroners in the following categories and these are described below:

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

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

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

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

Under section 27(1) of the Coroners Act, my annual report is required to include a specific report on the death of each person held in care. A Table of the investigations into deaths of persons held in care that were finalised by inquest in the past financial year appears at page 37 of this report [Table M]. Following that Table, at pages 38 to 52 are the specific reports on the deaths of each person held in care, arranged in the order in which they appear on the Table.

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

- Two investigations were finalised by inquest in respect of deaths of persons held in custody under the *Prisons Act* 1981;
- One investigation was finalised by inquest in respect of the death of a person under the control, care or custody of a member of the Police Force;
- Five investigations were finalised by inquest in respect of a child who was the subject of a protection order under the *Children and Community Services Act 2004*; and
- Six investigations were finalised by inquest in respect of the death of an involuntary patient within the meaning of the *Mental Health Act* 1996 or the *Mental Health Act* 2014.

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

In three out of the 14 mandated inquests, the coroner made adverse comment about the quality of supervision, treatment and/or care of the deceased (Mr Beasley, Mr Kanawati, and LCTM [name suppressed]).

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

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

They all concerned police pursuits or intercepts.

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

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

(c) Mandated inquests – suspected deaths

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

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

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

A Table of the eighteen investigations appears at pages 34-35 of this Report.

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

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

In exercising the discretion under this statutory function the coroner will have regard to whether an inquest will assist in reaching the findings required to be made, if possible, under section 25(1) of the Coroners Act and/or whether there are reasons for highlighting issues of public health or safety in connection with the death. The coroner will also take account of the reasons provided by any person who makes a request for an inquest under section 24(1) of the Coroners Act.

Of the 63 investigations finalised by inquest in the past financial year, a total of 24, being approximately 38%, comprised investigations where the inquest was discretionary.

A Table of all of the investigations that were finalised by inquest appears at pages 29 to 32 of this Report. The mandated inquests are marked as such, leaving the remainder on that Table, a total of 24, as the discretionary inquests.

The Coronial Counselling Service

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

Over this reporting year, the Coronial Counselling Service has focussed on its core function which is to ensure, as far as practicable, that persons coming into contact with the coronial system are able to speak with an experienced counsellor who will endeavour to address their questions and concerns and explain the coronial process to them. The service dealt with over 6600 telephone contacts.

The range of services provided by the Coronial Counselling Service and statistical information on work output is set out at pages 22-23 of this Report.

The Death Prevention Role and the Coronial Ethics Committee

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

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

The Office of the State Coroner has a working relationship with the Department of Health, the Patient Safety Surveillance Unit (PSSU). Their specialist medical consultant reviews coronial findings and related information. The salient points are de-identified and where appropriate 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 125 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 24 to 25 of this Report.

Acknowledgements

I wish to acknowledge the ongoing and assiduous endeavours on the part of Deputy State Coroner Evelyn Vicker, Coroner Barry King and Coroner Sarah Linton to finalise investigations and reduce the backlog. This year, the court has also been assisted by Coroner Kelvin Fisher for nine weeks, for the purpose of finalising investigations, and I am grateful for his important contribution.

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

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

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

Every member of the Police Force of Western Australia is contemporaneously a coroner's investigator. The Coroner's Court of Western Australia continued to be well supported by all of

the coroner's investigators, including those at the Coronial Investigation Squad, by the forensic pathologists and other PathWest staff, and the toxicologists and other ChemCentre staff. I use this opportunity to express my gratitude to these officers and staff members in all of these agencies that ably assist the Coroner's Court on a daily basis.

I am grateful for the assistance of a number of officers from the Department of Justice over the past year in connection with the progression of the reform proposals and, together with PathWest staff the progression towards the deployment of a dedicated CT Scanner for the forensic pathologists. These initiatives take time and energy and the Coroner's Court has been well served by their efforts.

I am pleased to present the 2017/18 Annual Report of the Office of the State Coroner.

R V C FOGLIANI
STATE CORONER

Office Structure

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

Table A

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

Registry and Statistics

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

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

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

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

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

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

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

The number of cases about to enter into backlog in any given month is calculated; and the Coroner's Court endeavours to finalise more than that number in an effort to prevent the backlog from increasing. A total of 2291 reportable deaths were reported to the coroner for full investigation in the past financial year and 2322 cases were completed representing a clearance rate of just over 100%.

With regard to the 2322 cases completed in the past reporting year the breakdown is as follows:

- 2259 – the number of investigations finalised by administrative finding, of which 1161 (51%) were backlog cases, and

- 63 - the number of investigations finalised by inquest, of which 58 (92%) 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 2127, of which 368 were backlog cases (over 12 months old).

The backlog increased from 347 in 2016/17 to 368 in 2017/18.

Of those 368 backlog cases, 128 were inquest cases waiting to be heard or pending finalisation by a coroner.

The following Tables provide an overview of the work of the Coroner's Court in the 2017/18 year.

Table B

CASES RECEIVED	*PERTH*	*COUNTRY*	*TOTAL*
Full Investigation	**1665**	**626**	**2291**
Death Certificates	**1280**	**n/a**	**1280**

CASES COMPLETED	*PERTH*	*COUNTRY*	*TOTAL*
Finalised by Inquiry	**1644**	**615**	**2259**
Finalised by Inquest	**50**	**13**	**63**
TOTALS	**1694**	**628**	**2322**

BACKLOG	*PERTH*	*COUNTRY*	*TOTAL*
	260	**108**	**368**

CASES ON HAND	*PERTH*	*COUNTRY*	*TOTAL*
	1607	**520**	**2127**

FINALISATION RATIO		
Finalised by Inquiry	**97.3%**	**2259**
Finalised by Inquest	**2.7%**	**63**

Table C

Table C below shows the age of a coronial file when closed calculated from the date of death. It will be seen that 48% (1103) of files were closed in under 12 months and 52% (1219) of files were over 12 months old at closure (i.e. backlog files).

	INQUIRY		**INQUEST**	
TIMELINES	*PERTH*	*COUNTRY*	*PERTH*	*COUNTRY*
< 3 mths	**135**	**40**	**1**	**0**
3-6 mths	**149**	**166**	**0**	**0**
6-12 mths	**402**	**206**	**4**	**0**
12-18 mths	**892**	**150**	**6**	**0**
18-24 mths	**30**	**32**	**4**	**2**
>24 mths	**36**	**21**	**35**	**11**
TOTALS	**1644**	**615**	**50**	**13**

Table D

Table D below shows the total number of deaths reported and cases completed during the 2017/18 year for Perth and Regional WA.

TOTAL NUMBER OF DEATHS REPORTED TO THE CORONER			
Death certificates			1280
Metropolitan deaths	1665		
Regional deaths	626		
• **Albany**		89	
• **Broome**		26	
• **Bunbury**		211	
• **Carnarvon**		38	
• **Islands**		0	
• **Geraldton**		73	
• **Kalgoorlie**		68	
• **Kununurra**		19	
• **Northam**		57	
• **Port Hedland**		45	
TOTAL NUMBER OF REPORTABLE DEATHS	2291		1280
CASES COMPLETED	**PERTH**	**COUNTRY**	**TOTAL**
Finalised by Inquiry	1644	615	2259
Finalised by Inquest	50	13	63
TOTALS	1694	628	2322

Table E

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

MANNER OF DEATH	*2013-2014*	*2014-2015*	*2015-2016*	*2016-2017*	*2017-2018*
Accident	622	580	635	700	811
Misadventure	34	25	44	61	40
Natural Causes	849	915	851	1039	908
No Jurisdiction	0	5	3	7	4
Open Finding	125	103	105	139	116
Self Defence	1	0	1	3	3
Suicide	336	340	322	420	392
Unlawful Homicide	69	53	88	53	48
TOTALS	**2036**	**2021**	**2049**	**2422**	**2322**

Post Mortem Examinations

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

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

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

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

Objections to Post Mortem Examinations

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

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

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

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

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

The discussions between the senior next of kin and the members of the coronial counselling service are a vital component of the process for objections. The counsellors have experience in dealing compassionately with sensitive matters and are cognisant of cultural issues that may impact upon decision making in this area. The work of the coronial counselling service is further addressed at pages 22 to 23 of this Report.

Table F

Table F below shows the number of post mortem examinations and the number of objections received in the 2017/18 year and the outcomes:

Deaths reported to Coroner's Court of Western Australia:

REPORTED DEATHS	
Immediate post mortem	**43**
No objection to post mortem	**1837**
Objection to post mortem	**320**
No post mortem conducted (missing person, death certificate originally issued or by order of coroner etc)	**91**
NUMBER OF REPORTED DEATHS	**2291**

Outcomes in cases where an objection was initially received:

OBJECTIONS TO POST MORTEMS	
Objection accepted	**238**
Objection withdrawn	**81**
Objection withdrawn after coroner overruled	**1**
Applications to Supreme Court	**0**
TOTAL OBJECTIONS TO POST MORTEMS	**320**

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, in the previous financial year the State Coroner had piloted a scheme to support the forensic pathologist's use of the least invasive procedures that are available and appropriate in the conduct of post mortem examinations. Given the success of that pilot, it has been implemented throughout the 2017/18 year for metropolitan and regional areas.

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.

It is anticipated that, once a dedicated CT Scanner is made available to the pathologists, the range of cases where pathologists may recommend an external post mortem examination will be broadened.

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	**268**
PRE approved by Coroner or Principal Registrar [as delegate]	**261**
PRE not approved by Coroner - Full PM	**0**
PRE rejected by next of kin - Full PM	**4**
PRE approved – Partial PM	**3**
TOTAL PATHOLOGIST RECOMMENDED EXTERNAL	**268**

Coronial Counselling Service Functions

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

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

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

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

Coronial counsellors are able to offer counselling in relation to grief, loss, and trauma. All cases are assessed on an individual basis. The CCS is not established for the purposes of providing ongoing counselling. If the counsellors consider that this is required, appropriate referrals are suggested for ongoing assistance in this area. They run education sessions with various professional groups and liaise closely with a number of different government departments to ensure that a person's death and its ramifications are handled as sensitively as possible.

Coronial counsellors are able to facilitate the viewing of selected case material from the coronial files to assist next of kin to better understand what happened to their family member. This process involves supporting the next of kin during the viewing as appropriate and being available to answer questions.

Coronial counsellors are able to attend at the State Mortuary to support next of kin if they require that support when viewing their loved one. They will conduct home visits if required and if it is possible.

The Perth based CCS has continued to establish productive links with on-site counselling services in regional and/or remote areas, to better service the needs of persons in those areas who would benefit from personal (as opposed to telephone) contact. The liaison with on-site services has worked well, and community members have engaged with the outreach.

The CCS will also work towards developing a network of clinicians willing to assist, should an incident requiring initiation of the Disaster Victim Identification Protocols occur.

Table H

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

TYPE OF SERVICE	*2013-2014*	*2014-2015*	*2015-2016*	*2016-2017*	*2017-2018*
Phone, Office/Home Visits	**6529**	**6979**	**6993**	**7274**	**6885**
Offers of Service	**1092**	**1377**	**547**	**577**	**701**
Mortuary/file viewings	**2129**	**2397**	**2566**	**3390**	**3195**
TOTAL CONTACTS	**9750**	**10753**	**10106**	**11241**	**10781**

For the 2017/18 year the above categories are explained as follows:

- Phone, Office/Home visits refers to all telephone calls (6615) visits to home addresses (5) and attendances at other offices or attendances by others at the Court (265);
- Offers of Service refers to letters offering counselling (701); and
- Mortuary/file viewings refers to emails (1270), interoffice liaison (1922) and mortuary contact (3).

Coronial Ethics Committee Functions

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

Coronial data is confidential. An application for the provision of coronial data must be accompanied by a detailed written submission to the Coronial Ethics Committee. Applications are primarily made for research purposes.

On average this past reporting year, the Coronial Ethics Committee has met bi-monthly to consider applications. In decision-making, the Committee members attempt to strike a balance between family concerns (including privacy, confidentiality, and consent issues), and the benefits of research to the community at large. Once an application has been considered, the Coronial Ethics Committee makes its recommendation to the State Coroner about whether the coronial data sought should be released, and under what conditions.

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

The members of the Coronial Ethics Committee are as follows:

Dr Alistair Vickery	Chairperson, Associate Professor, UWA
Dr Jodi White	Deputy Chairperson, Forensic Pathologist, PathWest
Mr Barry King	Coroner
Associate Professor Jennet Harvey	Member with relevant research experience
Ms Simone Brand	Member with counselling background
Reverend Brian Carey (until September 2017)	Member with a pastoral background
Ms Christine Pittman	Legal Member
Ms Natalie Gately	Lay member
Dr Thomas Hitchcock (from February 2018)	Member with relevant research experience
Dr Rosemary Coates (from April 2018)	Lay member
Ms Kate Ellson	Secretary, Legal Member, Principal Counsel Assisting

In September 2017, Reverend Brian Carey resigned from the Committee. Reverend Carey was a valued member of the Committee for a number of years, and contributed to its business significantly during his membership.

In February 2018, the Committee welcomed Dr Thomas Hitchcock as a new member. Dr Hitchcock, an intensivist, comes to the Committee with an extensive background in health research. In April 2018, Dr Rosemary Coates joined the Committee. Although Dr Coates has been welcomed into the Committee as a layperson member, Dr Coates brings with her significant experience in academic ethics work.

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

Table I

Number of Projects Considered	**Number of projects approved**	**Number of projects not approved**	**Deferred**
27	20	2	5
Number of Requests for renewal Considered	**Number of Requests for renewal Approved**	**Number of Requests for renewal Not approved**	**Deferred**
4	3	0	1
Number of Amendments	**Number of amendments approved**	**Number of amendments not approved**	
8	6	0	2

The Ethics Committee deferred its consideration of a number of applications due to legal issues arising in connection with the release of coronial information in those circumstances. As part of the review of the LRCWA recommendations, the Department of Justice has recommended legislative reform in this area, supported by the State Coroner, to allow the release of coronial information to a person conducting research, subject to ethics approval, and/or in the public interest. The Attorney General supports this recommendation.

Principal Registrar and Coroner's Registrars

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

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

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

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

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

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

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

The timely execution of these functions by the Principal Registrar has enabled the coroners to focus on more complex and/or pressing matters. This financial year the Principal Registrar finalised 460 non-narrative natural cause administrative findings and approved 186 pathologist recommended external examinations.

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

The Principal Registrar executes the State Coroner's directions in relation to the conduct of coronial investigations. The Principal Registrar manages all mandatory inquest files up to

and including allocation to counsel assisting and identifies potential matters for inquest, submitting recommendations to the State Coroner.

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

This financial year the Principal Registrar has continued to work closely with senior officers of the Department of Justice, and with the staff of PathWest to progress the business case for the deployment of a CT Scanner at the State Mortuary.

The Principal Registrar has also provided ongoing and comprehensive assistance in connection with the legislative reform recommendations of the LRCWA in *its Review of Coronial Practice in Western Australia, project no. 100,* January 2012.

Counsel Assisting the Coroner

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

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

Ms Stephanie Teoh worked with the Coroners Court for a six month period during this reporting year. Ms Teoh was transferred from the State Solicitor's Office to assist, as counsel, with progressing a number of aged and/or urgent cases.

The efforts of all the counsel assisting have primarily been directed to assisting in the reduction of the number of aged inquest matters awaiting hearing by a coroner. I acknowledge their hard work and dedication.

Police Assisting the Coroner

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

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

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

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

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

Inquests

Table J

Table J below shows the total number of inquests **(63)** finalised in the 2017/18. An inquest is finalised when the coroner signs the inquest finding.

SURNAME OF DECEASED	*DATE OF DEATH*	*DATE OF INQUEST*	*FINDING*	*DATE OF FINDING*
*BEASLEY (aka Graeme Leslie Syme)	12/6/2014	19/4/2017	Suicide	11/7/2017
PU Maung	30/9/2012	1-2/12/2016	Natural Causes	14/7/2017
KAUR Satwant	5/12/2013	1-2/11/2016 and 15-16/2/2017	Unlawful Homicide	31/7/2017
*TURVILLE Christine (aka NICHOLLS)	26/3/2015	27-28/2/2017	Natural Causes	3/8/2017
BICKNELL Nicole Emily	2/11/2014	23-25/5/2017	Misadventure	18/8/2017
BABY CJ	16/3/2014	2/5/2017	Natural Causes	22/8/2017
JARICK Marjorie Joy	10/7/2013	8/3/2017	Misadventure	23/8/2017
*CNR	26/6/2013	9/5/2017	Natural Causes	28/8/2017
*YUNG James Michael Chee Ming	20/6/2015	15/6/2017	Accident	6/9/2017
*DIALLO Mamadou Hady	22/5/2015	15/6/2017	Suicide	6/9/2017
Van Der WALT Mary Josephine	23/4/2014	4/7/2017	Suicide	15/9/2017
OLSEN Jared Charles	5/3/2015	8-10/6/2016, 28/6/016 and 13/10/2016	Misadventure	26/9/2017
KUSTER Anthony William	20/4/2013	12-13/6/2017	Open Finding	9/10/2017
MILLS Damien Mark	31/10/2014	6-8/6/2017	Accident	30/10/2017
#ALBERT Petronella	Between 28/4/1999 and 5/5/1999	4-5/7/2017	Open Finding	16/11/2017

*JDC	22/5/2012	11/10/2017	Accident	20/11/2017
#WILSON Rohan Daniel	15/6/2017	15/11/2017	Accident	23/11/2017
KITE Reef Jason Bruce	13/10/2015	23/10/2017	Accident	24/11/2017
LOBBAN June Valerie	9/5/2014	25-27/7/2017 and 1/8/2017	Natural Causes	7/12/2017
#BACHE Matthias Ashley	8/3/2016	11/8/2017	Misadventure	7/12/2017
KITCHEN Nigel Paradine #HINDS Andrew Trevor	29/5/2016	7/8/2017	Accident	29/12/2017
^SINGH Kuldeep ^BARRETT Sean Duncan ^FRYER Gavin Wayne ^RUNDELL Jordan Damon ^NARRIER Kyra Marjorie Carmen ^EL BAKDADI Hassan	19/10/2012 19/10/2012 12/2/2013 11/1/2014 13/11/2014 21/12/2014	7-30/3/2017 and 3-11/4/2017	Unlawful Homicide Unlawful Homicide Unlawful Homicide Accident Unlawful Homicide Accident	29/12/2017
*SCHWENKE Vincent Tavita Tolai	11/12/2015	30/11/2017 and 1/12/2017	Open Finding	15/1/2018
*KPLW	29/3/2013	10/1/2018	Natural Causes	30/1/2018
^BILICK Anthony John	6/2/2016	12-13/10/2017	Accident	22/1/2018
#LYDDIETH Gary John	Between 3/5/2014 and 1/8/2014	17/10/2017	Open Finding	30/1/2018
HAMPTON Jarrod Arthur	14/4/2012	15-18/5/2017 and 22-26/5/2017	Misadventure	13/2/2018
*KANAWATI Radwan	17/10/2014	22/8/2017	Accident	23/2/2018

TURNER Murray Allan #CARTER Mason Laurence #FAIRLEY Chad Alan	11/7/2015	24-28/7/2017	Accident	28/2/2018
*BARTLETT William Scott	25/9/2015	25/10/2017	Misadventure	7/3/2018
SOKIRI Moses	26/10/2014	7/11/2017	Suicide	8/3/2018
LI Chunjun #ZHANG Jiaolong	18/4/2015	20-23/11/2017	Accident	16/3/2018
CARTER Roderick Leslie	13/10/2014	9/11/2017	Natural Causes	15/3/2018
COLLOFF Steven John	22/11/2015	23/1/2018	Misadventure	22/3/2018
QUARTERMAINE Aileen Helen	26/7/2014	17/1/2018	Open Finding	22/3/2018
SOLTANI Ali Mohammad	26/4/2016	24/11/2017	Accident	23/3/2018
#BALE Norman Leslie	Between 23-27/9/2016	30/1/2018	Misadventure	29/3/2018
*HLS	Between 13-14/3/2013	7-10/8//2017	Misadventure	26/4/2018
BORRADAILE John Robert	4/2/2013	5-6/12/2017	Accident	30/4/2018
#MURRAY Luke Anthony	15/8/2016	18-19/1/2018	Open Finding	30/4/2018
#McDOUGALL Chantelle Jane #McDOUGALL Leela #POPIC Antonio Konstantin #FELTON Gary	N/A	6-8/12/2017	Open Finding	2/5/2018

*RODDA Robert Paul	14/10/2015	2/2/2018	Natural Causes	2/5/2018
MITCHELL Lachlan James	10/11/2015	20-21/11/2017	Accident	30/5/2018
#DEL BORRELLO Giuseppe	1/1/1979	22/5/2018	Open Finding	31/5/2018
#TUDAWALI Charles	15/12/1976	29/5/2018	Open Finding	31/5/2018
#FIELD John Lindsay	13/5/1976	22/5/2018	Open Finding	31/5/2018
#REVELL Patricia Alicia	20/7/1978	29/5/2018	Accident	11/6/2018
RZEPCZYNSKI Anne	20/2/2012	13-14/2/2017 and 17/1/2018	Natural Causes	14/6/2018
KEARING Isiah Duane	29/12/2013	28-29/8/2017 and 7/12/2017	Suicide	22/6/2018
*LCTM	24/2/2014	11-13/12/2017	Unlawful Homicide	25/6/2018
*CAIN Brook Damian	13/11/2014	23/1/2018	Suicide	27/6/2018

^ = Death that appeared to be caused or contributed to by any action of a member of the police force (7)

= Missing person (18)

* = Person held in care (14)

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

Total Inquests : 63

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

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

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

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

Table K

Table K below shows the number of inquests **(7)** finalised in 2017/18 year into deaths that appeared to be caused, or contributed to, by any action of a member of the Police Force.

NAME	*DATE OF DEATH*	*DATE OF INQUEST*	*FINDING*	*DATE OF FINDING*
^SINGH Kuldeep	19/10/2012	7-30/3/2017 and 3-11/4/2017	Unlawful Homicide	29/12/2017
^BARRETT Sean Duncan	19/10/2012		Unlawful Homicide	
^FRYER Gavin Wayne	12/2/2013		Unlawful Homicide	
^RUNDELL Jordan Damon	11/1/2014		Accident	
^NARRIER Kyra Marjorie Carmen	13/11/2014		Unlawful Homicide	
^EL BAKDADI Hassan	21/12/2014		Accident	
^BILICK Anthony John	6/2/2016	12-13/10/2017	Accident	22/1/2018

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

The police were not found to have caused, or contributed to, any of the deaths.

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

SUSPECTED DEATHS

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

Table L

Table L below shows the number of inquests **(18)** finalised in 2017/18 year into suspected deaths.

NAME	*DATE OF DEATH*	*DATE OF INQUEST*	*FINDING*	*DATE OF FINDING*
#ALBERT Petronella	Between 28/4/1999 and 5/5/1999	4-5/7/2017	Open Finding	16/11/2017
#WILSON Rohan Daniel	15/6/2017	15/11/2017	Accident	23/11/2017
#BACHE Matthias Ashley	8/3/2016	11/8/2017	Misadventure	7/12/2017
#HINDS Andrew Trevor	29/5/2016	7/8/2017	Accident	29/12/2017
#LYDDIETH Gary John	Between 3/5/2014 and 1/8/2014	17/10/2017	Open Finding	30/1/2018
#CARTER Mason Laurence #TURNER Chad Alan	11/7/2015	24-28/7/2017	Accident	28/2/2018
#ZHANG Jiaolong	18/4/2015	20-23/11/2017	Accident	16/3/2018
#BALE Norman Leslie	Between 23-27/9/2016	30/1/2018	Misadventure	29/3/2018
#MURRAY Luke Anthony	15/8/2016	18-19/1/2018	Open Finding	30/4/2018

#McDOUGALL Chantelle Jane #McDOUGALL Leela #POPIC Antonio Konstantin #FELTON Gary	NA	6-8/12/2017	Open Finding	2/5/2018
#DEL BORRELLO Giuseppe	1/1/1979	22/5/2018	Open Finding	31/5/2018
#TUDAWALI Charles	15/12/1976	29/5/2018	Open Finding	31/5/2018
#FIELD John Lindsay	13/5/1976	22/5/2018	Open Finding	31/5/2018
#REVELL Patricia Alicia	20/7/1978	29/5/2018	Accident	11/6/2018

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

In the matters of McDOUGALL, C., McDOUGALL, L., POPIC, A., and FELTON, G., the coroner did not find on the evidence presently available, that the deaths were established beyond all reasonable doubt, but added, for clarity, that this conclusion does not mean that the coroner has found that any of them is alive.

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

PERSONS HELD IN CARE

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

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

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

or

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

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

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

(c) a person

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

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

Table M overleaf shows the number of inquests **(14)** finalised in 2017/18 into deaths of persons held in care.

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

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

Table M

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

NAME	*DATE OF DEATH*	*DATE OF INQUEST*	*FINDING*	*DATE OF FINDING*
*BEASLEY (aka Graeme Leslie Syme)	12/6/2014	19/4/2017	Suicide	11/7/2017
*TURVILLE Christine (aka NICHOLLS)	26/3/2015	27-28/2/2017	Natural Causes	3/8/2017
*CNR	26/6/2013	9/5/2017	Natural Causes	28/8/2017
*YUNG James Michael Chee Ming	20/6/2015	15/6/2017	Accident	6/9/2017
*DIALLO Mamadou Hady	22/5/2015	15/6/2017	Suicide	6/9/2017
*JDC	22/5/2012	11/10/2017	Accident	20/11/2017
*SCHWENKE Vincent Tavita Tolai	11/12/2015	30/11/2017 and 1/12/2017	Open Finding	15/1/2018
*KPLW	29/3/2013	10/1/2018	Natural Causes	30/1/2018
*KANAWATI Radwan	17/10/2014	22/8/2017	Accident	23/2/2018
*BARTLETT William Scott	25/9/2015	25/10/2017	Misadventure	7/3/2018
*HLS	Between 13-14/3/2013	7-10/8//2017	Misadventure	26/4/2018
*RODDA Robert Paul	14/10/2015	2/2/2018	Natural Causes	2/5/2018
*LCTM	24/2/2014	11-13/12/2017	Unlawful Homicide	25/6/2018
*CAIN Brook Damian	13/11/2014	23/1/2018	Suicide	27/6/2018

PERSONS HELD IN CARE – specific reports

BEASLEY (aka Graeme Leslie Syme)
Inquest held in Perth 19 April 2017, investigation finalised 11 July 2017

Mr Beasley (aka Graeme Leslie Syme) (the deceased) died on 12 June 2014 at Royal Perth Hospital from complications of penetrating sharp force injuries through the chest and abdomen (surgically treated) in a man with coronary artery atherosclerosis. The coroner found the manner of death was suicide. He was 49 years old.

Immediately before death the deceased was a "person held in care" under the *Coroners Act 1996* because at the time of his death he was a sentenced prisoner. He was in the custody of the Chief Executive Officer of the Department of Corrective Services under s 16 of the *Prisons Act 1971*.

The focus of the inquest was on the Adult Community Corrections' supervision of the deceased while he was on parole, Adult Community Corrections' decision to suspend the parole order, and the legislative requirement that the Board notify parolees in writing of the cancellation of their parole orders.

The deceased had been placed on parole, but on 26 May 2014 his parole order was suspended by Adult Community Corrections officers after he had tested positive to methylamphetamine.

On 28 May 2014 the Prisoners Review Board cancelled his parole order and, in accordance with the relevant legislation, notified him by letter that the parole was cancelled and that he would have to return to prison. The Board issued a warrant for the deceased's arrest, but the warrant was never executed.

On 10 June 2014 the deceased attended the Adult Community Corrections Wangara Reporting Centre where he produced a knife and stabbed himself with it repeatedly. He was taken by ambulance to Royal Perth Hospital, but he died from his injuries two days later.

The Coroner concluded that after learning that his parole order had been cancelled, the deceased committed suicide in a dramatic and disturbing way rather than having to face a return to prison.

The Coroner found the deceased's treatment and care while at Royal Perth Hospital was appropriate, but that the Adult Community Corrections' supervision of him while he was on parole did not comply with the requirements of the conditions on the parole order.

The Coroner made a recommendation that government consider amending or repealing the legislative requirement for the Board to notify parolees in writing as soon as practicable of parole cancellations.

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

Christine TURVILLE
Inquest held in Perth 27-28 February 2017, investigation finalised 3 August 2017

Ms Christine Turville (the deceased) died on 26 March 2015 at Jarrahdale. The Deputy State Coroner found the manner of death was natural causes. The cause of death was bronchial asthma and emphysema. The deceased was 56 years old.

Immediately before death the deceased was a "person held in care" under the *Coroners Act 1996* because she was an involuntary patient under the *Mental Health Act 1996.*

The deceased had a long history of respiratory disease, exacerbated by her continued and heavy smoking. The Deputy State Coroner was satisfied the deceased had a long and difficult history of mental health issues and had been diagnosed with schizophrenia by at least 1990.

The deceased presented as being physically unwell in early March 2015 and as a result was hospitalised, but due to her lack of compliance with her antipsychotic medications, she had also become mentally unstable. Following treatment for her physical difficulties she was assessed by the mental health team and transferred to the psychiatric ward on 5 March 2015 and detained as an involuntary patient in an attempt to stabilise her mental health issues.

The deceased suffered from low oxygen saturations due to her continued smoking and respiratory disease. She was provided with ground access on 20 March 2015, and she started to make requests for leave to go home to attend to the welfare of her cat, a matter that was considered important to her mental welfare. On 24 March 2015 the deceased was granted overnight leave to check on the welfare of her cat given the remoteness of her residence. A consultant respiratory physician considered that granting overnight leave was reasonable in all the deceased's circumstances.

The Deputy State Coroner was unable to determine whether upon returning home the deceased became distressed as a result of not being able to find her cat and decided to stay one extra day which made her late for her return, or she had made a decision she would not return at all. On the evidence it was likely the deceased made a decision to leave her home on the morning of 26 March 2015, but became unwell as she attempted to reach the road and died.

Overall the Deputy State Coroner found the deceased's supervision, treatment and care were appropriate.

The Deputy State Coroner did not make any recommendations.

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

CNR (Subject to a Suppression Order)
Inquest held in Perth 9 May 2017, investigation finalised 28 August 2017

CNR (the deceased) died on 26 June 2013 at Princess Margaret Hospital. The Coroner found the manner of death was natural causes. The cause of death was heart failure due to chronic rheumatic heart disease. He was 16 years old.

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

The deceased was born into a loving family in a remote community. For his first nine years he was generally well but in February 2006 he was diagnosed with rheumatic fever. He was prescribed monthly bicillin injections but was not always compliant. In January 2010 he developed valvular heart disease and heart failure.

In October 2010 the deceased underwent mitral valve and aortic valve repair at Princess Margaret Hospital. Post operatively there was a poor blood supply to the heart muscle which caused significant damage. He developed biventricular congestive heart failure with ongoing aortic and mitral incompetence as well as tricuspid incompetence, with both right and left ventricles contracting poorly.

On 12 January 2011 the deceased attended Princess Margaret Hospital cardiology outpatient clinic in significant heart failure. He was reviewed, and returned home on 20 January 2011. He was admitted to hospital on a number of occasions between August 2011 and March 2012 with heart failure related to poor compliance with medications. For much of 2012 he was admitted to Kalgoorlie Regional Hospital. In November 2012 he was transferred to Royal Perth Hospital where he underwent a radio frequency ablation procedure and the insertion of a pacemaker/defibrillator. He was assessed as not suitable for cardiac transplantation because of his psycho-social capabilities, and as not suitable for a mechanical heart pump because of the condition of his heart.

The deceased was managed in Princess Margaret Hospital for the first part of 2013. He was in congestive heart failure and required large doses of diuretics to keep his weight gain and peripheral oedema under control. Concerns were expressed about his parents' inability to supervise his medication. He was taken into care by the Department of Child Protection and discharged to high needs foster carers in early March 2013 so that he could be managed for his last few months through outpatient visits and admissions to Princess Margaret Hospital.

In April 2013 the deceased was admitted to Princess Margaret Hospital with acute kidney failure. From that time until his death he spent most of his time in hospital as his condition continued to deteriorate. On 26 June 2013 he died in his sleep.

The Coroner found that the care which the deceased received after he was taken into care was exemplary, and that the treatment and care prior to that time was appropriate in the circumstances.

The Coroner did not make any recommendations.

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

James Michael Chee Ming YUNG
Inquest held in Perth 15 June 2017, investigation finalised 6 September 2017

Mr James Michael Chee Ming Yung (the deceased) died on 20 June 2015 at Jarrahdale. The Coroner found the manner of death was accident. The cause of death was multiple injuries. He was 42 years old.

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

The inquest focused primarily on the psychiatric care provided to the deceased while on the final Community Treatment Order prior to his death, as well as the circumstances of his death and the question of his fitness to drive given his psychiatric disorder.

The deceased was first diagnosed with a mental illness in 1993, which led to a number of inpatient hospital admissions in the UK and Australia. On 19 August 2013 the deceased was admitted to a psychiatric hospital in the UK on a secure ward with a diagnosis of schizoaffective disorder, manic type, and was administered paliperidone depot medication and oral medication. He was discharged on 23 December 2013 after his mental state improved sufficiently. He returned to Australia.

He was seen by his treating consultant psychiatrist on 7 January 2014. During the interview the deceased was highly aroused, with evidence of psychotic and manic features, and he became threatening. He was admitted to Graylands Hospital as an involuntary patient for a period of 80 days. He was discharged on 27 March 2014 on a Community Treatment Order. He was readmitted on two more occasions until he was discharged on 10 March 2015 on his last Community Treatment Order with depot medication. It was due to expire on 9 June 2015 The consultant psychiatrist recommended that the deceased's Community Treatment Order continue, and it was extended until 9 September 2015 to ensure the deceased was compliant with taking his depot medication.

The deceased feared readmission and absconded. When he returned to Western Australia, he was seen by his parents but his treating team were unable to locate him.

On Sunday 20 June 2015 while driving his vehicle southwest along Jarrahdale Road the deceased failed to negotiate a bend in the road and rolled the vehicle and collided with a tree. The deceased died at the scene of the crash.

The Coroner concluded that the deceased had a longstanding psychotic illness that was difficult to manage due to his recurring pattern of non-adherence to medication and disengagement from his treating team.

The Coroner found the medical treatment of the deceased while he was on the Community Treatment Order was appropriate, and did not find that there was any evidence that suggests that an error was made in permitting the deceased to continue to drive.

The Coroner did not make any recommendations.

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

Mamadou Hady DIALLO
Inquest held in Perth 15 June 2017, investigation finalised 6 September 2017

Mr Mamadou Hady Diallo (the deceased) died on 22 May 2015 on the Great Eastern Highway in Wundowie. The Coroner found the manner of death was suicide. The cause of death was multiple injuries. He was 39 years old.

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

The inquest focused primarily on the care provided to the deceased while on the Community Treatment Order, as well as the circumstances of his death and his fitness to drive given his psychiatric disorder.

The deceased came to Australia in 2005. On 18 November the deceased was admitted to Royal Perth Hospital with acute paranoid psychosis. He was given medication to sedate him and was stabilised on risperidone and venlafaxine. On discharge he was referred to Inner City Mental Health and admitted into the Community Recovery Program in April 2006. He was diagnosed with acute polymorphic psychotic disorder with symptoms of schizophrenia.

On 7 May 2014 the deceased presented to the Bentley Mental Health Service due to his low mood, socially withdrawn behaviour and non-compliance with his medication. The deceased was placed on antidepressant and antipsychotic medication. On 13 July 2014 the deceased was taken to Royal Perth Hospital and admitted to a locked ward after he made attempts to harm himself. The deceased was transferred to Bentley Hospital on 20 July 2014 and placed on depot paliperidone. He was discharged on 13 August 2014, but his paranoid schizophrenia relapsed and he was readmitted to the Bentley Hospital on 28 August 2014. He was then discharged on a Community Treatment Order on 30 October 2014, which remained in place until the deceased's death.

On 22 May 2015 while driving his vehicle east along Great Eastern Highway the deceased swerved into the path of an oncoming truck and they collided head on. The deceased sustained non-survivable injuries in the collision.

At the time of his death the deceased had appeared to be generally well and making plans for the future, including trying to obtain a commercial truck driver's licence to create new job opportunities. The Coroner noted that although the process by which he was found fit to obtain a learners permit for commercial truck driving was flawed, in that his general practitioner mistakenly performed the assessment when he was not in fact qualified to do so, this error did not play any role in the deceased's death. The Coroner concluded the deceased was not driving a truck at the time he died, and there was no evidence prior to the crash to suggest that he was not fit to drive a private vehicle.

The Coroner did not make any recommendations.

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

JDC (Subject to a Suppression Order)
Inquest held in Perth 11 October 2017, investigation finalised 20 November 2017

JDC (the deceased) died on 22 May 2012 at Royal Perth Hospital. The Coroner found the manner of death was by way of accident. The cause of death was fungal brain infection and infarction complicating fungal infection of a scalp laceration sustained in a motor vehicle collision. She was 17 years old.

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

The focus of the inquest was primarily on the care provided to the deceased while in the care of the Department of Child Protection and Family Support in the final years prior to death, as well as the circumstances of her death.

The Court heard evidence that the deceased was placed into the care of the Department at a very early age, with allegations of abuse and neglect involving family members. The Department's records indicate that from as young as 13 years of age the deceased was engaging in risky behaviour and lifestyle choices, including drug and alcohol misuse, criminal behaviour and an intermittent dangerous relationship with a violent older man. For most of the deceased's teenage years she was not engaged in school or training and appeared to have no real structure or boundaries in her life. Despite the Department offering the deceased placements and support the deceased elected to self-select where to live.

On 19 April 2012 the deceased was at a party where she had been drinking alcohol. Shortly after 5.30am the deceased decided to leave the party and followed her uncle to his car. She asked him for a lift to Roebourne. The deceased's uncle told the deceased he was too drunk to drive. The deceased's uncle then got into the passenger side of his car, as he intended to lie down so he could go to sleep. The deceased got into the driver's seat of her uncle's car. The keys to the vehicle were in the ignition of the car and the deceased has been able to start the car. She had never held a drivers' licence. The deceased commenced to drive the car towards Roebourne while the deceased's uncle fell asleep. At about 6.00am that day, approximately 5 kilometres from Roebourne, the car swerved and rolled over several times. The car eventually landed upside down on the right hand side of the road with the front end facing away from Roebourne.

Witnesses to the vehicle crash rendered assistance at the scene and called police. The deceased was conveyed by ambulance to the Roebourne Hospital, examined and was transferred to the Nickol Bay Hospital in Karratha. The deceased was found to have head wounds to her right forehead and right cheek and a degloving injury to the left parietal area of her scalp, as well as marked swelling around her right eye and right side of her face. She also had a deep laceration to her knee, laceration to her outer left ankle and minor abrasions to her torso. The deceased's case was discussed with a Trauma Registrar at Royal Perth Hospital and it was agreed the deceased should be transferred by Royal Flying Doctor Service to Royal Perth Hospital.

The deceased arrived at Royal Perth Hospital in the early evening of 19 April 2012 where she was treated and underwent surgery the following day. The deceased remained at Royal Perth

Hospital, where she received ongoing treatment. The deceased developed a serious infection, which was complicated by her previously undiagnosed diabetes. Despite intensive treatment she succumbed to the infection and died on 22 May 2012.

The Coroner was satisfied that there was nothing that the Department did or failed to do that contributed to the deceased's death. The deceased's diabetes may have been able to be diagnosed at an earlier stage, if she had attended medical reviews, but even if diagnosed it was not clear whether she would have been able to manage her condition given the Department's limited ability to change her lifestyle without her cooperation.

The Coroner did not make any recommendations.

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

Vincent Tavita Tolai SCHWENKE
Inquest held in Perth 30 November 2017 and 1 December 2017, investigation finalised 15 January 2018

Mr Rowan Wallace Schwenke (the deceased) died on 11 December 2015 at Sir Charles Gairdner Hospital. The Coroner made an open finding in respect of the manner of death. The cause of death was complications of ligature compression of the neck (hanging). He was 24 years old.

Immediately before death the deceased was a "person held in care" under the *Coroners Act 1996* because he was an involuntary patient under the *Mental Health Act 2014.*

The focus of the inquest was primarily on the medical care and supervision provided to the deceased while a patient at Royal Perth Hospital and St John of God Public Hospital in Midland, and events leading up to the incident where he was found hanging.

The deceased developed sudden onset symptoms of psychosis and mood disorder with suicidal thoughts. With support from his family the deceased took appropriate steps to obtain medical treatment from his general practitioner and later presenting at a hospital Emergency Department as his symptoms escalated. He was eventually admitted to St John of God Public Hospital Midland on 8 December 2015 as an involuntary patient. Before a clear diagnosis was made for his psychotic symptoms, and while an involuntary patient at St John of God Public Hospital, the deceased sustained irreversible brain damage after attempting to hang himself in his room.

The Coroner heard evidence about the difficulty for medical staff, because the deceased's suicidal ideation appeared to be fluctuating. This made it very difficult to pick when he might be suicidal. The evidence suggested the deceased's mental state had undergone a change on the morning that he hanged himself and he had woken up actively suicidal. The Coroner noted that it was difficult to conclude the deceased had a full capacity to understand that he might die from his actions. The Coroner noted the deceased's actions may have been affected by his psychosis, given there was an element of lack of rationality in his behaviour overnight. The Coroner concluded there was not enough evidence that the deceased was in a position to know and understand the nature and consequences of his actions and, accordingly, made an open finding as to the manner of death.

The Coroner concluded the deceased received a reasonable standard of medical care and the evidence suggested his death was unpredictable and unexpected. The Coroner noted that hospital staff responded appropriately to the level of risk he appeared to present to himself at that time. They also acted appropriately to provide him with emergency care when he was later discovered hanging.

The Coroner did not make any recommendations.

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

KPLW (Subject to a Suppression Order)
Inquest held in Perth 10 January 2018, investigation finalised 30 January 2018

KPLW (the deceased) died on 29 March 2013 at Northam Regional Hospital. The Coroner found the manner of death was by natural causes. The cause of death was consistent with respiratory failure and acute pancreatitis in a young girl with cerebral palsy, seizure disorder and chronic respiratory problems. She was seven years old.

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

The focus of the inquest was primarily on the care and supervision provided to the deceased prior to death by the foster carers arranged by the Department.

The deceased was healthy at birth and quickly discharged home from hospital to live with her biological parents and older sibling. When the deceased was six weeks old she was taken by her family to the Peel Health Campus in poor health. She was transferred to Princess Margaret Hospital where extensive medical tests revealed an acquired brain injury and various other injuries to the deceased's body. The deceased's family were unable to give an explanation as to how the deceased had been injured, although the nature of the injuries suggested the deceased had been violently shaken. An investigation failed to identify the perpetrator. However, the Department's investigation raised concerns that the deceased's parents may have been involved in causing harm to the deceased through rough handling, and at the very least they had not been sufficiently protective of the deceased.

Due to the deceased's profound physical and cognitive disabilities the deceased required high level 24-hour care. In June 2006 the deceased was placed with foster carers who were experienced in providing care to children with special needs. The deceased remained with these foster carers until her death.

In March 2013 the deceased had been unwell with a respiratory illness and had received medical treatment. On 29 March 2013 the deceased's foster mother woke up and observed the deceased's breathing was laboured. She immediately checked the deceased's blood oxygen levels and temperature and noted that both were low. The deceased was driven to the Northam Regional Hospital and the deceased's foster mother noticed that the deceased was crying and struggling to breathe during the journey. A few minutes before reaching the hospital the deceased gave a cry and stopped breathing altogether. The deceased's foster mother immediately delivered a few blows to the deceased's back in an attempt to start her breathing again but was not successful. Upon arriving at the hospital staff immediately attended and began to give the deceased CPR in an attempt to resuscitate her. Two doctors attended and assisted in resuscitation efforts. Despite all efforts the deceased was certified life extinct.

The Coroner noted the deceased's foster carers were committed to providing a safe, supportive and loving environment for the deceased throughout the deceased's relatively short life. The Coroner was satisfied the deceased's care and supervision was appropriate and of a very high standard.

The Coroner did not make any recommendations.
The Finding is on the website of the Coroner's Court of Western Australia.

Radwan KANAWATI
Inquest held in Perth 22 August 2017, investigation finalised 23 February 2018

Mr Radwan Kanawati (the deceased) died on 17 October 2014 at Kenwick. The cause of death was atropine toxicity and the coroner found the manner of death was by way of accident. He was 41 years old.

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

The deceased was admitted to Bentley Hospital from 21 March 2012 until 13 October 2014. He was initially admitted with a psychotic episode and was noted to have limited intellectual capacity, impulsivity and a degree of unpredictability. The staff at the Bentley Hospital found it difficult to manage his physical health, especially his diabetes. He had been prescribed orally administered atropine for hypersalivation.

A multi-agency group met to plan the deceased's discharge from Bentley Hospital and determined that he required 24 hour support in the community to manage his mental health and his risk of re-offending. Planning for his discharge focused on controlling his diabetes. There was no discussion about supervising his use of atropine as it was presumed that he was capable of self-administering it. The people involved in the deceased's care, including the clinicians, were unaware of the toxic nature of atropine. He was discharged on 13 October 2014 and made subject to a Community Treatment Order.

On the evening of 16 October 2014 the deceased was at his home with his live-in carer. He became angry and punched his bedroom window, cutting his hand. He was taken to a medical centre for a superficial laceration to his right index finger. On returning home, he went into his room and watched TV.

At about 1.30 am on 17 October 2014 the deceased's carer cooked him some food, which the deceased ate. He then returned to his room. At about 6.40 am the deceased's carer went into the deceased's bedroom and found him lying on the floor next to his bed, cold to the touch and without a pulse. Post mortem examinations revealed that the cause of death was atropine toxicity.

The Coroner noted that there were shortcomings in the deceased's care which allowed for an accident to occur, but that the shortcomings were the result of an understandable assumptions rather than incompetence or lack of goodwill. The Coroner concluded that the supervision and care was deficient to the extent that the deceased was provided with atropine in toxic quantities and was left to administer it to himself from a container which facilitated an overdose.

The Coroner did not make any recommendations.

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

William Scott BARTLETT
Inquest held in Perth 25 October 2017, investigation finalised 7 March 2018

Mr William Scott Bartlett (the deceased) died on 25 September 2015 at Royal Perth Hospital. The Coroner found the manner of death was misadventure. The cause of death was hypoxic brain injury and myocardial ischaemia following cardiac arrest during restraint in a man with likely drug affect. He was 36 years old.

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

In the early evening on 24 September 2015 the deceased was walking along Eden Street in West Perth. He was under the influence of methylamphetamine and was acting erratically. Witnesses from a gym observed him smash the windscreen of a parked car so they chased him, restrained him on the ground and contacted police. The deceased resisted their restraint with an unusual strength, but by the time police officers arrived he had stopped struggling. When police arrived, they saw the deceased was being restrained by three men, and that he was moving his head around.

Police officers handcuffed the deceased who was compliant with their requests by moving his arm at their direction. As police were in the process of telling him that he was under arrest, he became unresponsive and stopped breathing. They called for an ambulance, removed the handcuffs, and administered chest compressions. Ambulance paramedics took over the resuscitation and conveyed the deceased to the emergency department Royal Perth Hospital. His condition deteriorated and he died the next morning.

The Coroner was satisfied that the force used to restrain the deceased was appropriate in the circumstances and that the restraint did not cause or contribute to the death.

The Coroner did not make any recommendations.

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

HLS (Subject to a Suppression Order)
Inquest held in Broome 7-10 August 2017, investigation finalised 26 April 2018

HLS (the deceased) died between 13 and 14 March 2013 at La Djadarr Bay, Dampier Peninsula. The Coroner found the manner of death was by misadventure. The cause of death was consistent with immersion in a young man with traumatic amputation of the left foot and multiple soft tissue injuries. He was 15 years old

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

The focus of the inquest was primarily on the deceased's diagnosis of Fetal Alcohol Syndrome (FASD) and what flowed as a consequence of that diagnosis in terms of his care needs.

The deceased was identified as requiring a high level of supervision due to his absconding behaviours and solvent abuse. Special Purpose Subsidy funding was approved and the carers he was placed with worked for the organisation known as Life Without Barriers. After one unsuccessful placement, that broke down after the deceased absconded, on 24 April 2012 the deceased was placed at La Djadarr Bay, a small community on the Dampier Peninsula. The placement was considered to be "on country" and gave him opportunities to develop his cultural understanding and independent living and social skills.

In the weeks prior to his death the deceased and another boy stole a car and absconded from La Djadarr Bay. They were found in Broome and eventually returned to La Djadarr Bay the day before the deceased's death.

On 13 March 2013 police officers at Dampier Peninsula Police Station were contacted by Life Without Barriers who reported the deceased had gone missing. He had been seen walking out into the mangroves, which are crocodile infested. Given the serious concerns for the deceased's safety, a search was commenced immediately. On 14 March 2013 the deceased's body was found in thick mangrove approximately 5 km from La Djadarr Bay Community. He had a severe leg injury consistent with a crocodile attack.

The Court heard evidence from two experts in the field of diagnosis and management of children with FASD in Western Australia. The Coroner recommended the continuation of universal screening and support for pregnant women for alcohol use and that all children identified through that screening as being at risk of neurodevelopmental impairment on the basis of antenatal exposure to alcohol and/or early life trauma be assessed at specified stages.

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

Robert Paul RODDA
Inquest held in Perth 2 February 2018, investigation finalised 2 May 2018

Mr Robert Paul Rodda (the deceased) died on 14 October 2015 at Fiona Stanley Hospital. The Deputy State Coroner found the cause of death was multi-organ failure following surgical repair of abdominal aortic aneurysm. The manner of death was natural causes. He was 62 years old.

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

The deceased had been declared a terminally ill prisoner in 2012 due to the severity of his cardiac and respiratory disease, and in December 2012 had first been diagnosed with an abdominal aortic aneurysm. Surgery was contraindicated due to the severity of the deceased's other morbidities. On 21 September 2015 the deceased was on route to Royal Perth Hospital for a scheduled cardiology appointment with a SERCO escort when he complained of chest pains and the ambulance was diverted to Fiona Stanley Hospital.

While in hospital, on 22 September 2015 the indications were that his abdominal aortic aneurysm had ruptured and he was taken to theatre for emergency surgery to repair the rupture. The necessary surgery caused the deceased to suffer renal failure requiring permanent dialysis. The deceased found the dialysis extremely taxing. On 12 October 2015 the deceased withdrew himself from dialysis and palliative care was commenced.

The Deputy State Coroner, after considering all of the evidence, found the deceased's supervision, treatment and care was appropriate and clearly better than he would have achieved in the community at large.

The Deputy State Coroner did not make any recommendations.

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

LCTM (Subject to Suppression Order)
Inquest held in Bunbury 11 to 13 December 2017, investigation finalised 25 June 2018

LCTM (the deceased) died on 24 February 2014 at Princess Margaret Hospital. The Coroner found the manner of death was unlawful homicide. The cause of death was complications of head injury. He was one month old.

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

The deceased was born six weeks premature on 21 January 2014 at Bunbury Regional Hospital. He remained in hospital for several weeks after his birth for medical reasons relating to his prematurity. The deceased was the first child of his teenaged parents. The deceased's father was in the care of the CEO of the Department of Child Protection and Family Support and he had a history of substance abuse, violence and crime. His relationship with the deceased's mother was highly volatile and suspected of being marred by domestic violence.

The Department of Child Protection and Family Support became involved with the family for Signs of Safety planning after the birth.

On 5 February 2014 the Department decided that there was insufficient evidence to take action to remove the deceased from his parents' care and a plan was developed for him to be discharged home with his parents. This was despite a previous Code Black incident involving the deceased's father at the hospital.

On 15 February 2014 the deceased's parents collected the deceased from the nursery and took him to their room at the hospital. His mother left the room leaving the deceased alone with his father. This was the first time the deceased's father had been alone with him. In a timeframe of three to ten minutes the deceased's father deliberately struck the deceased's head against a hard surface in the room with considerable force at least twice. These blows fractured the deceased's skull and caused severe brain injuries. The deceased's father did not go and seek assistance for him but remained with him in the hospital room.

The deceased's mother returned to the room and realised the deceased was not breathing. She rushed him to the nursery where efforts were made to resuscitate him. The deceased was subsequently transferred to Princess Margaret Hospital for further treatment. Sadly, the deceased could not recover from his injuries and he died.

The deceased's father was subsequently charged and convicted of manslaughter in relation to the death. The father was later found to have FASD, which raised questions about whether an earlier diagnosis would have affected the outcome.

The Coroner concluded that whilst the exact events of 15 February 2014 could not have been easily predicted, nevertheless there were warning signs that were not properly heeded by those involved, largely due to a lack of real understanding and knowledge about the father and his increasing violence and lack of ability to regulate his emotions. As a result there were missed opportunities to prioritise the deceased's safety and wellbeing.

The Coroner did not make any recommendations.
The Finding is on the website of the Coroner's Court of Western Australia.

Brook Damian CAIN
Inquest held in Perth 23 January 2018, investigation finalised 27 June 2018

Mr Brook Damian Cain (the deceased) died on 13 November 2014 at Carey Park. The cause of death was ligature compression of the neck (hanging) and the coroner found the manner of death was by way of suicide. He was 39 years old.

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

At an early age the deceased began to abuse cannabis and alcohol and tried other drugs. He became addicted to amphetamine and at about 23 years of age he began to experience severe mental health problems. In 2006 he was diagnosed with drug-induced psychosis. That diagnosis was later revised to schizophrenia and then schizoaffective disorder with anti-social personality traits. He had a history of self-harm and suicide attempts when he was acutely unwell. He was involved with mental health facilities as a voluntary patient, an involuntary in-patient and as an out-patient on a Community Treatment Order. Difficulties in treating him were compounded by his lack of insight, non-compliance with oral medication and on-going drug abuse, which exacerbated his symptoms.

On 12 November 2014 the deceased had an altercation with an acquaintance, leading to the deceased throwing a vase through the acquaintance's window and threatening him with a knife. Police arrested the deceased and took him to the police station to charge him. The deceased's mother contacted the police station to ask that police take the deceased to Bunbury Hospital for mental assessment. The deceased showed no indication that he was in danger of self-harm or that he required assessment, so police officers took him home after charging him.

The next morning, the deceased's mother was unable to contact the deceased, so she rang the deceased's case manager, who conducted a welfare check and found the deceased hanging by the neck with washing line tied to an article in the rear yard of his unit.

The Coroner was satisfied that everyone involved in the deceased's supervision, treatment and care while he was on a CTO acted in what they considered to be the deceased's best interests and that whilst improvements could have been made, the standard of care was generally acceptable.

The Coroner made a recommendation directed at improving the training of police officers when dealing with persons with mental health issues.

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