# Office of the State Coroner

## Annual Report

# 2012-2013

State Coroner Western Australia

10th floor, Central Law Courts
501 Hay Street
PERTH WA 6000

*Telephone :* (08) 9425 2900
*Facsimile :* (08) 9425 2920
Website : www.coronerscourt.wa.gov.au

7 October 2013

Our Ref : A-1

The Honourable Michael Michin LLB(Hons) BJuris(Hons) MLC
Attorney General
10th floor, Dumas House
2 Havelock Street
WEST PERTH WA 6005

Dear Minister

In accordance with Section 27 of the *Coroners Act 1996* I hereby submit for your information and presentation to each House of Parliament the report of the Office of the State Coroner prepared by, Mr Alastair Hope, State Coroner, for the year ending 30 June, 2013.

The Coroners Act 1996 was proclaimed on 7 April 1997 and this is the 17th annual report of a State Coroner pursuant to that Act.

Yours sincerely

Evelyn Vicker

Evelyn Vicker
A/STATE CORONER

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## State Coroner's Overview

This will be the last Annual Report submitted by me as State Coroner pursuant to section 27 of the *Coroners Act 1996*.

At the time of writing I have resigned from office by written notice addressed to the Governor. That resignation will be effective as from 10 January 2014, I will, however, be taking accrued annual and long service leave prior to that date so that my last working day is anticipated to be Friday 2 August 2013.

I was appointed as the first State Coroner for the State of Western Australia on 5 November 1996 and in that capacity have been responsible for implementing major changes to the coronial system which were required by the *Coroners Act 1996*.

At this time there have been over 35,500 deaths reported to me for investigation. In addition, during this period there have been over 941 inquest hearings conducted.

During my period as State Coroner the workload of the Coroner's Court has increased considerably. This increase has been partly because of the increased population resulting in more deaths, but also because of much greater public expectations as to the extent and quality of death investigations.

The Registry Overview herein provides a helpful analysis of the increased amount of work completed by the office during the last financial year. In addition that report contains a chart detailing the office structure setting out the substantive positions and non-recurrent funded positions as at the end of 2013.

The Coroner's Court has been very much dependent on non-recurrent funding for staff for a number of years but I am hopeful that provision will be made for recurrent funding in respect of all temporary positions held by staff at the Coroner's Court. This will mean an increase from the original substantive positions of 11 (with one additional findings clerk position recently added) and two coroners to 23 positions in the office and four coroners. As only five of the 23 positions are currently held by a person who is not acting in the position, this will involve a significant process of recruitment and appointment.

The provision of this recurrent funding reflects a commitment by Government to the ongoing proper functioning of the Coroner's Court which is welcomed.

During the financial year the number of cases completed was substantially higher than the number of deaths reported for the second year in a row. In relation to cases which are ultimately completed by way of administrative findings, this office is currently reducing backlog numbers on a relatively regular basis.

In respect of cases to be inquested, action has been taken to address what has been an unacceptably large backlog of cases. It will take years rather than

months, even with the current increase in resources, to reduce that backlog to what I would consider to be acceptable numbers.

Unfortunately in respect of the three Counsel Assisting positions in the office, two of those were not recurrently funded and the holders of those positions vacated their positions at the conclusion of their 12 month contracts on 30 June 2013. The Coroner's Court was only funded to offer temporary positions until August, a period of two months, and it was not possible to fill those vacant positions for that short period, so there was a significant reduction in the planned listing of cases for inquest hearing for late 2013. Every effort, however, was taken to limit the impact of this unfortunate situation.

It is pleasing to note that the problem experienced at the end of this financial year will not occur in future as there will be ongoing funding for the positions.

### *Law Reform Commission Report and Strategic Review*

As noted in the Annual Report for 2011-2012 in January 2012 the Law Reform Commission of Western Australia released its final report on the Review of Coronial Practice in Western Australia. Recommendation 5 of that report proposed that a strategic review of the office of the State Coroner should be conducted by a suitably qualified and independent person or persons at the earliest opportunity.

With a view to complying with that recommendation and Section 57 of the *Coroner's Act 1996*, which requires the Attorney General to carry out a review of the operations of the Act every five years, AOT Consulting Pty Ltd was engaged by the Department of the Attorney General in May 2012. AOT Consulting Pty Ltd completed reports in late 2012 and I have responded to the Attorney General in relation to both of those reports.

In relation to the Law Reform Commission Report, that report is publically available and I have prepared a response to the contents of that report which has been provided to the Attorney General and to the Department. A copy of that response is attached hereto at Annexure A, subject to a section which has been redacted for privacy and confidentiality reasons.

### *Inquest Call-Overs*

In order to reduce the backlog of cases to be inquested and in order to make maximum use of additional resources a system of call-over has been put in place.

This system will address many of the concerns expressed by the Law Reform Commission in relation to inquest management.

Under this system cases which have been identified as requiring an inquest hearing will be listed in court with a view to determining what action needs to be taken before they can be listed for hearing or, in the event that they can be listed for hearing, allocating a listing date.

The system involves sending letters to the family of the deceased and any identified individuals or organisations in respect of whom it is considered that an adverse finding may be made advising them of the call-over date.

A letter is also to be sent to the State Solicitor's Office and offices of other departments or organisations which are likely to have an interest in the call-over. This should enable input at an early stage in the inquest process from these organisations and assist them with the prioritising of their work.

Initially only cases which have been largely prepared have been listed at the call-overs, but it is intended that when the system is fully implemented all cases to be inquested will be listed. The plan is that when the system is fully operational cases will be listed in the next call-over after the decision has been made to inquest.

It is considered that this procedure will have a number of significant ongoing benefits, one of which will be that the process will be transparent and the reasons for delays will be known. It is also anticipated that this process will encourage all parties to be more involved in the process and importantly should enable individuals or organisations in respect of whom an adverse finding may be made to be prepared well in advance of the hearing.

Using the above procedure it is my expectation that the call-over system should enable the court to:

- be aware of the position in respect of all inquest files;
- ensure that all cases are being actively managed;
- ensure that cases are prepared for inquest earlier which will enable listing to take place earlier, summonses to be issued earlier and input from parties to be obtained earlier; and
- ensure that once cases are prepared and witness lists are settled, briefs are prepared and provided to interested parties who can prepare for the inquest at an earlier time.

### *Coroners involvement in the decision as to whether a full Post Mortem Examination is required*

A concern of the Law Reform Commission was that there should be greater involvement of coroners in the decision as to whether an internal post mortem examination is required in all cases, including cases where there is no objection to an internal post mortem examination being performed.

With a view to addressing this concern and in order to bring Western Australian practices into line with the practices in other states and territories of Australia, a gradual process of greater coroner intervention has commenced.

As a first step a procedure has been implemented which requires a reasoned decision to be made by a coroner as to whether an internal post mortem examination is required in the case of all deaths of persons over 80 years of age.

In effect, there is to be a default position of not having an internal examination in these cases unless good reasons exist for having one.

A new form has been prepared which requires a coroner to review each of these cases and to make a number of relevant decisions, including in cases where no internal examination is to be required, as to whether an external examination is required, whether toxicology is required and whether medical records or notes need to be reviewed.

This procedure is intended to reduce the number of post mortem examinations being performed and provide greater direction to police officers conducting investigations and to limit the extent of investigation in appropriate cases.

Our review of past cases has resulted in a conclusion that age is often an important factor in determining whether an internal examination is required. A graduated process is intended to take place following review of the results of this initiative which will increase the extent of coroner involvement in all decisions about internal examinations.

### *Changes to the Coroner's Brochure 'When a Person Dies Suddenly'*

In order to accommodate the changes described above, the Coroner's Court brochure 'When a Person Dies Suddenly' has been amended to inform family members that any person may ask for an internal post mortem examination to be conducted on a body.

The brochure also encourages any person making such an application to lodge the application as soon as possible and advises that applications to have an internal post mortem examination will be responded to at any time prior to the body being released.

The brochure has also been altered to advise family members wishing to object to an internal examinational that objections to an internal post mortem examination will be responded to at any time prior to the examination commencing. Advice is provided that the shortest time for commencing a post mortem examination will depend on a number of practical factors including the place of death and the day of the week when the brochure was served.

### *Vision for the Future*

Recurrent funding for the Coroner's Court will enable it to operate efficiently, it is important that long term plans are made and a suitable vision for the future is identified.

Particularly important in the context of any future plans will be enhancing the death prevention role of the Coroner's Court.

It is often said that coroners speak for the dead to protect the living.

In my view it is also important that the public health role of the Coroner's Court should be enhanced.

In many ways the functions of the Coroner's Court straddle law and medicine. While the Australian model is to place the coronial jurisdiction in a predominantly legal context and the Western Australian Coroner's Court is a court within the State's judicial system (with which I agree) the court also has an important public health function to perform.

In seeking to address the high suicide rates in Western Australia, for example, an obvious starting point would be to resource better information gathering within the Coroner's Court. It is the Coroner's Court which obtains information in respect of every suicide in the State. Privacy and confidentiality issues, which are extremely important in this context, pose serious problems for outside researchers seeking to identify underlying causes of suicide. These privacy and confidentiality issues would largely be overcome if important research was conducted by a research officer working for the court.

If there was a research officer working within the Court reviewing all suicide cases, that person could also have a role in assisting with the direction of information gathering. Unless comprehensive questions are consistently asked in all investigations there will not be a suitable statistical basis for high quality research. It is the Coroner's Court which directs the relevant information gathering and input from such a person could result in the obtaining of more useful and comprehensive information.

In the area of unexpected baby deaths, also, it is easy to see how a person involved in reviewing these cases within the Coroner's Court could perform an important role in monitoring the way in which information is gathered and comparing information gathering in Western Australia with the information which is obtained interstate and overseas.

Such a person could also assist with auditing the quality of information which has been gathered to ensure that it is both reliable and of use.

Such a person working within the Coroner's Court would be well placed to interact with the Coronial Ethics Committee and researchers to ensure that access is provided to useful information on an ethical basis. This person would also be well placed to provide information to members of parliament and others seeking statistical information about a range of issues such as cases of apparent cluster suicide deaths.

### *The holding of Inquests shortly after a death occurs*

In the event that the inquest backlog could be eliminated or significantly reduced, it would be possible to list cases for inquest within a relatively short timeframe which would be hugely beneficial in some cases. In cases where, for example, deaths have resulted from a product defect, an early inquest could result in recall of the product avoiding further deaths. This is one example of a range of cases where early inquest hearings could serve to identify problems and promote the need for change in order to save lives.

### *Coroner's Court Staff*

Staff at the Coroner's Court have worked extremely hard in difficult circumstances for a number of years.

Most staff have responded extremely positively to the proposed changes and worked hard to ensure that the additional resources which have been provided have been used effectively.

I have been extremely proud of the work ethic and performance of all staff during my period as State Coroner.

### *Pathologists and PathWest Staff*

I wish to publicly recognise the very positive interaction which has always existed between the WA Coroner's Court and the Forensic Pathologists and others at PathWest.

In some states there has been unfortunate differences of opinion between coroners and pathologists, but this has never been a problem in Western Australia. I particularly wish to thank the Chief Forensic Pathologist, Dr Clive Cooke, for his ongoing support and for the great contribution of all of his staff.

### *ChemCentre*

I also wish to recognise the contribution which has been provided by the ChemCentre in providing toxicological reports in a timely and efficient manner throughout my period as State Coroner. I particularly wish to thank, Mr Robert Hansson, for his ongoing cooperation and support.

### *Western Australia Police*

The Western Australia Police have provided a generally high quality service in investigating sudden deaths during my period as State Coroner. The quality of most investigations has been high considering resource limitations and I have been impressed with recent improvements in the quality of many investigations. My task as State Coroner has been made easier by the very positive contribution of WA Police.

WA Police have also provided this office with two high quality, senior police officers throughout my period as State Coroner and those officers have performed an invaluable role in interacting with police investigators throughout the State, performing a range of tasks such as issuing warrants etc, and in a number of cases assisting with the conduct of inquest hearings.

The Coronial Investigation Unit of WA Police has generally produced high quality investigation results in difficult circumstances and I am grateful to the officers involved for their good work. The current head of the Coronial Investigation Unit, Inspector Valdo Sorgiovanni, is the most recent of a number of officers in charge of the unit who have worked hard to provide a good quality service.

### *Coronial Ethics Committee*

It is important also that the excellent work of the Coronial Ethics Committee is recognised. Members of the committee perform their important function on a voluntary basis and over many years have provided high level ethical review of many applications for access to coronial information. They have played a fundamentally important part in the death prevention role of the Coroner's Court.

### *Conclusion*

In conclusion I wish to record that it has been a privilege to be State Coroner of this great State. I consider that the Coroner's Court is a most important institution.

In the 'Guidelines for Coroners' attached to my first annual report for the year ended 30 June 1997 I referred to the coronial system in the following terms:

> It is the paramount duty of any state to protect the lives of its citizens. To this end, it is important that the coronial system monitor all deaths and particularly that it provides to the community a review of the circumstances surrounding deaths that appear preventable. Every effort should be made to obtain recommendations which might prevent similar deaths in the future.
>
> It is the role of the Coroner's Court to speak for the dead to protect the living.
>
> The coroner has a vital role to play as an independent judicial officer serving the Crown and the public. It is in the interest of all that the circumstances of certain types of death are carefully and independently examined in public.
>
> A coronial system is essentially a fact finding system and should reflect commitment to the community and particularly commitment to relatives of deceased persons.
>
> The system should be efficient, consistent throughout the state, thorough, and yet compassionate and ever mindful of human distress and the need to preserve human dignity.

After over 16 years of working as State Coroner my views expressed above remain unchanged.

## Registry Overview

Throughout 2012-13 the Coroner's Court has continued to improve its performance and increase it outputs as a result of the Government's continuing provision of additional staff and judicial resources. The main focus of the Coroner's court remains on clearing the backlog of coronial cases and the timely finalisation of cases.

Strategies were employed to identify older cases that were awaiting an investigation report and the outcome was one third of all the cases closed were over 12 months old.

The backlog of cases was reduced from 572 in 2011-12 to 425 as at June 2013, a reduction of 147 cases. This is significant given that new backlog cases (any case over 12 months old) are added to the backlog on a daily basis on the anniversary of the date the case was reported to a coroner.

The total number of cases referred for investigation and the number of reportable deaths referred to the Coroner's Court was 2,830. (including 675 death certificates). This is an increase of 151 deaths on 2011-12.

The number of deaths ultimately determined to be reportable also increased by 239 cases, to 2,155 in 2012-13. In all reportable death cases it is necessary for the coroner investigating the death to make findings pursuant to section 25 of the *Coroners Act 1996.*

The number of cases finalised was again higher than the number of deaths reported for the second year in a row with a record number of 2,217 cases being finalised in 2012-13. The number of cases finalised by inquest normalised from a high of 98 cases in 2011-12 (due to Christmas Island inquest involving 50 deaths) to 56 in 2012-13. (A case in this context refers to the investigation of the death of an individual).

At the conclusion of the financial year the cases on hand referred to a coroner amounted to 1926 of which 425 were backlog cases (over 12 months old).

The following tables show an overview of the work of the office in 2012-13.

| CASES RECEIVED | Perth | Country | TOTAL |
|---|---|---|---|
| **Full Investigation** | 1589 | 566 | 2155 |
| **Death Certificates** | 675 | n/a | 675 |

| CASES COMPLETED | Perth | Country | TOTAL |
|---|---|---|---|
| **Finalised by Inquiry** | 1662 | 499 | 2161 |
| **Finalised by Inquest** | 42 | 14 | 56 |
| **TOTALS** | **1704** | **513** | **2217** |

| BACKLOG | Perth | Country | TOTAL |
|---|---|---|---|
| **Backlog** | 314 | 111 | 425 |

| CASES ON HAND | Perth | Country | TOTAL |
|---|---|---|---|
| | 1483 | 443 | 1926 |

| FINALISATION RATIO | | |
|---|---|---|
| **Finalised by Inquiry** | 97.47% | (2161) |
| **Finalised by Inquest** | 2.53% | (56) |

The table below shows the age of a file at the time of closure. It will be seen that 70.5% (1562) of files were closed in under 12 months and 29.5% (655) were over 12 months old (i.e. backlog files).

| | INQUIRY | | INQUEST | |
|---|---|---|---|---|
| TIMELINES | Perth | Country | Perth | Country |
| **< 3 mths** | 146 | 72 | 1 | 0 |
| **3-6 mths** | 282 | 171 | 0 | 0 |
| **6-12 mths** | 721 | 166 | 3 | 0 |
| **12-18 mths** | 321 | 44 | 1 | 1 |
| **18-24 mths** | 70 | 14 | 7 | 1 |
| **> 24 mths** | 122 | 32 | 30 | 12 |
| **TOTALS** | **1662** | **499** | **42** | **14** |

The table below shows the courts performance in these areas over the last three years.

| | 2010/11 | 2011/12 | 2012/13 |
|---|---|---|---|
| **Backlog** | 846 | 572 | 425 |
| **Cases on Hand** | 2312 | 2013 | 1926 |
| **Cases Reported** | 1994 | 1916 | 2155 |
| **Case finalisations** | 2193 | 2184 | 2217 |

A total of 2,830 deaths were referred to a coroner during the year. Of these deaths, in 675 cases, death certificates were ultimately issued by doctors. In a significant number of these cases there are sometimes problems experienced in locating a treating doctors or a treating doctor had initial reservations about signing a certificate which were ultimately resolved.

In the Perth Metropolitan area there were 1,589 reported coroner's cases and in the country regions there were 566 reported coroner's cases, a total of 2,155 cases (an increase of 239 cases) on the previous year.

Coroner's cases are 'reportable deaths' as defined in section 3 of the *Coroners Act 1996*. In every coroner's case the body is under the control of the coroner until released for burial or cremation. In all coroners' cases an investigation takes place and either on the basis of that investigation or following an inquest subsequent to the investigation, a coroner completes findings as to the identity of the deceased, how the death occurred and the cause of death. Statistics relating to the manner of deaths referred for investigation by a coroner are detailed below.

| *Manner of Death* | *2008/09* | *2009/10* | *2010/11* | *2011/12* | *2012/13* |
|---|---|---|---|---|---|
| **Accident** | **469** | **563** | **338** | **682** | **678** |
| **Misadventure** | **6** | **10** | **7** | **22** | **3** |
| **Natural Causes** | **928** | **887** | **776** | **875** | **991** |
| **Open Finding** | **68** | **79** | **47** | **145** | **53** |
| **Self Defence** | **1** | **0** | **0** | **1** | **1** |
| **Suicide** | **288** | **337** | **150** | **399** | **372** |
| **Unlawful Homicide** | **50** | **49** | **45** | **68** | **57** |
| **Totals** | **1,810** | **1,925** | **1,363** | **2,192** | **2,155** |

### *Involvement of Relatives*

The *Coroners Act 1996* considers relatives of deceased persons in the coronial process. The Act requires a Coroner to provide information to one of the deceased person's next of kin about the coronial process in every case where the Coroner has jurisdiction to investigate the death.

In practice the information is contained in the Coroner's Brochure which is provided to the next of kin by a police officer who is also required to explain the brochure. A police officer is also required to complete details on the

mortuary admission form about service of the brochure which is taken into account by a coroner or a delegate prior to any decision being made about whether or not a post mortem should be conducted.

During the year a total of 2,830 deaths were referred to the Coroners Court. In 675 cases a death certificate was ultimately issued. Of the remaining 2,155 cases a total of 305 objections were made to the conducting of a post mortem examination.

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

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

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

The following tables detail statistics relating to objections to post mortem examinations for the year. The cases where a death certificate was issued by a doctor have *not* been included.

### *Deaths Referred to the Coroner's Court*

| *Reported Deaths* | |
|---|---|
| **Immediate post mortem** | 56 |
| **No objection to post mortem** | 1762 |
| **Objection to post mortem** | 305 |
| **No post mortem conducted (missing person etc.)** | 32 |
| **Number of Reported Deaths** | 2155 |

### *Outcomes in cases where an Objection was initially received*

| *Objections to Post Mortems* | |
|---|---|
| **Objection accepted** | 185 |
| **Objection withdrawn** | 118 |
| **Objection withdrawn after coroner over-ruled** | 2 |
| **Applications to Supreme Court** | 0 |
| **Total Objections to Post Mortems** | 305 |

It can be seen from the above tables that of all the deaths referred to the Coroners Court relatively few were subject to objections.

In the majority of cases where an objection was received the decision which was ultimately made was in accordance with the wishes of the family. There were a total of 305 objections (an increase of 105 on 2011-12) of which 118 were withdrawn prior to a ruling being given by a coroner and 185 were accepted by a coroner and no post mortem examinations were ordered. In two cases the family withdrew the objection.

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

### *Review of the Office*

On 23 February 2012 the Law Reform Commission of Western Australia (LRCWA) tabled the final report in State Parliament regarding its Review of Coronial Practice in WA which contained a total of 113 recommendations for reform.

While the majority of recommendations address legislative reform or clarification, there are a number of recommendations that invite reform to practices and policies, both of the Coroner's Court and of other agencies with peripheral involvement in the delivery of coronial services in Western Australia. Many of these recommendations have been addressed or are in progress.

Recommendation 5 – *That a strategic review of the Office of the State Coroner be conducted by a suitably qualified independent person or persons at the earliest opportunity.*

In May of 2012 an independent consultant was engaged by the Department of the Attorney General (DotAG) to undertake both the Strategic Review of the Office of the State Coroner and section 57 (*Coroners Act 1996*) Review of the operations of the *Coroner's Act 1996*. The Strategic Review was completed in mid-November 2012 and the section 57 Review in mid-December 2012.

A staged implementation strategy over three years is proposed to address the recommendations of the Review, this will include a Legislative Project to progress:

- Amendments to the *Coroners Act 1996*;
- The drafting of new regulations/amendments to the Coroners Regulations 1997;
- The provision for Rules of Court and the power to publish Practice Directions in relation to how court procedures should be followed; and
- The development and update of Coroner's Guidelines.

The Legislative Project is considered to be critical in establishing the foundations for reform within the Coroner's Court and the improvement of the State's coronial system.

### *Case Management*

In May 2013 as a consequence of the independent review of the Coroner's Court work commenced on a project to develop the business case for a new coronial case management system (CCMS). It is envisaged the CCMS will meet the everyday case management needs of the court and be capable of producing much needed management and statistical reports.

### *Office Structure*

The table below shows the number of coroners and staff employed at the Coroner's Court from 2009 to the end of 2013.

| | A | | B | | C |
|---|---|---|---|---|---|
| | **Substantive Positions** | | **August 2009 Funding** | | **EERC Funding 2011 - 2013** |
| | **State Coroner** | | | | **Coroner** |
| | **Deputy State Coroner** | | | | **Coroner** |
| 1 | Office Manager | 14 | Senior Counsellor | 19 | Principal Registrar |
| 2 | Registry Manager | 15 | Counsel Assisting | 20 | Court Officer |
| 3 | Assistant Registry Officer | 16 | Counsel Assisting | 21 | Court Officer |
| 4 | Court Support Officer | 17 | Court Officer | 22 | Listings Manager |
| 5 | Court Support Officer | 18 | Receptionist | 23 | Findings Clerk |
| 6 | Systems Information Officer | | | | |
| 7 | Coronial Counsellor | | | | |
| 8 | Coronial Counsellor | | | | |
| 9 | Administrator | | | | |
| 10 | Secretary | | | | |
| 11 | Data Entry | | | | |
| 12 | Senior Counsel Assisting | | | | |
| 13 | Findings Clerk | | | | |

**Column 'A'** shows the number of full time coroners and staff at the Coroner's Office.

**Column 'B'** shows additional staff provided by temporary funding from August 2009.

**Column 'C'** shows additional staff provided by additional temporary funding from late 2011 to 2012-13 - a total of 4 Coroners and 23 staff.

### *Counselling Service*

The Coronial Counselling Service workload increased by 58.8% during 2012 - 13. During the past year the three coronial counsellors (two permanent, one temporary) recorded a total of 12,199 contacts. This equates to 4,066 contacts per counsellor, an increase of 1,505 more contacts per counsellor, compared with the 2011 – 12.

Coronial counsellors are available daily between 7am – 6pm and provide free counselling information and support to family members. This service is provided to regional as well as metropolitan coronial cases and may continue after the Finding is determined and the case is completed. In some instances coronial counsellors may deal with cases where the death occurred as long as 20 – 30 years ago. Families may still have an interest in viewing the file; they may require counselling or referral or have unresolved queries about the death.

Community standards have changed over the years and grieving families have an ever increasing expectation with regard to timeliness, information provision and dedication.

### *REFERRALS – CORONIAL COUNSELLING SERVICE*

| *Type of Service* | *2009-2010* | *2010-2011* | *2011-2012* | *2012-2013* |
|---|---|---|---|---|
| **Phone, Office/Home Visits** | 3,626 | 4,204 | 5,196 | 9,144 |
| **Offers of Service** | 960 | 919 | 949 | 1,080 |
| **Mortuary/file viewings etc.** | 1,198 | 896 | 1,538 | 1,975 |
| **Total Contacts** | **5,784** | **6,019** | **7,683** | **12,199** |

## *Coronial Ethics Committee*

The Coronial Ethics Committee was set up under the *Coroners Act 1996* 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.

The Committee requires a detailed written submission in relation to requests for Coronial data. The Committee meets at least quarterly to consider each request, and attempts 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 Committee makes recommendations to the State Coroner about whether the information should be released and under what conditions.

The Coroner's Court is very grateful for the considerable work done by Ethics Committee members. A large volume of material is often required to be read before each meeting, and the Committee members give up their own time to prepare for meetings and attend. The members of the Committee provide their services on a voluntary basis and their time and dedication is very much appreciated.

The members of the Committee are as follows:

| | |
|---|---|
| Dr Adrian Charles | Chairperson<br>Pediatric Pathologist, Princess Margaret Hospital |
| Associate Professor Jennet Harvey | Department of Pathology, UWA |
| Ms Evelyn Vicker | Deputy State Coroner |
| Dr Jodi White | Forensic Pathologist, PathWest |
| Mr Jim Fitzgerald | Lay member |
| Ms Heather Leaney | Lay member |
| Reverend Brian Carey | Pastoral member |
| Ms Christine Pitt | Lay member |
| Ms Kate Ellson | Secretary, Senior Counsel Assisting |

This financial year, the Committee met five times and has addressed the following number of projects as indicated in the tables below.

| *Number of projects considered* | *Number of projects approved* | *Number of projects not approved* |
|---|---|---|
| **13** | **13** | **0** |

| *Number of requests for renewal considered* | *Number of requests for renewal approved* | *Number of requests for renewal not approved* |
|---|---|---|
| **2** | **2** | **0** |

In addition to its usual business, the Committee conducted an audit of its current applications and developed an approach to encourage those conducting existing projects to report annually to the Committee and to advise the Committee of any developments or changes to projects.

## *Counsel Assisting the Coroner*

Ms Kate Ellson commenced to work on a 12 month contract as counsel assisting in January 2012. Ms Ellson was appointed to the Senior Counsel Assisting position in December 2012. Ms Ellson has worked hard to prepare files for listing of inquest hearings as well as competently carry out her role as Secretary to the Ethics Committee.

After working in the office for 3 years on a 12 month contract basis, Mr Jeremy Johnston resigned to take up a position at the Department of Mines and Petroleum.

Ms Emily Winborne commenced working as counsel assisting in January 2013 taking over Mr Johnston's practice. Ms Winborne was appointed on a 6 month contract which completed on 30 June 2013. Ms Winborne returned to the New South Wales Director of Public Prosecutions to continue her career.

Ms Melanie Smith resigned on 30 June 2013 after working as counsel assisting for a period of 3 years, again on a 12 month contract basis.

Currently the only in-house-counsel assisting the Coroner's Court has is Ms Kate Ellson who currently holds a permanent position.

## *WA Police Assisting the Coroner*

Sergeant Lyle Housiaux has ably conducted a number of inquests throughout the year to help fill the gap left by the loss of in-house counsel assisting.

Sergeant Housiaux has been assisted throughout the year by Senior Constable Eric Langton.

Both police officers perform a very important role and function within Coroner's Court.

## *Inquests*

There were 74 new inquest hearings which were commenced for the year.

In total 56 inquest matters have been completed and finalised.

2 inquest hearings had been adjourned from the previous year for further evidence and they have now been completed and finalised.

12 inquests are awaiting coroners to complete their findings.

12 inquest hearings have been adjourned for further evidence.

The tables below detail the Inquests conducted during the year.

INQUESTS STARTED BEFORE 1 JULY 2012 BUT WHERE FINDINGS WERE DELIVERED

| | Deceased | Date of Death | Date of Inquest | Sitting Days | Coroner | Venue | Finding | Date of Finding |
|---|---|---|---|---|---|---|---|---|
| 1 | *NEBRO Daniel Rowley | 3/07/29 | 2/06/11 | 1 | Packington | Bunbury & Perth | Suicide | 7/08/12 |
| 2 | *DOYLE Blake Michael | 25/11/09 | 7/06/11 | 1 | Packington | Perth | Suicide | 7/08/12 |
| 3 | *MORATO Henrique Gregorio | 9/10/08 | 9/06/2011 | 1 | Packington | Perth | Suicide | 7/08/12 |
| 4 | *NEUMANN Karl | 23/09/09 | 11-14/6/11 | 4 | Packington | Perth | Suicide | 7/08/12 |
| 5 | *HENDERSON-STUART Brody Andrew | 28/03/07 | 12-15/6/12 | 4 | Deputy | Perth | Open Finding | 2/08/12 |

INQUESTS COMMENCING BEFORE 1 JULY 2012 BUT CONTINUED INTO THE FINANCIAL YEAR

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 1 | *JAMIESON Tjantju (known as Sandy) | 19/01/10 | 22-24/5/12<br>9/07/12 | 4 | Deputy | Perth | Natural Causes | 31/08/12 |
| 2 | KEOGH Kellie Anne | 10/11/08 | 5/06/12<br>17-19/9/12<br>16/10/12 | 5 | Deputy | Perth | Natural Causes | 19/12/12 |

* Denotes the case is a death in custody and/or appears in more than one table.

INQUESTS COMMENCED 2012/2013

| | Deceased | Date of Death | Date of Inquest | Sitting Days | Coroner | Venue | Finding | Date of Finding |
|---|---|---|---|---|---|---|---|---|
| 1 | SCOTT-HEALY Hayley | 1/01/08 | 2-3/7/12<br>10/10/12 | 3 | Deputy | Perth | Accident | 19/10/12 |
| 2 | RASMUSSEN Vaughn Richard | 17/11/09 | 9-13/7/12<br>7/08/2012 | 6 | Mulligan | Perth | Misad'ture | 5/10/12 |
| 3 | *STONE Pamela Josephine | 26/03/09 | 16-20/7/12 | 5 | Deputy | Albany | Suicide | 31/08/12 |
| 4 | *WINMAR Grantley Ross | 22/03/10 | 24-27/7/12<br>21-22/8/12 | 6 | Mulligan | CLC | Natural Causes | 12/10/12 |
| 5 | *GILBERT David George James | On or about 13/8/10 | 30/07/2012 | 1 | Collins | CLC | Open Finding | 9/08/12 |
| 6 | DAHLENBURG Mark Andrew | 16/4/11 to 17/4/11 | 31/7-1/8/12 | 2 | State | CLC | Accident | 2/08/12 |
| 7 | BRADANOVICH Anthony John | 21/01/11 | 3/08/12<br>6-7/9/12 | 3 | Tavener | CLC | Accident | 13/11/12 |
| 8 | MULVANEY Linda Christina | 17/06/08 | 13-16/8/12 | 4 | Deputy | CLC | Misad'ture | 7/09/12 |
| 9 | *GORDON Ritchie | 12/07/05 | 27/08/12 | 1 | Mulligan | CLC | Adj for finding | |
| 10 | *SCOTT Robert Kenneith | 22/05/08 | 28-31/8/12 | 3 | Mulligan | CLC | Adj for finding | |
| 11 | NANNUP Benjamin Joseph | 27/06/2008 | 3-6/9/12<br>6-7/11/12 | 6 | Mulligan | CLC | Accident | 29/01/13 |
| 12 | NANNUP Jeremy Patrick | 27/06/2008 | 3-6/9/12<br>6-7/11/12 | 6 | Mulligan | CLC | Accident | 29/01/13 |
| 13 | HUMES Quinton Brandon | 27/06/08 | 3-6/9/12<br>6-7/11/12 | 6 | Mulligan | CLC | Accident | 29/01/13 |
| 14 | INDICH Matthew Andre | 27/06/08 | 3-6/9/12<br>6-7/11/12 | 6 | Mulligan | CLC | Accident | 29/01/13 |
| 15 | MOORE Trevor Ronald | 24/12/08 | 10-15/9/12<br>16/12/12 | 7 | Collins | CLC | Accident | 19/12/12 |
| 16 | DAWKINS Amy Lee | 11/01/09 | 10-14/9/12 | 5 | Deputy | CLC | Natural Causes | 23/11/12 |
| 17 | THAMBIAIYA Tharmeswaran | 1/11/09 | 14/9/2012<br>22-24/10/<br>2012 | 4 | State | CLC | Accident | 12/12/12 |
| 18 | ASLETT Wendy May | 29/10/10 | 21/09/12<br>5-6/12/12 | 3 | State | CLC | Accident | 17/01/13 |
| 19 | WEBB Violet | 9/11/09 | 27/10/12 | 1 | Deputy | CLC | Accident | 4/09/13 |
| 20 | DALEY Richard James | 25/11/09 | 2-3/10/12 | 2 | State | CLC | Suicide | 3/10/12 |
| 21 | *DREWETT Wayne Dennis George | On or about 15/4/2003 | 2-5/10/12 | 4 | Collins | CLC | Open Finding | 17/12/12 |
| 22 | POOLE Raymond Thomas | 23/04/11 | 8/10/12 | 1 | Mulligan | CLC | Suicide | 21/12/12 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 23 | GALLAGER Shane | On or about 30/9/03 | 15/10/12 | 1 | Collins | CLC | Open Finding | 16/11/12 |
| 24 | *WOODS Deon David | 14/03/10 | 15-18/10/12 | 4 | State | CLC | Natural Causes | 18/12/12 |
| 25 | DEVINE | 16/03/07 | 22-25/10/12 | 4 | Mulligan | CLC | Adj for finding | |
| 26 | DODDEMEAD William | 7/09/10 | 29/10/12<br>3/04/13<br>14/06/13 | 3 | State | CLC | Suicide | 27/06/13 |
| 27 | *SMALL Michael John | 1/08/01 | 5-8/11/12 | 4 | Collins | CLC | Open Finding | 17/12/12 |
| 28 | *PHILLIPS Dennis John | 8/01/11 | 12-13/<br>11-Dec | 2 | Deputy | Kalgoorlie | Natural causes | 31/01/13 |
| 29 | *HARRIS Dannie Darn | 2/02/10 | 14-16/<br>11-Dec | 3 | Deputy | Kalgoorlie | Natural Causes | 31/01/13 |
| 29 | NUSKE Peter Rudolph | 15/11/08 | 29/10/2012<br>19-22/3/13 | 5 | King | CLC | Accident | 1/05/13 |
| 30 | McKay-Hall Julienne Maria | 13/05/08 | 26-30/11/12 | 5 | State | CLC | Misadventure | 17/01/13 |
| 31 | MARTIN Bryn Albert Edward | 10/10/11 | 3/12/12 | 1 | State | CLC | Accident | 12/12/12 |
| 32 | *HURLEY-GOODACRE Adam Michael | 20/02/07 | 4-6/12/12 | 3 | Deputy | CLC | Suicide | 1/02/13 |
| 33 | *MCMAHON Sarah Anne | Last seen alive November 2000 | 11-14/12/12 | 4 | State | CLC | Homicide | 17/01/13 |
| 34 | CARROLL Peter Martin | 8/06/07 | 10-12, 14 & 20/12/12 | 5 | Mulligan | CLC | Accident | 11/02/13 |
| 35 | *RUTHERFORD | 27/12/09 | 17/12/2012<br>11-13/3/12<br>15/04/13 | 5 | Mulligan | CLC | Adj for finding | |
| 36 | *GILBERT | 22/01/10 | 13/03/13<br>15/04/13 | 2 | Mulligan | CLC | Adj for finding | |
| 37 | *COLLINS | 31/08/10 | 18-19/3/13<br>16/04/2013 | 3 | Mulligan | CLC | Adj for finding | |
| 38 | *FORKIN | 29/01/10 | 20-22/3/13<br>16/04/2013 | 4 | Mulligan | CLC | Adj for finding | |
| 39 | *HUNT | 22/02/11 | 25/03/13 | 1 | Mulligan | CLC | Adj for finding | |
| | | | | | | | | |
| 40 | *PRISGROVE | 12/07/11 | 27-28/3/13<br>2/04/13 | 3 | Mulligan | CLC | Adj for finding | |
| 41 | *FOSKI | 6/05/12 | 3-4/4/13<br>17/04/13 | 3 | Mulligan | CLC | Adj for finding | |
| 42 | *WILLIAMS | 13/10/12 | 5/04/13<br>8-19/4/13 | 11 | Mulligan | CLC | Adj for finding | |
| 43 | BEARUP Jake Preston | Between<br>10-13/1/10 | 15/01/13 | 1 | King | CLC | Open Finding | 18/01/13 |
| 44 | THOMS Gemma Geraldine | 2/02/09 | 21-25 &<br>29/01/13 | 6 | Mulligan | CLC | Accident | 8/03/13 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 45 | *HALE David Maxwell | 22/01/11 | 22/01/13 | 1 | State | CLC | Natural Causes | 13/02/13 |
| 46 | *MARSHALL Tracy Margaret | On or about 21/2/11 | 5-6/2/13 | 2 | State | CLC | Open Finding | 14/02/13 |
| 47 | *MARTELLA David Rhys | 6/01/07 | 6-7/2/13 | 2 | Deputy | CLC | Accident | 16/05/13 |
| 48 | GANASALA Pavan Kumar | 28/12/10 | 18-22 & 25/2/13 | 6 | Mulligan | CLC | Accident | 6/05/13 |
| 49 | PAGADALA SHIVA Praveen Kumar | 28/12/10 | 18-22 & 25/2/13 | 6 | Mulligan | CLC | Accident | 6/05/13 |
| 50 | BERG | 11/05/08 | 25-29/2/13 | 5 | Deputy | CLC | Adj. 5-16/8/2013 | |
| 51 | *DENIRO Alen | 5/05/11 | 26-28/2/13 | 3 | King | CLC | Suicide | 8/03/13 |
| 52 | *SHACKLETON Edward Cyril | Between 12 & 20/12/10 | 5/03/13 | 1 | King | CLC | Open Finding | 21/03/13 |
| 53 | FOSTER Shorn Allic | 3/11/08 | 25-27/3/13 | 3 | Deputy | CLC | Open Finding | 24/05/13 |
| 54 | *VAN VEGTEN Phillip | 3/11/08 | 2/04/2013 | 1 | King | CLC | Natural Causes | 23/04/13 |
| 55 | BERWICK Daniel Peter | 16/04/11 | 8-11/4/13 | 4 | King | Bunbury | Open Finding | 1/05/2013 |
| 56 | LEVISSIANOS Katina | 4/11/09 | 5-6/3/13 | 2 | Deputy | CLC | Misad'ture | 16/05/13 |
| 57 | *MCDONALD Charles Edward | 26/07/07 | 9-11/4/13 | 3 | Deputy | CLC | Misad'ture | 30/05/13 |
| 58 | OSBORNE Wendy Elaine | 1/07/10 | 23/04/13 | 1 | King | CLC | Accident | 3/07/13 |
| 59 | IBRAHIMI (aka RAHIMI) Khalilullah (aka Khalil) | 21/06/12 | 30/05/13<br>25-26/6/13<br>24-26/7/13 | | State | CLC | Accident | 31/07/13 |
| 60 | HUSSAIN Sabir | 21/06/12 | 30/05/13<br>25-26/6/13<br>24-26/7/13 | | State | CLC | Accident | 31/07/13 |
| 61 | HUSSAIN Sarfraz | 21/06/12 | 30/05/13<br>25-26/6/13<br>24-26/7/13 | | State | CLC | Accident | 31/07/13 |
| 62 | NADIRI Abbass | 21/06/12 | 30/05/13<br>25-26/6/13<br>24-26/7/13 | | State | CLC | Accident | 31/07/13 |
| 63 | ABBAS Mazhar | 21/06/12 | 30/05/13<br>25-26/6/13<br>24-26/7/13 | | State | CLC | Accident | 31/07/13 |
| 64 | UNKNOWN Male | 21/06/12 | 30/05/13<br>25-26/6/13<br>24-26/7/13 | | State | CLC | Accident | 31/07/13 |
| 65 | AHMED (AKA AHMAD) Nazir | 21/06/12 | 30/05/13<br>25-26/6/13<br>24-26/7/13 | | State | CLC | Accident | 31/07/13 |
| 66 | MEHMOOD Syed | 21/06/12 | 30/05/13<br>25-26/6/13 | | State | CLC | Accident | 31/07/13 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | 24-26/7/13 | | | | | |
| 67 | HUSSAIN Asad | 21/06/12 | 30/05/2013 | | State | CLC | Accident | 31/07/13 |
| | | | 25-26/6/13 | | | | | |
| | | | 24-26/7/13 | | | | | |
| 68 | MOHAMMAD Ghulam | 21/06/12 | 30/05/13 | | State | CLC | Accident | 31/07/13 |
| | | | 25-26/6/13 | | | | | |
| | | | 24-26/7/13 | | | | | |
| 69 | GHULAMI Amanulla | 21/06/12 | 30/05/13 | | State | CLC | Accident | 31/07/13 |
| | | | 25-26/6/13 | | | | | |
| | | | 24-26/7/13 | | | | | |
| 70 | SCAFIDAS | | 4-7/6/13 | 4 | Mulligan | CLC | Adj. 6-7/8/13 | |
| 71 | *MELFI Luke | 27/09/12 | 12/06/13 | 1 | State | CLC | Accident | 12/06/13 |
| 72 | MURPHY Sean Gordon | 20/09/10 | 17-21/6/13 | 5 | State | CLC | Open | 19/07/13 |
| 73 | *BANH Bac Lam | 5/09/12 | 25/06/13 | 1 | Mulligan | CLC | Natural Causes | 3/07/13 |
| 74 | *BROPHO Robert | 24/10/11 | 27-28/6/13 | 2 | King | CLC | Natural Causes | 19/07/13 |

* Denotes case is a death in custody and/or appears in more than one table.

## *Deaths in Care*

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

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

## *Involuntary patients pursuant to the Mental Health Act 1996.*

There were 11 number of inquests dealt with during the year –

| | Deceased | Date of Death | Date of Inquest | Sitting Days | Coroner | Venue | Finding | Date of Finding |
|---|---|---|---|---|---|---|---|---|
| 1 | *STONE Pamela Josephine | 26/03/09 | 16-20/7/12 | 5 | Deputy | Albany | Suicide | 31/08/12 |
| 2 | *GORDON Ritchie | 12/07/05 | 27/08/12 | 1 | Mulligan | CLC | | |
| 3 | *SCOTT Robert Kenneith | 22/05/08 | 28-31/8/12 | 3 | Mulligan | CLC | | |
| 4 | *RUTHERFORD | 27/12/09 | 17/12/12 | 5 | Mulligan | CLC | | |
| | | | 11-13/3/12 | | | | | |
| | | | 15/04/13 | | | | | |
| 5 | *GILBERT | 22/01/10 | 13/03/13 | 2 | Mulligan | CLC | | |
| | | | 15/04/13 | | | | | |
| 6 | *COLLINS | 31/08/10 | 18-19/3/13 | 3 | Mulligan | CLC | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | 16/04/13 | | | | | |
| 7 | *FORKIN | 29/1/10 | 20-22/3/13 | 4 | Mulligan | CLC | | |
| | | | 16/04/13 | | | | | |
| 8 | *HUNT | 22/02/11 | 25/03/13 | 1 | Mulligan | CLC | | |
| 9 | *PRISGROVE | 12/07/11 | 27-28/3/13 | 3 | Mulligan | CLC | | |
| | | | 2/04/13 | | | | | |
| 10 | *FOSKI | 6/05/12 | 3-4/4/13 | 3 | Mulligan | CLC | | |
| | | | 17/04/13 | | | | | |
| 11 | *WILLIAMS | 13/10/12 | 5/04/13 | 11 | Mulligan | CLC | | |
| | | | 8-19/4/13 | | | | | |

Where findings have been made in these matters they can be found on the Coroner's Court Website.

## *Deaths possibly caused or contributed to by actions of members of the Police Service*

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

There were 4 number of inquests dealt with during the year –

| | Deceased | Date of Death | Date of Inquest | Sitting Days | Coroner | Venue | Finding | Date of Finding |
|---|---|---|---|---|---|---|---|---|
| 1 | *WOODS Deon David | 14/03/2010 | 15-18/10/12 | 4 | State | CLC | Natural Causes | 18/12/2012 |
| 2 | *PHILLIPS Dennis John | 8/01/2011 | 12-13/ | 2 | Deputy | Kalgoorlie | Natural causes | 31/01/2013 |
| | | | 11-Dec | | | | | |
| 3 | *HARRIS Dannie Darn | 2/02/2010 | 14-16/ | 3 | Deputy | Kalgoorlie | Natural Causes | 31/01/2013 |
| | | | 11-Dec | | | | | |
| 4 | *DENIRO Alen | 5/05/2011 | 26-28/2/13 | 3 | King | CLC | Suicide | 8/03/2013 |

Where findings have been made in these matters they can be found on the Coroner's Court Website.

## *Inquests – Deaths in Care – Department for Corrective Services*

During the year 10 Inquests were conducted into the deaths of persons who died while in the custody of the Department of Corrective Services.

| | Deceased | Date of Death | Date of Inquest | Sitting Days | Coroner | Venue | Finding | Date of Finding |
|---|---|---|---|---|---|---|---|---|
| 1 | *NEBRO Daniel Rowley | 3/07/09 | 2/06/11 | 1 | Packington | Bunbury & Perth | Suicide | 7/08/12 |
| 2 | *DOYLE Blake Michael | 25/11/09 | 7/06/11 | 1 | Packington | Perth | Suicide | 7/08/12 |
| 3 | *MORATO Henrique Gregorio | 9/10/08 | 9/06/11 | 1 | Packington | Perth | Suicide | 7/08/12 |
| 4 | *NEUMANN Karl | 23/09/09 | 11-14/6/11 | 4 | Packington | Perth | Suicide | 7/08/12 |
| 5 | *WINMAR Grantley Ross | 22/03/10 | 24-27/7/12<br>21-22/8/12 | 6 | Mulligan | CLC | Natural Causes | 12/10/12 |
| 6 | *HALE David Maxwell | 22/01/11 | 22/01/13 | 1 | State | CLC | Natural Causes | 13/02/13 |
| 7 | *VAN VEGTEN Phillip | 3/11/08 | 2/04/13 | 1 | King | CLC | Natural Causes | 23/04/13 |
| 8 | *MCDONALD Charles Edward | 26/07/07 | 9-11/4/13 | 3 | Deputy | CLC | Misad'ture | 30/05/13 |
| 9 | *BANH Bac Lam | 5/09/12 | 25/06/13 | 1 | Mulligan | CLC | Natural Causes | 3/07/2013 |
| 10 | *BROPHO Robert | 24/10/11 | 27-28/6/13 | 2 | King | CLC | Natural Causes | 19/07/13 |

Where findings have been made in these matters they can be found on the Coroner's Court Website.

*Annexure 'A'*

***REVIEW OF CORONIAL PRACTICE IN WESTERN AUSTRALIA:***

***FINAL REPORT OF THE LAW REFORM COMMISSION OF WESTERN AUSTRALIA JANUARY 2012***

***RESPONSE BY STATE CORONER***

***THE MECHANISMS FOR EFFECTING CHANGE***

One aspect of the Law Reform Commission report which was disappointing to me was the lack of any comprehensive consideration of the various means which could be used to effect change.

In some cases recommendations made by the Commission suggest legislative change, when the purposes of the recommendations could be effected by administrative steps or by adoption of different approaches in practice. In these cases the Commission has often failed to provide any reason for recommending legislative change rather than the use of other, simpler and easier to put in place, processes for effecting change.

For the Coroners' Court there are a number of different mechanisms which could be used to effect change, these include:

- amendments to the *Coroners Act 1996*;
- the drafting of new regulations or amendment to the Coroners Regulations 1997;
- provision for Rules of Court and the power to publish Practice Directions in relation to how court procedures should be followed; *and*
- guidelines.

In addition a number of changes can be effected by taking simple, practical steps which do not require any of the above.

In my contention a number of the recommendations suggesting legislative change could be better effected by new regulations, court rules, practice directions or guidelines.

There would have to be changes to the Act to enable Rules of Court and Practice Directions to be made.

## *REQUIRED LEGISLATIVE CHANGES NOT ADDRESSED IN THE REPORT*

### *Directions by the State Coroner*

Section 21 of the Act provides that "*with the prior approval of the Chief Magistrate of the Magistrate's Court the State Coroner may give to a coroner directions about investigations ...*" The portion of this provision which refers to the Chief Magistrate should be deleted as the Chief Magistrate has no interest in directions about investigations into deaths. This aspect of the provision was presumably inserted at a time when the expectation was that the only coroners, apart from the State Coroner, would be magistrates.

### *The Definition of Post Mortem Examination*

Section 3 of the Act defines post mortem examination in the following terms:

> *post mortem examination* means an examination of the body of a person who has died, for the purpose of investigating the death;

On its face this definition is inadequate and in the context of the sections of the Act which deal with post mortem examinations, it is confusing and unhelpful. Sections 34 and 36 deal with objections to "post mortem examinations" and applications for "post mortem examinations" in terms which clearly suggest that what is intended is internal post mortem examinations.

In addition, it is clear that there must be some post mortem examination of the body of a person who has died, at least externally, in every case. It is obvious that it is necessary to look for knife wounds, bullet holes or other injuries etc and that this will take place before any issues arise in relation to whether or not an internal examination is required.

### *Warrant of Apprehension Where a Witness Fails to Appear*

Form 11 in the Coroners Regulations 1997, which purports to provide for warrants to be used when a witness fails to appear (Section 46(4)), is deficient in that the last paragraph commencing, "I DIRECT ..." is not supported by the Act and provides for an unenforceable undertaking.

This type of form could best be provided for in Rules of Court.

### *Position of Medical Adviser*

The position of Medical Adviser is an important one within the Coroner's Court and in my view should be a statutory position with statutory protections under the Act.

### *Misuse of Coronial Information*

Recent cases have highlighted a need for an offence provision with substantial penalty in cases where private and confidential coronial information has been misused.

Misuse of this information can cause great distress to involved families and irretrievable damage to public confidence in the coronial process.

There have been two recent instances of WA Police officers misusing coronial information. In one photographs of deceased persons was emailed to a large number of officers with no legitimate interest in the case and in the other photographs were shown at a Christmas party (see attachment "A").

In Victoria the Ombudsman recently investigated a number of very serious cases of misuse of coronial information including post mortem reports.

### *Appeals*

As the coronial jurisdiction is inquisitorial and not adversarial the Act should provide for the court to be represented on appeals. There would be a number of advantages if this was the case and no disadvantages.

Advantages would include:

- often it is the court which is seeking to explore avenues of investigation and the only represented parties may have an interest in limiting the investigation;
- without input from the Coroner's Court there is a danger that an appeal court could act on a misunderstanding or misinformation;
- the families of deceased persons often cannot obtain legal representation and the Court, if represented, could ensure that their interests are taken into account;
- at inquest hearings much of the information received is not referred to in open court and without assistance an appellate court could fall into error in determining appeals in relation to these hearings; and

- in the case of appeals when there has not been an inquest practical issues and health concerns can be difficult to appreciate without the assistance of submissions.

### *The Law Reform Commission Recommendations*

#### 1. Objects of the Coroners Act

While it is agreed that an objects clause is desirable, paragraph (c) which provides as an object, 'to establish a co-ordinated coronial system for Western Australia with defined coronial regions ...' is not supported.

In my view it is important that there should be a consistent coronial system which provides a high quality service throughout Western Australia. I am not supportive of dividing the state into regions. In my view persons in the country should not be disadvantaged because of where they live, which would be the inevitable outcome of a regional system.

In any event, it is not appropriate to have a reference to "coronial regions" in an objects clause. The other "objects" referred to in the suggested provision all relate to outcomes, whereas this reference is to a mechanism for producing an outcome.

I suggest the reference to "coronial regions" not be incorporated in any objects section.

#### 2. No Ex Officio Coroners

I agree with the proposition that magistrates should no longer hold automatic contemporaneous ex officio appointments as coroners.
Coronial work is becoming increasingly specialised and throughout Australia the move is away from use of coroners who are not appointed as such.

As State Coroner I have no involvement in the appointment of magistrates and would not be happy with some appointees holding office as coroner. It should be recognised that the work of the Magistrates' Court and the Coroner's Court could hardly be more different and those suited to one set of tasks would not be necessarily suited to the other.

In my view there is no need for magistrates to be coroners by virtue of their office, if there was a need to appoint a magistrate as a coroner, section 11(2) of the Act would enable this to take place.

### 3. Establish Coronial Regions

I do not support the separation of Western Australia into three coronial regions.

The numbers of deaths do not support the divisions contended for, as in the last financial year there were only 183 deaths in the proposed northern region and 332 deaths in the proposed southern region but 1400 deaths in the metropolitan region.

In addition, it is noted that the suggested regions are not homogeneous. The proposed northern region would include the Kimberley, Pilbara and Gascoyne. There is no common feature or consistent approach required for dealing with deaths in these different regions.

The southern region would encompass regions as disparate as the Albany, Kalgoorlie and Northam regions which again do not have common features. There does not appear to be any possible advantage for Kalgoorlie, for example, if that region was to be run by a magistrate based in Bunbury rather than from Perth.

In the context of the suggested southern region, it would seem very strange that a Bunbury based coroner would be dealing with matters in Northam, only one hours drive from Perth.

A benefit of a single statewide system is that it enables coroners to rely on support which would not be available in country regions. Coroners in Perth, for example, have immediate access to medical advisors who can provide helpful advice from time to time as required.

Provision of Coroners from Perth and completion of country administrative findings in Perth does not mean there would be no country input. Police investigators will be situated in local regions and should have a good appreciation of local issues and all country courts would still have coronial functions to perform and country registrars would be expected to raise local concerns from time to time.

### 4. Dedicated Regional Coroners

For reasons outlined above I do not support this recommendation. I do not consider it would be helpful or cost effective to have coroners based in local regions.

In the event that coroners were to be based in the local region, provision of support staff would be extremely costly and it would be very difficult to arrange for cover for

leave, training sessions or a number of practical issues which would need to be dealt with.

While a regional system appears to have worked reasonably well in Queensland, the demographics there are very different from Western Australia. Cairns and Southport, where the existing regional coroners preside, have six and eight other magistrates respectively, who can assist with cover for leave and provide some collegial support. Those centres also have residential forensic pathologists, regional police headquarters, tertiary hospitals and universities.

## 5. Strategic Review

This is happening.

## 6. Status and Tenure of the State Coroner

While I agree with the recommendation to the effect that the State Coroner should be a judge of the District Court, I am not supportive of a limited tenure even if the person appointed is eligible for reappointment.

In my view the appointment should be for life as with other judicial appointments as this would:

- remove the possibility of political interference in the reappointment process;
- remove problems relating to planning which would otherwise arise at the end of each five year period; and
- ensure that a dedicated person would be appointed to the position with a real interest in coronial work.

## 7. Status and Tenure of the Deputy State Coroner

In my view the same considerations apply in respect to the tenure of the Deputy State Coroner as apply to the State Coroner. In addition the position of Deputy State Coroner should be of higher standing than that of a coroner or a magistrate to reflect the responsibilities associated with the position.

In the case of the Deputy State Coroner it is particularly important that the appointment be held for life as likely applicants may not be attracted to the position if there is a possibility that they would be required to do magisterial work (which as pointed out earlier could hardly be more different from coronial work).

## 8. Status and Tenure of Other Coroners Including Dedicated Regional Coroners

I am very much opposed with the proposal that other coroners be magistrates appointed by the Governor on the recommendation of the Attorney General after consultation with the State Coroner and the Chief Magistrate of the magistrates court. The Chief Magistrate has no interest in the appointment of coroners and should not be involved in the process.

In relation to these positions I consider it particularly important that the appointments be for life and that the appointees should not be at risk of becoming magistrates contrary to their will.

People with medical as well as legal qualifications and people particularly interested in the death prevention role of coroners might be very much attracted to these positions and make excellent coroners. These persons would not be likely to be attracted to magisterial work.

### 9. Acting Coroners

Section 11(2) of the Act already enables the appointment of coroners and the proposed recommendation does not improve on the existing subsection.

### 10. Oath of Office

This is a not controversial and should be addressed by Parliamentary Counsel.

### 11. Principal Registrar

I am supportive of creation of the position of Principal Registrar and note that in Queensland where a Principal Registrar has been appointed, that has resulted in positive outcomes.

The Principal Registrar position is particularly important for the Coroner's Court because the State Coroner, as a judicial officer, has a limited ability to interact with government departments, agencies and various organisations which are interested in putting in place a range of different arrangements with the Coroner's Court. The Principal Registrar can represent the court in negotiations and ultimately, in appropriate cases, enter into agreements.

### 12. Delegation from State Coroner to Coroner's Registrars

It is doubtful whether this provision is needed.

Most of the identified functions or powers which it is recommended should not be delegated have never been delegated. In respect of the following I do not agree with the proposed restriction:

(1) I do not agree with 2(b) while country magistrates are still working as coroners. In country regions at present it is important that registrars can direct that a post mortem be performed when the coroner is not be available on circuit or may not be able to respond promptly.

(2) I do not agree with 2(d) which relates to "releasing a body". Unless there is a dispute as to whom the body should be released, bodies should be released as promptly as possible. It is only in the case of disputes when a coroner needs to become involved.

### 13. Training of Coroners, Acting Coroners and Coroner's Registrars

This is a practical matter.

### 14. Coroners Jurisdiction

This recommendation relates to stillbirths, a complex legal matter which merits proper consideration.

### 15, 16, 17

These recommendations are all straightforward and should be referred to Parliamentary Counsel.

### 18. Reportability of Healthcare Related Deaths

This is a more complex matter than those referred to above, but as it is supported by all involved, should be referred to Parliamentary Counsel.

### 19. State Coroner's Guidelines: Reportable Deaths

This is a matter which should be addressed by the State Coroner at the completion of the current reviews.

### 20. Informing Medical Practitioners of Relevant Changes to the Coroners Act

This is a practical matter.

### 21. Authorisation to Issue a Cause of Death Certificate

While this recommendation may not have significant implications for the Court, it is supported and should be referred to Parliamentary Counsel.

### 22. State Coroner's Guidelines: Authorisation to Issue a Cause of Death Certificate

see above

### 23. Review of 'Death in Hospital' Form

This is a matter which can be addressed after proposed changes to the legislation.

### 24. Review of 'Medical Certificate of Cause of Death' Form

This relates in part to recommendation 21 and does not appear to need statutory backing.

### 25. Coroner to Inform Registrar of Births, Deaths and Marriages of Certain Information

This is a practical matter which can be addressed without legislative change.

### 26. Provision of Interim Coronial Determinations

This is a practical matter which can be addressed without legislative change.

### 27. State Coroner's Guidelines: Police

This is the matter for the State Coroner after completion of current reviews.

### 28. Adoption of the National Police Form

This is a practical matter.

The Coronial Investigation Unit is currently examining practical issues relating to adoption of the form. In recent times a senior officer of that unit and Coroner Peter Collins separately visited Brisbane and received information in relation to the use of the form.

### 29. Restriction of Access to the Area

This is not contentious and should be referred to Parliamentary Counsel.

### 30. Penalty for Obstructing a Coroner or Coroner's Investigator

Refer to Parliamentary Counsel.

### 31. Regulations for Dealing with Items Seized by Coroner's Investigators

It is questionable whether this is a matter which should be dealt with by way of Regulation, particularly as the ability to store various items seized by coroner's investigators may change from time to time.

This is a matter which involves the input of WA Police.

### 32. Coroner May Require Medical Practitioner's Report

This is a matter which I strongly support. I recommend that this matter be referred to Parliamentary Counsel.

In respect of point 7, which suggests provision for a fee for medical practitioners to provide a report, I do not support that aspect of the recommendation.
Arranging for payment of such fees involves considerable administrative resources and is not justified by the nature of the task required. No fees are payable in Queensland where a similar provision exists.

In this context I note that the document, 'Good Medical Practice: A Code of Conduct for Doctors in Australia' at 8.10.3 provides that it is a responsibility of doctors to assist the coroner where an inquest or inquiry is held into a patient's death by responding to enquiries and offering all relevant information.

It is, therefore, a requirement of the Code of Conduct of medical practitioners to provide such information.

### 33. Power to Request Documents or Prepare Statements

I strongly support this recommendation which will assist with the implementation of a number of other recommendations, enable earlier completion of matters and earlier preparation of cases for inquest hearings. Provision of statements well in advance of inquest hearings will also better enable counsel assisting to identify those at risk of adverse findings and ensure that other witnesses are alert to issues raised in the statements.

This should be referred to Parliamentary Counsel

### 34. Extend Protection Against Self Incrimination

This recommendation flows from recommendation 33 and is appropriate if that recommendation is accepted

### 35. Penalty for Failure to Provide Information to a Coroner

This recommendation is relevant to recommendations 33 and 34.

### 36. Co-operation Between WorkSafe Safety Inspectors and Coronial Police

Coronial police have been prepared to work with WorkSafe Safety Inspectors and up until recent years did so. It is only as a result of advice provided by the Office of the State Solicitor to the departments concerned that co-operation has broken down. In the absence of legislative change it is unlikely that those inspectors will be prepared to work co-operatively with police.

### 37. Information Sharing and Confidentiality

The recommendation as framed appears to place an onus on the coroner to provide information to other agencies. The problem has been the refusal of other agencies to provide information to the coroner.

### 38. Department of Corrective Services Policy Directive 30.

This is for the department to implement.

### 39. State Coroner's Guidelines: Deaths in Custody

This is a matter for the State Coroner following the outcome of current reviews.

### 40. Coronial Training for Major Crime Squad

This is a matter for WA Police.

### 41. Joint Attendance With Coronial Investigation Unit for Deaths in Custody

This is a practical matter for consideration by WA Police and the State Coroner.

### 42. Collaboration With the Office of the Inspector of Custodial Services

This is a practical matter which has been addressed.

### 43. Oversight of Police Related Deaths by Corruption and Crime Commission

This is a matter which is being addressed by the Director General.

### 44. Specialist Healthcare Death Investigation Team

While the concept of a healthcare-related death investigation team is supported in a general sense, on the basis of current resourcing this recommendation is unrealistic.

There has been a move in the Coroner's Court towards greater medical input into these deaths and the appointment of a Medical Adviser has resulted in considerably improved investigations being conducted.

As suggested earlier herein, the Act should be amended to specifically refer to the appointment of medical advisers and to provide that the advisers' advice should be confidential and the medical advisers not be witnesses at inquest hearings except with their consent.

It should be noted that most reportable deaths which occur in hospital are not healthcare-related deaths, but rather are deaths of persons who were close to death prior to arrival at hospital.

It is important that WA Police officers are involved in obtaining information from hospitals in these cases and develop skills in relation to medical issues.

### 45. Investigations of Deaths in Mental Health Facilities

This is a matter for WA Police.

### 46. State Coroner's Guidelines: Investigation of Possible Mental Health Related Deaths

This is a matter for guidelines at the conclusion of current reviews.

### 47. Assistance to and From Coroners in Other Jurisdictions

This is a non controversial matter which has been discussed by COAG and should be referred to Parliamentary Counsel.

### 48. Statement of Referral in Records of Investigation.

In cases where the Record of Investigation is not made public (administrative findings) there is no reason to mention a referral having taken place.

In the case of inquest hearings, to which this recommendation presumably is intended to relate, this recommendation is reasonable although its usefulness is questionable.

Following an inquest if a coroner advises that there has been a referral to the Director of Public Prosecutions or the Commissioner of Police, there will usually be little or no doubt as to who has been referred.

### 49. Discretionary Comment Function

**50.** It is not apparent why this recommendation is only said to refer to section 25(2) and not also to section 25(3) of the Act.

This recommendation appears to only insert a reference to "the prevention of future deaths in similar circumstances" which would be non-controversial and could be referred to Parliamentary Counsel.

### 50. Re-opening of Investigation or Inquest on Coroner's Initiative

This recommendation could involve additional work for coroners, particularly if there were multiple frivolous requests to re-open inquests.

There is no need for legislative change to re-open investigations, this could occur at any time at present.

In respect of inquests, there is benefit in an inquest providing some finality which should encourage those involved to provide all available evidence at the hearing. That being said, the experience in Queensland is that there have been relatively few frivolous applications.

### 51. Application to Coroner to Re-open Investigation or Inquest

See above.

### 52. Form of Application to Coroner to Re-open Investigation Or Inquest

This should be addressed in Rules of Court not Regulations.

### 53. Superior Court Review of Coroner's Findings

This recommendation follows from recommendation 51 and is otherwise not controversial.

### 54. Power to Correct Errors in Records of Investigation

This should be referred to Parliamentary Counsel.

### 55. Non-narrative Findings.

This should be referred to Parliamentary Counsel.

### 56. Power of Coroner to Discontinue the Investigation in Certain Cases

I am uncertain as to how useful this provision would be. It appears to relate to recommendation 21, authorisation to issue death certificates.

### 57, 58 and 59

Refer to Parliamentary Counsel.

### 60. State Coroner's Guidelines: Persons Held in Custody and Care

This is the matter for the State Coroner on completion of current reviews and any relevant amendment of the Act.

### 61. Informing People About Relevant Changes to the Definitions of "Persons Held in Custody" and "Persons Held in Care"

See above. Police would presumably implement changes to the COPS Manual and a letter would be sent to all departments concerned.

### 62. Removal of Standard of Proof for Suspected Deaths

Refer to Parliamentary Counsel – this is a matter which has been discussed at COAG..

### 63. Guidance for Coroners on When an Inquest Should be Held

I do not consider this is a matter which should be addressed by amendment of the Act. This guidance could better be provided by Rules of Court, Practice Directions and Guidelines.

I have recently prepared a paper, "Inquest Hearings in Western Australia" which has been put on the Coroner's Court website and provides guidance in this regard.

### 64. State Coroner's Guidelines: When an Inquest Should be Held

This is a matter for the State Coroner on completion of current reviews.

### 65. Application to Coroner for Inquest

In respect of a form, it is doubtful what "fields for information" should be provided, but an application form should be placed on the website. The form itself should be in Rules of Court or a Practice Direction

### 66. Superior Court to Review Coroner's Decision to Refuse Inquest

Refer to Parliamentary Counsel.

### 67. Joint Inquests

This is not a matter which should be addressed by changes to the Act. Rules of Court, Practice Directions and Guidelines would more appropriately enable change to be effected.

This is a matter which has been referred to in the recent paper published on the website.

### 68. Interested Persons

This recommendation appears to relate to limited circumstance where a special interest advocacy group wishes to appear at an inquest and would enable that group

to be treated as an interested person, but would limit the ability of the group to making submissions on comments or recommendations.

This recommendation is not opposed although it is of doubtful usefulness.

### 69. Inquest Brief to be Provided by Coroner's Court

This is not a matter which should be addressed in the Act. Arrangements in relation to the copying of documents and provision of briefs of evidence are significantly impacted upon by resourcing issues. In the event that resourcing issues are addressed, any perceived need for such provision will fall away.

### 70. Inquest Brief in Electronic Form

This is a practical and resourcing issue.

### 71. Pre Inquest Hearings

Refer to Parliamentary Counsel.

### 72. Notification and Publication of Pre Inquest and Inquest Hearing Dates

This is a matter for Rules of Court, not changes to the legislation.

1. Appears impracticable as it would not be feasible for the Coroner's Court to even identify all potential interested persons. One of the reasons for holding Directions Hearings is to seek to encourage potentially interested persons to come forward.

### 73. Procedural Fairness – Identify Interested Persons

This is a practice and resourcing issue.

### 74. Funding for Legal Representation at Inquest

This is an issue for government.

### 75. State Coroner's Guidelines: Conduct of Hearings

The conduct of hearings could be the subject of a Practice Direction or Guidelines. Any Guidelines would be issued after the current reviews and any changes to the Act.

### 76. Enhanced Legal Professional Education

This is a matter being addressed.

### 77. Use of Concurrent Expert Evidence at Inquest

This is unlikely to be of much use but is not opposed.

### 78. Use of Affidavits at an Inquest

This is unnecessary.

### 79. Interruption of an Inquest

Refer to Parliamentary Counsel.

### 80. Power to Expel from Inquest

Refer to Parliamentary Counsel.

### 81. Restriction of Publication

Refer to Parliamentary Counsel

### 82. Publication of Inquest Findings, Comments and Recommendations

Resourcing and practical issue.

### 83. Support for the Coroner's Prevention Role

While it may not be necessary to appoint an entire team to support the coroner's prevention role, there should be resourcing support for the matters referred to.

### 84. Coroner's Power to Make Recommendations

Refer to Parliamentary Counsel.

### 85. Considerations Relevant to Making Comments or Recommendations

This appears to be unnecessary.

### 86. Notification of Coroner's Recommendations

This is a practical matter.

### 87. Mandatory Response to Coronial Recommendations

This is an important matter which has been the subject of considerable debate within Australia and internationally.

I support a requirement that a report be provided within three months which should be ample to enable a response. It should be noted that prior to a recommendation being made, the authority or entity would have had some notice of the relevant concerns which form the basis of the recommendation.

A response could be that a recommendation was supported, but was not yet implemented.

In respect to **point 4**, the legality or otherwise of this aspect of the recommendation can be considered by Parliamentary Counsel.

### 88. Cultural Competency Training, Police and Coronial Staff

This is a resource and practical issue.

### 89. Coronial Counselling Service

I do not accept that any stigma attaches to the word "counselling".

The suggested provision of a dedicated administrative assistant is a resourcing matter.

### 90. Provision of Coronial Counselling and Liaison to Aboriginal People

This is a practical issue. In my view arrangements need to go further than the recommendation suggests. It should be for the coronial counsellors to liaise with local organisations and agencies which could provide appropriate support.

### 91. Community Awareness, Education and Training

This is a resourcing and practical issue.

### 92. Expand Available Translations of Important Coronial Information

The first aspect of this recommendation has been addressed and will be implemented. There is a limit to the extent translations can be provided and this should be recognised.

### 93. Use of Interpreters

In my view point 2 of this recommendation fails to appreciate the importance of communicating with family members directly at a time when the family is experiencing grief. The recommendation is also impractical and does not recognise the reality of the situation.

In respect of point 3, the family or their representative should raise with the Coroner's Court any need for an interpreter which can then be addressed. This is a practical issue.

### 94. Coronial Information Service

This is a practical and software issue.

### 95. Release of Post Mortem Examination Report

I do not support providing medical reports through the mail to grieving family members. The current approach of the office is to provide a post mortem report to a general practitioner who can provide an explanation in a supportive environment.

Very few family members request copies of post mortem reports and almost none object to the current procedure.

### 96. Coroner's Court Website

This is a practical matter.

### 97. State Coroner's Guidelines, Review, Update and Publish

This is a practical matter which will be addressed following completion of current reviews.

### 98. Coronial Forms

This is a matter which should be addressed in the Rules of Court or Practice Directions. With the update of the website relevant forms will be included.

### 99. Viewing and Touching the Deceased

This is a resourcing and practical issue.

### 100. Police to Seal Body Bags

This is the type of practical issue which is solved almost every day by this office.

### 101. Coroner May Order External or Preliminary Post Mortem Examination

This is a matter which should be referred to Parliamentary Counsel. As suggested earlier herein, it is my view that the definition of "post mortem examination" should be altered to address this point in part.

It would be helpful if the Act recognised that all of the matters referred to at point 3 can take place irrespective of whether or not there is to be a "post mortem examination".

### 102. Principles Governing Conduct of Post Mortem Examinations

I do not consider that this is a matter which should be addressed by amendment of the legislation.

Point 1 is unnecessary.

In respect of Point 2, this does not appear to take into account the fact that in some cases the family wants an internal autopsy to be conducted.

In my view the suggested amendment would not be helpful.

### 103. Factors That a Coroner Must Consider When Ordering an Internal Post Mortem Examination

In my view this is not a matter which should be addressed in the Act.

This is a matter which could be addressed by Guidelines.

In respect of Point 6, medical records of the deceased may not be available in time to be taken into account.

### 104. Objection May Only Be Made to Internal Post Mortem Examination

This is agreed and should be referred to Parliamentary Counsel.

See comments in relation to Recommendation 101.

### 105 Time for Objection To Internal Post Mortem Examination

This is a matter which is being addressed and hopefully the concerns of the Commission are taken into account in the proposed altered brochure which recognises issues for persons in country regions and in many ways goes further than the recommendation e.g by advising that for the Kimberley and Pilbara a minimum period of 72 hours will apply while retaining a period of 24 hours as an absolute minimum period for the metropolitan region.

### 106. Supreme Court of Western Australia Website

No comment.

### 107. Preparation of Bodies for Release From State Mortuary

This is a practical issue.

### 108. Preparation of Bodies for Transport Outside the Perth Metropolitan Area

This is a practical issue.

### 109. Need for Urgent Attention to State Mortuary

It is agreed that the State Mortuary requires urgent improvement. This is a matter for the Health Department.

### 110. Release of Body by a Coroner

This is not necessary.

### 111. Application for Release of Body by a Coroner

This is a matter which could be considered by Parliamentary Counsel.

### 112 Supreme Court Review of Coroner's Decision to Release a Body

This recommendation would significantly limit the power of the Supreme Court to review as it would only apply to 'an error of law'.

### 113. Providing Information About Release to Families

This has be done

## CONSIDERATIONS FOR LEGISLATIVE REVIEW

Recommendations which could be referred to Parliamentary Counsel immediately.

## MY SUGGESTIONS THAT:

(1) there should be rules of court and an ability to make practice directions;

(2) Section 21 be amended to remove the need for the Chief Magistrate to approve directions by the State Coroner to coroners;

(3) the term "post mortem" be redefined;

(4) Form 11 dealing with Warrants of Apprehension be altered;

(5) the position of "medical adviser" be recognised;

(6) misuse of coronial information be an offence; and

(7) the Coroner's Court be represented on appeals.