OFFICE

of the

STATE CORONER

for

WESTERN AUSTRALIA

ANNUAL REPORT

2013-2014

State Coroner Western Australia

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Our Ref : Annual Report

4 November, 2014

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Dear Attorney

ANNUAL REPORT 2013-2014

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, 2014.

Yours sincerely

R V C FOGLIANI
STATE CORONER

TABLE OF CONTENTS

STATE CORONER'S OVERVIEW **3**
Structure of the Report 3
The Coroner's Court of Western Australia – information available to the public 3
The Focus over the past Financial Year : The Backlog of Coronial Cases and the Legislative Project 4
Report on Inquests that are required by Law to be held (Mandated Inquests) 5
(A) Mandated Inquests – Persons Held in Care immediately before Death 6
(B) Mandated Inquests – Where it appeared the Death was caused, contributed to, by any action of a Member of the Police Force 8
(C) Mandated Inquests – Suspected Deaths 8
Report on Inquests that are held pursuant to an exercise of discretion by the Coroner (Discretionary Inquests) 8
The Coronial Counselling Service 10
The Death Prevention Role and the Coronial Ethics Committee 10
A Case Management System 12
Recommendations 12
Acknowledgements 12

OFFICE STRUCTURE **14**
Table A 14

REGISTRY AND STATISTICS **14**
Table B 16
Table C 17
Table D 18
Table E 19

POST MORTEM EXAMINATIONS **20**
OBJECTION TO POST MORTEM EXAMINATIONS **21**
Table F 22

CORONIAL COUNSELLING SERVICE **23**
Table G 24

CORONIAL ETHICS COMMITTEE **25**
Table H 26

PRINCIPAL REGISTRARS AND CORONER'S REGISTRARS **27**
COUNSEL ASSISTING THE CORONER **28**
POLICE ASSISTING THE CORONER **28**
INQUESTS **29**
Table I 29
Deaths that appeared to be caused, or contributed to, by any action of a member of the Police Force 34
Table J 34
Suspected Deaths 34
Table K 35
Persons Held in Care 36
Table L 37
PERSONS HELD IN CARE – SPECIFIC REPORTS **39**
ANNEXURE A RESPONSES TO CORONIAL RECOMMENDATIONS **64**

State Coroner's Overview

This is the first Annual Report submitted by me as State Coroner for Western Australia, after being in this position for approximately ten months since my appointment on 13 January 2014.

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 2014.

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* 1996 (the Coroners Act). Where a coroner has made a recommendation in connection with a death of a person held in care, the Ministerial or Departmental response to that recommendation is included in this Report, at Annexure A.

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 whose freedoms have been removed by operation of law and who die whilst held in care. They include prisoners and involuntary mental health patients.

Except where they are counted within the figures as part of the cases received by the Office, investigations (including inquests) that have not been finalised are not the subject of a specific report. An inquest is part of an investigation.

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 over 90% of cases, an investigation is finalised without holding an inquest.

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 coroner may hold an inquest to investigate a reportable death under certain circumstances. Some of those circumstances are mandated by law, others are an exercise

of discretion. Where an inquest has been held, a coroner may make recommendations on any matter connected with the death including public health or safety or the administration of justice.

Where a coroner has investigated a reportable death at an inquest, the coroner's written record of that investigation is required to be published on the website of the Coroner's Court of Western Australia, under "Inquest Findings" for that year, within seven days of its date.

From the commencement of the 2014 calendar year these published Inquest Findings can be searched on the website by keywords, including by name of deceased or the manner of death.

Where a coroner has made a recommendation in the Inquest Finding, the Coroner's Court will notify the Minister that administers the relevant legislation or the responsible entity, to which a recommendation relates.

From the commencement of the 2014 calendar year the written response of the Minister or the responsible entity, specifying a statement or action (if any) that has, is or will be taken in relation to the recommendation is published on the website page for the relevant Inquest Finding.

There were 77 inquests heard and finalised by Inquest Findings by coroners in the past financial year, comprising approximately 4% of all reportable deaths investigated in the 2013/2014-year.

Where a coroner has investigated a death other than at an inquest, the coroner's written record of that investigation (referred to as an Administrative Finding) is provided to the next of kin of the deceased but the details are not published on the website or otherwise made public. A coroner does not make a recommendation in an Administrative Finding.

There were 1959 Administrative Findings finalised by coroners in the 2013/2014-year comprising approximately 96% of all reportable deaths investigated for this year.

The focus over the 2013/2014-year: The Backlog of Coronial Cases and the Legislative Project

In August 2009, Government provided the Office of the State Coroner with additional funding, which increased in 2010/11 and 2012/13. This funding was made recurrent in August 2013, thus enabling the appointment of two additional full time coroners and a number of staff members to assist me in the discharge of my statutory functions under the Coroners Act. This brings the total number of coroners to four for the first time in the history of the office.

Together with the coroners and the staff members, a total of 27 of us, a concerted effort has been made to investigate and where possible, finalise findings on reportable deaths. Much of this effort has been aimed towards addressing the accumulated backlog of cases within the Office. 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.

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.

The Office of necessity operates within the constraints of the available resources, including the resources devoted to coroners' investigators. The availability of the recurrent funding for the Office has been of significant assistance in addressing the backlog of cases.

The other significant work for the Office over the past financial year has arisen in light 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. They are recommendations pertaining to the legislation, practices and procedures associated with this Office. The Coroner's Court Legislative Project Reference Committee was established on 23 June 2014 to oversee the process to amend the *Coroners Act* 1996 in accordance with the agreed recommendations and to assess additional amendments that are proposed.

The Committee is formed by myself, the Director Magistrates Court and Tribunals and the Director Strategic and Business Development from the Court and Tribunal Services Division of the Department of the Attorney General and is supported by members from the Coroner's Court Legislative Review Project Working Group. The availability of the recurrent funding for the Office has been of significant assistance in allowing for some of my time to be devoted to the work to be undertaken to review and implement the agreed recommendations. The Committee has now examined most of the recommendations and in early 2015 will be making a submission to The Honourable Attorney General for consideration of the proposed amendment to the *Coroners Act* 1996.

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. They include where the deceased was, immediately before death, a person held in care. They include where it appears that the death was caused, or contributed to, by any action of the police force. There are other categories set out in section 22(1) of the Coroners Act.

Under section 23 of the Coroners Act, a directed investigation into the suspected death of a missing person requires the holding of an inquest into the circumstances of the suspected death.

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 77 investigations finalised by inquest in the past financial year and of those, a total of 34, being approximately 44%, comprised investigations where an inquest was mandated by law.

The 34 mandated inquests were finalised by coroners in the following categories and these are described below:

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

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

A deceased will have been a "person held in care" under the circumstances specified in section 3 of the Coroners Act. They include persons in custody under the *Prisons Act* 1981 and involuntary patients under the *Mental Health Act* 1996.

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

Under section 27(1) of the Coroners Act, my annual report is required to include a specific report on the death of each person held in care. A Table of the investigations into deaths of persons held in care that were finalised by inquest in the past financial year appears at pages 37-38 of this Report. Following that Table, at pages 39-63 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 24 investigations of deaths of persons held in care finalised by inquest. Of those:

- 16 investigations were finalised by inquest in respect of deaths of involuntary patients within the meaning of the *Mental Health Act* 1996, including one person under a community treatment order under that Act;
- 7 investigations were finalised by inquest in respect of deaths of persons held in custody under the *Prisons Act* 1981; and
- 1 investigation was finalised by inquest in respect of a child who was the subject of a care and protection order under the *Children and Community Services Act 2004*.

Of the 16 investigations finalised by inquest in relation to deaths of involuntary patients, 10 related to persons who had been, immediately before death, involuntary patients at Graylands Hospital and these were investigated at a joint inquest held over various dates and finalised on 25 February 2014. Of these 10, in four instances, the manner of death was by way of natural causes, in five instances the manner of death was by way of suicide and in one instance the manner of death was by way of misadventure.

In respect of the Graylands Hospital inquests, the coroner heard evidence relating to general or systemic issues pertinent to Graylands Hospital, but did not find that evidence to be sufficiently connected with all of the deaths such as to generate any adverse comment under sections 25(2) or 25(3) of the Coroners Act. Accordingly, the specific reports into these deaths turn on their own facts.

In respect of one of the Graylands Hospital inquests, the investigation into the death of Mr Tom FOSKI (Finding delivered 11 April 2014), the coroner made a recommendation and a response was received. That is addressed in the specific report at page 58 of this Report.

There were no other recommendations made by the coroner in respect of the Graylands Hospital Inquests.

Of the remaining 6 investigations finalised by inquest in relation to the deaths of involuntary patients, in one instance, the investigation into the death of Mr Lynn Desmond Ernest CHURCH (Finding delivered 11 June 2014) the coroner made a recommendation and a response was received. That is addressed in the specific report at page 61 of this Report.

Of the seven investigations finalised by inquest in respect of deaths of persons held in custody under the *Prisons Act* 1981, in six instances the manner of death was by way of natural causes and in one instance the manner of death was by way of suicide.

In two of the seven investigations finalised by inquest in respect of deaths of persons held in custody under the *Prisons Act* 1981, the coroner made recommendations (Mr Bac Lam BANH, Finding delivered 3 July 2014 and Mr Robert BROPHO, Finding delivered 19 July 2013) and responses were received in both cases. They are addressed in the specific reports at pages 39 and 40 of this Report.

In respect of all of the 24 investigations of deaths of persons held in care finalised by mandated inquest this past financial 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. There were no adverse comments made by a coroner regarding the quality of the supervision, treatment and care of those deceased persons, save for the investigation into the death of Ms Antoinette WILLIAMS (Finding delivered 11 April 2014). That matter is addressed at page 58 of this report. Under section 50 of the Coroners Act the coroner referred that matter to the Australian Health Practitioner Regulation Agency.

The specific reports in respect of all of the 24 investigations finalised by mandated inquest appear at pages 39-63 of this Report and, where the coroner has made a recommendation, the relevant Ministerial and/or Departmental response is addressed in the specific report and copied at Annexure A to this Report.

In respect of the specific reports, the full text of the Record of Investigation into Death, namely the Inquest Finding, and any relevant Ministerial and/or Departmental responses appear on the website of the Coroner's Court of Western Australia.

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

There was one investigation that was finalised by inquest where it appeared that the death was caused, or contributed to, by any action of a member of the police force. It was the inquest into the death of Miss Keannita SAMSON, a child, Finding delivered 27 June 2014. It concerned a vehicle pursuit by police. The Deputy State Coroner found that all the actions taken by the police were reasonable and within the policies and guidelines in place at the time for the purposes of law enforcement. The Deputy State Coroner did not make any recommendations. The full text of the Record of Investigation into Death, namely the Inquest Finding appears on the website of the Coroner's Court of Western Australia.

(c) Mandated inquests – suspected deaths

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. A Table of the investigations into the suspected deaths of the nine missing persons that were finalised by inquest in the past financial year appears at page 35 of this Report. In each case, the coroner found that the death of the person had been established beyond all reasonable doubt. In four of the cases the coroner was unable to reach a conclusion on the manner of death and made an open finding. In respect of each of the nine mandated inquests, the full text of the Record of Investigation into Death, namely the Inquest Finding appears on the website of the Coroner's Court of Western Australia.

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.

Of the 77 investigations finalised by inquest in the past financial year, a total of 43, being approximately 55%, comprised investigations where the inquest was discretionary.

Where the holding of an inquest is discretionary the coroner gives consideration as to whether an inquest is desirable and is guided by a number of factors including, but not limited to, whether an inquest will assist in reaching the findings required to be made, if possible, under section 25(1) of the Coroners Act in relation to cause and manner of death and whether the particular circumstances of the death raise issues for consideration in relation to public health or safety or the administration of justice, such as to be likely to generate comment under section 25(2) of the Coroners Act.

Where an inquest is not mandated by law, pursuant to section 24 of the Coroners Act, any person may ask the coroner to hold an inquest into a death which a coroner has jurisdiction to investigate. In practice these applications are primarily received from family members. They are required to be in writing and to contain reasons. These applications are approved where the coroner believes it is desirable to hold an inquest, taking into account the written application and applying the same criteria as in all other discretionary inquests.

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.

Not all applications for inquests into deaths are able to be approved. If the coroner refuses an application, the coroner will provide written reasons to the applicant. There are a range of reasons as to why an inquest may not be desirable and where an application is refused, the reasons are explained having regard to the particular circumstances of the case under consideration. The applicant has a right to apply to the Supreme Court for a review of the coroner's decision to refuse an application for an inquest.

Where an application for an inquest is refused, the reportable death will be investigated by the coroner having regard to all of the available and relevant information and a written Record of Investigation into death, namely an Administrative Finding that sets out the cause and manner of the death, will be issued to the next of kin of the deceased. The

Administrative Finding is not published on the website of the Coroner's Court of Western Australia and does not become a public document.

A Table of all of the investigations that were finalised by inquest in the past financial year appears at pages 29-33 of this Report. The mandated inquests are marked as such, leaving the remainder on that Table, a total of 43, 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.

There are three coronial counsellors attached to the Coroner's Court of Western Australia, all of whom have qualifications in psychology or social work. Members of the public coming into contact with the coronial system can expect sensitive assistance and support from the coronial counselling service. The coronial counsellors aim to impart clear and accurate information in a compassionate way.

Assistance in resolving issues or answering questions associated with the death of a loved one can be provided at any point after a death. The coronial counsellors are aware of different cultural approaches to death and grief and endeavour to provide a culturally sensitive service. Where there are language barriers, the Coronial Counselling Service uses various methods to facilitate accurate communication, including using translators where appropriate.

The Coronial Counselling Service is on call from 7:00am to 6:00pm every day of the year including public holidays. The coronial counsellors can be contacted after hours on a dedicated telephone number.

The range of services provided by the Coronial Counselling Service and statistical information on work output is set out at pages 23-24 of this Report.

The Death Prevention Role and the Coronial Ethics Committee

In the course of a coronial investigation important information is gathered about the cause and manner of death including all of the circumstances attending the manner of death. This is reflected in the findings of the coroners, though not exclusively so. Some of that information is also held on the coronial files as it would be impossible to reproduce, in a published Record of Investigation Into Death, all of the information gathered in connection with the death.

The information gathered in the course of a coronial investigation is important in the context of matters of public health or safety, which the coroner may comment on in connection with the death being investigated. 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 potential for drawing awareness to medical issues and quality of care in that regard is recognised in the Office's working relationship with the Department of Health, Office of Safety and Quality. A specialist medical consultant working in the Office of Safety and Quality reviews coronial findings and related information. The salient points related to certain aspects of medical management involved in the care of the deceased are de-identified and summaries are published in the booklet "From Death We Learn" which is then distributed to relevant clinical areas. The aim is to ensure that information relevant to death prevention is communicated to those who can best learn from it and use it for the future.

At a broader level, the information gathered about the cause and manner of death, 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.

As with the other jurisdictions, the Coroner's Court of Western Australia submits certain information to the National Coronial Information System. In addition to this the Coroner's Court of Western Australia is uniquely placed to make a contribution to a death prevention role by providing relevant coronial data to appropriate authorities and research bodies, as recognised by the Law Reform Commission in its Report, Recommendation 1(d) (Objects of the Coroners Act). This needs to be balanced with the need for confidentiality and privacy.

The Coronial Ethics Committee was established under section 58 of the Coroners Act and is attached to the Coroner's Court of Western Australia. The Coronial Ethics Committee considers incoming requests for coronial data and makes recommendations to the State Coroner on the ethical considerations involved in proposed research projects or matters touching on the use of coronial information. The Coronial Ethics Committee reports annually to the National Health and Medical Research Council.

Pursuant to paragraph 8 of the Guidelines for the Coronial Ethics Committee, the State Coroner is required to report annually on the operation of the Coronial Ethics Committee, including a specific report on any recommendation of the Coronial Ethics Committee which has been rejected by the State Coroner. The report on the operation of the Coronial Ethics Committee during the past financial year appears at pages 25-26 of this Report.

A case management system

The work output of the Coroner's Court of Western Australia would be optimised with the introduction of an electronic case management system. It would allow for a more efficient tracking of the progress of coronial investigations and facilitate a more proactive approach for addressing outstanding requests for information, both internal and external, so that investigations can be brought to a timely conclusion. It would also serve to simplify and expedite the process by which certain statistics are gathered for ongoing reporting obligations.

Another benefit that would flow from the introduction of an electronic case management system concerns the ability to record case specific data in a form that can best be utilised in the future in the death prevention role by filtering and retrieving information.

An electronic case management system for the Coroner's Court of Western Australia currently forms part of the Court and Tribunal Services eCourts Strategic Plan 2014-2017. It is hoped that the availability of this system can be prioritised, together with the support for its implementation and usage.

Recommendations

Having regard to the issues raised and addressed in the mandated inquests during this past financial year, I do not make any further recommendations under section 27(3) of the Coroners Act.

Acknowledgements

The past financial year has seen significant change characterised by the retirements and appointments of the coroners. Former State Coroner Mr Alastair Hope, my immediate predecessor retired and ceased his statutory functions from 5 August 2013. Mr Hope was appointed as the first State Coroner for the State of Western Australia on 5 November 1996 and in that capacity he had been responsible for implementing the major changes to the coronial system which were required following the introduction of the Coroners Act in 1997. I acknowledge, with gratitude, Mr Hope's consistent dedication and his valuable service to the community as its first State Coroner over a period of 16 years.

From 5 August 2013 Deputy State Coroner Ms Evelyn Vicker was Acting State Coroner until my appointment on 13 January 2014. I also acknowledge, with gratitude, Ms Vicker's long standing dedication having been appointed to her role in July 2000 and the valuable service that she continues to render to the Court and to the community in the discharge of her statutory functions.

Coroner Barry King's appointment was confirmed on 30 November 2013. Following my appointment on 13 January 2014, Coroner Sarah Linton was appointed on 3 February 2014.

From this last date, the Coroner's Court of Western has had its four coroners at the Court in Perth. The appointment of the two additional coroners has facilitated the greater focus on the backlog of coronial cases, reflected in the assiduous dedication of Coroner King and Coroner Linton in that regard.

In addition, every Magistrate in Western Australia is contemporaneously a coroner and I also acknowledge their considerable efforts in the discharge of their statutory functions under the Coroners Act as and when required.

The Coroner's Court of Western Australia is well supported and assisted by the coroner's investigators at the Western Australia Police, the forensic pathologists and other PathWest staff, and the toxicologists and other ChemCentre staff. I use this opportunity to express my gratitude to the officers and staff members in all of these agencies that ably assist the Coroner's Court of Western Australia on a daily basis. I particularly acknowledge the efforts of Detective Superintendent Anthony Lee Major Crime Division, the head and acting head of the Coronial Investigation Unit at WA Police Inspector Valdo Sorgiovanni and Acting Inspector Neville Beard respectively, Chief Forensic Pathologist Dr Clive Cooke and Mr Robert Hansson, Manager Forensic Toxicology.

I acknowledge the commitment of the Acting Director General of the Health Department of Western Australia, Professor Bryant Stokes, to the safety and quality of the WA health system, reflected in the outcomes detailed in his biannual reporting to me on the actions taken by the Department of Health and key stakeholders in response to the findings and recommendations arising from coronial inquests.

The Coroner's Court Legislative Project Reference Committee continues to be assisted by the solicitors at the Office of the State Solicitor for Western Australia. I principally acknowledge the assistance of former Deputy State Solicitor Robert Mitchell SC, now The Honourable Justice Mitchell of the Supreme Court of Western Australia.

By far the greatest resource of the Office of the State Coroner is its highly skilled and dedicated workforce. On a daily basis staff members work in a difficult and challenging area, often under significant time pressures. The respect and dignity that they afford to the deceased person and the care and empathy that they extend to grieving loved ones reflects their humanity. I am proud to work with them and to have been given this opportunity to oversee and coordinate the State coronial system for the people of Western Australia.

I am pleased to present the 2013-2014 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. The funding to enable this structure was made recurrent in August 2013 and the current appointments were finalised in February 2014.

Table A

Substantive Positions	2009 Funding	2011-2013 Funding
State Coroner	Counsel Assisting	Coroner
Deputy State Coroner	Counsel Assisting	Coroner
Counsel Assisting	Senior Coronial Counsellor	Principal Registrar
Office Manager	Customer Service Officer	Listings Manager
Registry Manager	Customer Service Officer	Snr Findings Clerk
Administrator		Findings Clerk
Asst. Registry Officer		Customer Service Officer
Systems Info Officer		Customer Service Officer
Coronial Counsellor		
Coronial Counsellor		
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.

The coroners at the Coroner's Court of Western Australia investigate reportable deaths and if possible, make findings in relation to the cause and manner of death.

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 Registry is 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 Office, the main focus in the past financial year has been on clearing the backlog of the coronial cases by finalising the investigation. Staff members within the Registry close the coronial files after the coroner has finalised the investigation by making the relevant findings, and Registry staff record the salient details, including the deceased's name, date of death and date of the coroner's finding.

With respect to the backlog of coronial cases it will be seen that the backlog reduced from 425 as reported in 2012/2013 to 415 in 2013/2014.

A case comes into backlog 12 months after the date the death was reported to the coroner and consequently new cases enter backlog on a daily basis.

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 2,009 reportable deaths were reported to the Coroner's Court of Western Australia for full investigation in the past financial year and 2036 cases were completed representing a clearance rate of 101.34%.

With regard to the 2036 cases completed in the past financial year the breakdown is as follows:

- 1959 – the number of investigations finalised by administrative finding, of which 915 (46.7%) were backlog cases, and

- 77 - the number of investigations finalised by inquest, of which 71 (92.2%) were backlog cases.

At the conclusion of the financial year, the cases on hand referred to the Coroner's Court of Western Australia for investigation by a coroner amounted to 1891, of which 415 were backlog cases (over 12 months old).

Of those 415 backlog cases, 149 were inquest cases waiting to be heard.

The following Tables provide an overview of the work of the Office in the 2013/2014-year.

Table B

CASES RECEIVED	*PERTH*	*COUNTRY*	*TOTAL*
Full Investigation	**1472**	**537**	**2009**
Death Certificates	**683**	**n/a**	**683**

CASES COMPLETED	*PERTH*	*COUNTRY*	*TOTAL*
Finalised by Inquiry	**1494**	**465**	**1959**
Finalised by Inquest	**45**	**32**	**77**
TOTALS	**1539**	**497**	**2036**

BACKLOG	*PERTH*	*COUNTRY*	*TOTAL*
	277	**138**	**415**

CASES ON HAND	*PERTH*	*COUNTRY*	*TOTAL*
	1411	**480**	**1891**

FINALISATION RATIO		
Finalised by Inquiry	**96.22%**	**1959**
Finalised by Inquest	**3.78%**	**77**

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 52% (1050) of files were closed in under 12 months and 48% (986) of files were over 12 months old at closure (i.e. backlog files).

	INQUIRY		**INQUEST**	
TIMELINES	*PERTH*	*COUNTRY*	*PERTH*	*COUNTRY*
< 3 mths	**43**	**44**	**0**	**0**
3-6 mths	**179**	**183**	**1**	**0**
6-12 mths	**450**	**145**	**3**	**2**
12-18 mths	**681**	**52**	**5**	**18**
18-24 mths	**55**	**18**	**7**	**1**
>24 mths	**86**	**23**	**29**	**11**
TOTALS	**1495**	**465**	**45**	**32**

Table D

Table D below shows the total number of deaths reported and completed during the 2013/2014-year for Perth and Regional WA.

TOTAL NUMBER OF DEATHS REPORTED TO THE CORONER			2692
TOTAL NUMBER OF REPORTABLE DEATHS		2009	2009
Death certificates			683
Metropolitan deaths	1472	1472	
Regional deaths			
Albany	69		
Broome	37		
Bunbury	143		
Carnarvon	38		
Islands	13		
Geraldton	63		
Kalgoorlie	69		
Kununurra	20		
Northam	44		
Port Hedland	41		
Total Regional Deaths		537	
CASES COMPLETED	**PERTH**	**COUNTRY**	**TOTAL**
Finalised by Inquiry	1494	465	1959
Finalised by Inquest	45	32	77
TOTALS	1539	497	2036

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	*2009-2010*	*2010-2011*	*2011-2012*	*2012-2013*	*2013-2014*
Accident	562	341	684	645	622
Misadventure	10	7	23	19	34
Natural Causes	887	777	881	975	849
No Jurisdiction	2	1	2	7	0
Open Finding	79	66	125	120	125
Self Defence	0	0	1	1	1
Suicide	337	150	404	383	336
Unlawful Homicide	49	45	72	75	69
TOTALS	**1926**	**1387**	**2192**	**2225**	**2036**

***** Unlike in past financial years, the statistical information for Table E in this Report was sourced from the data held by the National Coronial Information System in relation to closed cases and accordingly, some of the figures previously reported will have changed.

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. When the post mortem report becomes available the cause of death is set out in a letter sent to the senior next of kin.

If a next of kin in relation to the deceased wishes to obtain access to the contents of the post mortem report a request in writing must be made to the coroner. The post mortem report is a detailed and confidential medical document and access is usually granted by forwarding a copy to a medical practitioner of the next of kin's choice, who can review it and explain the contents to the next of kin. The copy of the post mortem report is not released to the next of kin.

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.

Unless there is an objection, the post mortem examination is performed without unnecessary delay. It facilitates the release of the deceased's body to the senior next of kin as quickly as is possible. Additional specialist testing e.g. toxicology may take some time to complete but additional testing will not delay the release of the body from the mortuary. Until the results of additional testing are known the post mortem examination is not complete.

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 Police Force 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 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, the coroner immediately gives notice in writing of that decision to the senior next of kin, with reasons. 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. They 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 23 of this Report.

Table F

Table F below shows the number of post mortem examinations and the number of objections received in the 2013/2014-year and the outcomes:

Deaths reported to Coroner's Court of Western Australia:

REPORTED DEATHS	
Immediate post mortem	**46**
No objection to post mortem	**1677**
Objection to post mortem	**256**
No post mortem conducted (missing person etc)	**30**
NUMBER OF REPORTED DEATHS	**2009**

Outcomes in cases where an objection was initially received:

OBJECTIONS TO POST MORTEMS	
Objection accepted	**160**
Objection withdrawn	**95**
Objection withdrawn after coroner overruled	**1**
Applications to Supreme Court	**0**
TOTAL OBJECTIONS TO POST MORTEMS	**256**

Coronial Counselling Service

Any person coming into contact with the coronial system may seek the assistance of the Coronial Counselling Service. The service is attached to the Coroner's Court of Western Australia under section 16 of the Coroners Act.

Coronial counsellors are able to provide assistance in a range of areas. Coronial counsellors may provide information to the next of kin about the expected progress of their loved one's case through the coronial system and where the case is at within that process. Coronial counsellors explain the process and the timelines involved when a senior next of kin objects to a post mortem examination.

Coronial counsellors are able to offer short term counselling in relation to grief, loss, and trauma. Where the coronial counsellors form the view that a person would benefit from ongoing clinical counselling, they will offer information about referral options. These can be general, for example provision of information about access to a psychologist under Medicare by seeing a GP, or specific, for example linking persons to support groups for specific issues.

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 loved one. This process involves supporting the next of kin during the viewing as appropriate and being available to answer questions.

Coronial counsellors are able to link people to the court companion service where volunteers are available to explain inquest proceedings and to accompany next of kin to inquests if required. They are able to attend at the State Mortuary to support next of kin if they require that support when viewing their loved one. They will conduct home visits if required and if it is possible.

In the event of mass casualty incidents, the coronial counsellors are available to support bereaved next of kin during the information collection and investigation phases of the response. As the investigation progresses, the coronial counsellors are a consistent source of information and care for those immediately affected and their support people. The coronial counsellors also work with other agencies to ensure that information provision and the support needs of the bereaved are met in the most sensitive and appropriate way possible.

Table G

Table G below shows the number and types of referrals dealt with by the Coronial Counselling Service in for the past four financial years.

TYPE OF SERVICE	*2010-2011*	*2011-2012*	*2012-2013*	*2013-2014*
Phone, Office/Home Visits	**4204**	**5196**	**6251***	**6529**
Offers of Service	**919**	**949**	**933***	**1092**
Mortuary/file viewings	**896**	**1538**	**1971***	**2129**
TOTAL CONTACTS	**6019**	**7683**	**9155***	**9750**

* The statistical information for the 2012/2013-year has been amended

For the 2013/2014-year the above categories are explained as follows:

- Phone, Office/Home visits refers to all telephone calls (6270) visits to home addresses (13) and attendances at other offices or attendances by others at the Court (246);
- Offers of Service refers to letters offering counselling (1092); and
- Mortuary/file viewings refers to emails (912), interoffice liaison (1217) and mortuary contact (0).

Coronial Ethics Committee

The Coronial Ethics Committee was set up under 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. The Coronial Ethics Committee meets quarterly (if required) to consider each application, 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 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 aims to draw from a range of representative categories so that a broad cross section of views may be put forward for discussion. The Coroner's Court of Western Australia is well served by the considerable work done by Coronial Ethics Committee members. They make their services available on a voluntary basis in a sensitive area that has the potential to make a vital contribution to the death prevention role.

The members of the Coronial Ethics Committee are as follows:

Dr Adrian Charles	Chairperson Paediatric Pathologist, Princess Margaret Hospital
Associate Professor Jennet Harvey	Department of Pathology, UWA
Ms Evelyn Vicker (until July 2013)	Deputy State Coroner
Mr Barry King (from October 2013)	Coroner
Dr Jodi White	Forensic Pathologist, PathWest
Mr Jim Fitzgerald	Lay member
Ms Heather Leaney	Lay member
Reverend Brian Carey	Member with a pastoral background
Ms Christine Pitt	Lay member, Legal Member
Kate Ellson	Secretary, Legal Member, Senior Counsel Assisting

It was with regret that due to work commitments overseas, Dr Adrian Charles is unable to continue as the Chairperson of the Coronial Ethics Committee, and he has tendered his resignation. The Coroner's Court of Western Australia acknowledges the many hours that Dr Charles has contributed on a voluntary basis over the years. Through the discharge of his functions as Chairperson, he has played an integral part in the proper and efficient conduct of the work of the Coronial Ethics Committee.

Also in July 2013 the Deputy State Coroner vacated her position as a member of the Coronial Ethics Committee after many years' service. I acknowledge the Deputy State Coroner's important contribution to the work of the Committee.

Table H

This past financial year, the Coronial Ethics Committee met three times and addressed the following number of projects.

Number of Projects Considered	Number of projects approved	Number of projects not approved
8	7	1
Number of Requests for renewal Considered	**Number of Requests for renewal Approved**	**Number of Requests for renewal Not approved**
1	1	0

With respect to the one project that was not approved, the State Coroner declined the application for coronial data on the recommendation of the Coronial Ethics Committee. The State Coroner did not reject any of the recommendations made by the Coronial Ethics Committee.

In addition to its usual business, the Coronial Ethics Committee continued to monitor the annual reporting by approved applicants conducting existing projects utilising coronial data. This monitoring is ongoing.

Principal Registrar and Coroner's Registrars

The Principal Registrar and the Coroner's Registrars have 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.

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

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

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

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 the exercise of non-delegated statutory functions. He executes the State Coroner's directions in relation to the conduct of coronial investigations. In situations where there is significant loss of life he takes a lead role in co-ordinating the administration of Disaster Victim Identification response.

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

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 work as senior counsel assisting the coroners and as secretary to the Coronial Ethics Committee throughout the past financial year. She has worked hard to continue the development of the Court's call-over system and to facilitate the listing of matters for inquest in a timely way.

Ms Ilona Burra-Robinson commenced work as counsel assisting the coroners in January 2014. Since commencing her employment, Ms Burra-Robinson has worked hard to ensure matters in her practice have been finalised in a timely way.

Ms Catherine Fitzgerald commenced work as counsel assisting the coroners in March 2014. Ms Fitzgerald has spent a large portion of her time preparing the 2007 Cyclone George matters for inquest. A large and complex matter, her assistance with this matter is greatly appreciated.

Police Assisting the Coroner

Sergeant Lyle Housiaux and Senior Constable Eric Langton have served as a critical link between the Office of the State Coroner and the Coronial Investigation Unit of the Western Australian Police.

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

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

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

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

INQUESTS

Table I below shows the total number of inquests **(77)** finalised in the 2013-2014 financial year. An inquest is finalised when the coroner signs the inquest finding.

Table I

SURNAME OF DECEASED	*DATE OF DEATH*	*DATE OF INQUEST*	*FINDING*	*DATE OF FINDING*
OSBORNE, Wendy Elaine	On or about 1/07/2010	23-24/04/2013	Accident	3/07/2013
***BANH, Bac Lam**	5/09/2012	25/06/2013	Natural Causes	3/07/2013
ROULSTON, Bradleigh Michael	13/02/2008	20-24/05/2013	Accident	5/07/2013
KEAN, Daniel Joseph	13/02/2008	20-24/05/2013	Accident	5/07/2013
#COFFEY, Sean Riley	Between 9-10/08/2012	5/07/2013	Accident	10/07/2013
WEPPNER, Bryce James	10/08/2012	5/07/2013	Immersion	10/07/2013
DAVIES, Adriana Elise	12/10/2005	4/12/2007 and 17/07/2013	Natural Causes	17/07/2013
***BROPHO, Robert Charles**	24/10/2011	27-28/06/2013	Natural Causes	19/07/2013
MURPHY, Sean Gordon Peter	20/09/2010	17-21/06/2013	Open Finding	19/07/2013
HUSSAIN, Hasmat	21/06/2012	30/05/2013, 25-26/06/2013 and 24/07/2013	Immersion	31/07/2013
HUSSAIN, Kamal	21/06/2012	30/05/2013, 25-26/06/2013 and 24/07/2013	Immersion	31/07/2013
HUSSAIN, Gulfam	21/06/2012	30/05/2013, 25-26/06/2013 and 24/07/2013	Immersion	31/07/2013
ALI, Zulffaqar	21/06/2012	30/05/2013, 25-26/06/2013 and 24/07/2013	Immersion	31/07/2013
ALI, Quambar	21/06/2012	30/05/2013, 25-26/06/2013 and 24/07/2013	Immersion	31/07/2013
UNKNOWN	21/06/2012	30/05/2013, 25-26/06/2013 and 24/07/2013	Immersion	31/07/2013
IBRAHIMI, Khalilullah	21/06/2012	30/05/2013, 25-26/06/2013 and 24/07/2013	Immersion	31/07/2013

HUSSAIN, Kyleni Sabir	21/06/2012	30/05/2013, 25-26/06/2013 and 24/07/2013	Immersion	31/07/2013
HUSSAIN, Sarfaraz	21/06/2012	30/05/2013, 25-26/06/2013 and 24/07/2013	Immersion	31/07/2013
NADIRI, Abbas	21/06/2012	30/05/2013, 25-26/06/2013 and 24/07/2013	Immersion	31/07/2013
HUSSAIN, Intezar	21/06/2012	30/05/2013, 25-26/06/2013 and 24/07/2013	Immersion	31/07/2013
ABBAS, Mazhar	21/06/2012	30/05/2013, 25-26/06/2013 and 24/07/2013	Immersion	31/07/2013
UNKNOWN	21/06/2012	30/05/2013, 25-26/06/2013 and 24/07/2013	Immersion	31/07/2013
AHMED, Nazir	21/06/2012	30/05/2013, 25-26/06/2013 and 24/07/2013	Immersion	31/07/2013
MEHMOOD, Sayed Shakeel	21/06/2012	30/05/2013, 25-26/06/2013 and 24/07/2013	Immersion	31/07/2013
HUSSAIN, Asad	21/06/2012	30/05/2013, 25-26/06/2013 and 24/07/2013	Immersion	31/07/2013
MOHAMMAD, Ghulam	21/06/2012	30/05/2013, 25-26/06/2013 and 24/07/2013	Immersion	31/07/2013
WEBB, Violet	9/11/2009	24-28/09/2013 and 30/07/2013	Accident	4/09/2013
FISHER, Hayley Bree	14/12/2009	15-17/07/2013	Accident	5/09/2013
DOHERTY, Craig James	Between 4-7/06/2010	15-17/07/2013	Accident	5/09/2013
TAYLOR, Evelyn	2/12/2010	20-21/05/2013 and 24/07/2013	Open Finding	11/09/2013
WHITEFORD, Carol Freda	6/03/2008	9-10/07/2013	Misadventure	24/09/2013
TRINH, Anh Thuy	12/05/2010	10/09/2013	Accident	26/09/2013
***MS D**	10/05/2008	25/02-1/03/2013 and 5-8/08/2013	Suicide	17/10/2013
BOX, James Gregory	11/03/2012	16-18/09/2013	Immersion (drowning)	30/10/2013

#MACK, Ah Bee	Between 18-29/12/2008	8/10/2013	Unlawful Homicide	1/11/2013
#LINDEN, Benjamin Charles	14/07/2012	11/10/2013	Misadventure	4/11/2013
JONES, Wilma Ray	21/03/2009	19-21/08/2013 and 23/08/2013	Natural Causes	11/11/2013
KERR, Henry Edwin	7/09/2011	11-13/09/2013	Natural Causes	11/11/2013
FORD, Valma May Ruth	22/11/2009	26-30/08/2013	Accident	12/11/2013
BRASIER, Thomas Michael	27/10/2009	13-17/05/2013 28/06/2013	Accident	13/11/2013
AHMED MUSE, Barkad	20/07/2012	25-26/07/2013, 29/07/2013, 19-23/08/2013	Accident	22/11/2013
SCAFIDAS, Allegra Amelie	5/05/2010	4-7/06/2013, 6-7/08/2013	Natural Causes	28/11/2013
ROLL, Robert	Between 22/07/2009 and 20/10/2009	14-15/10/2013	Open Finding	28/11/2013
NIELSON, Melissa Ann	15/09/2009	4-8/11/2013	Natural Causes	4/12/2013
***VOS, Glenis June**	24/04/2000	19/12/2013	Natural Causes	20/12/2013
***IBBOTSON, Graeme Ross**	5/04/2000	19/12/2013	Natural Causes	23/12/2013
***ZAPPACOSTA, Palermo**	16/02/2012	16/12/2013	Natural Causes	20/12/2013
***MACKENZIE, Alexander Ronald**	20/10/2012	16/12/2013	Natural Causes	23/12/2013
#LEWIS, Leslie Graham	24/12/2011	17/12/2013	Open Finding	23/12/2013
#GRAHAM, Michael Keith	Between 15/01/2013 and 11/02/2013	18/12/2013	Misadventure	8/01/2014
***TINKER, Amy**	15/09/2010	15-16/01/2014	Natural Causes	31/01/2014
***PORTELLI, Bill**	22/03/2012	6/02/2014	Natural Causes	24/02/2014
#SHARDLOW, Ian	16/08/2012	7/02/2014	Open Finding	24/02/2014
ROSS, Wayne Lance	11/04/2010	17/02/2014 to 19/02/2014	Accident	14/03/2014

***AXTELL, Anthony Nigel**	13/09/2012	4/03/2014	Natural Causes	20/03/2014
#HE, Beng Keong	4/11/2012	18/12/2013	Misadventure	28/03/2014
DIAMOND, Haley	19/06/2009	4 and 10-11/02/2014	Misadventure	31/03/2014
***GORDON, Ritchie**	12/07/2005	27/08/2012, 17-18 and 22/04/2013, and 25/02/2014	Natural Causes	11/04/2014
***SCOTT, Robert Kenneth**	22/05/2008	28-29/08/2012, 17-18 and 22/04/2013, and 25/02/2014	Suicide	11/04/2014
***RUTHERFORD, Sarah Jane**	27/12/2009	11/03/2013, 17-18 and 22/04/2013, and 25/02/2014	Suicide	11/04/2014
***GILBERT, Amanda Alison**	22/01/2010	13 and 15/03/2013, 17-18 and 22/04/2013, and 25/02/2014	Natural Causes	11/04/2014
***COLLINS, Kevin Maxwell**	31/08/2010	18-19/03/2013, 16-18 and 22/04/2013, and 25/02/2014	Natural Causes	11/04/2014
***FORKIN, Luke Isaac**	30/11/2010	20-22/03/2013, 16-18 and 22/04/2013, and 25/02/2014	Suicide	11/04/2014
***HUNT, Gregory Laurence**	22/02/2011	25/03/2013, 17-18 and 22/04/2013, and 25/02/2014	Suicide	11/04/2014
***PRISGROVE, Aaron Luke**	12/07/2011	27-28/03/2013, 2/04/2013, 17-18 and 22/04/2013, and 25/02/2014	Suicide	11/04/2014
***FOSKI, Tom**	6/05/2012	3-4/04/2013, 17-18/04/2013 and 22/04/2013 and 25/02/2014	Natural Causes	11/04/2014

***WILLIAMS, Antoinette**	13/10/2012	5,8-12/04/2013, 17-19/04/13. 22/04/2013 and 25/02/2014	Misadventure	11/04/2014
MINETT, Helen Barbara	28/09/2009	24-27/03/2014	Open Finding	15/05/2014
#KING, Arnold	Between 7-13/11/2011	10/03/2014	Open Finding	19/05/2014
***KIMOTO, Ayumi**	21/03/2010	5/05/2014	Suicide	23/05/2014
***DONE, Marjorie Mary**	3/12/2010	13/05/2014	Natural Causes	26/05/2014
GILBERT, Julissa Teresa	18/09/2008	4-5/03/2014	Misadventure	27/05/2014
DAVIES, Brian John	14/05/2011	7/03/2014	Natural Causes	27/05/2014
***CHURCH, Lynn Desmond Ernest**	6/07/2010	28-29/04/2014	Suicide	3/06/2014
***COOK-HILL, Daniel Jarvis**	12/10/2008	3/06/2014	Accident	11/06/2014
#FRENCH, William Maddison	Between 17/12/1997 and 10/11/1998	14/03/2014	Open Finding	16/06/2014
^SAMSON, Keannita	7/01/2010	9-11/04/2014	Unlawful Homicide	27/06/2014

^ = Deaths caused or contributed to by actions of member of police force

 # = Missing Persons

*** = Person Held in Care**

The balance of the matters listed (43) were discretionary inquests

The Tables appearing after Table I (Tables J, K and L) are subsets of the information contained in Table I, and they 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 J

Table J below shows the number of inquests **(1)** finalised in 2013/14-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*
SAMSON, Keannita	7/02/2010	9-11/04/2014	Unlawful Homicide	27/06/2014

This concerned a vehicle pursuit by police. The Deputy State Coroner found that all actions taken by police were reasonable and within the policies and guidelines at the time for law enforcement.

The Finding is 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 K

Table K below shows the number of inquests **(9)** finalised in 2013/14-year into suspected deaths.

NAME	*DATE OF DEATH*	*DATE OF INQUEST*	*FINDING*	*DATE OF FINDING*
COFFEY, Sean Riley	Between 9-10/08/2012	5/07/2013	Accident	10/07/2013
MACK, Ah Bee	Between 18-19/12/2008	8/10/2013	Unlawful Homicide	1/11/2013
LINDEN, Benjamin Charles	14/07/2012	11/10/2013	Misadventure	4/11/2013
LEWIS, Leslie Graham	24/12/2011	17/12/2013	Open Finding	23/12/2013
GRAHAM, Michael Keith	Between 15/01/2013 & 11/02/2013	18/12/2013	Misadventure	18/01/2014
SHARDLOW, Ian	16/08/2012	7/02/2014	Open Finding	24/02/2014
HE, Beng Keong	4/11/2012	18/12/2013	Misadventure	28/03/2014
KING, Arnold	Between 7-13/11/2011	10/03/2014	Open Finding	19/05/2014
FRENCH, William Maddison	Between 17/12/1997 & 10/11/1998	14/03/2014	Open Finding	16/06/2014

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;
(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;

(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 Drug Authority Act 1974*;

(c) a person who is an involuntary patient within meaning of the *Mental Health Act 1996* who is apprehended or detained under Part 3 of that Act; or

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

Table L below shows the number of inquests **(24)** finalised in 2013-14 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 the Table. Where a coroner has made a recommendation, the response appears at Annexure A commencing at page 64.

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

Table L

NAME	DATE OF DEATH	DATE OF INQUEST	FINDING	DATE OF FINDING
BANH, Bac Lam	5/09/2012	25/06/2013	Natural Causes	3/07/2013
BROPHO, Robert Charles	24/10/2011	27-28/06/2013	Natural Causes	19/07/2013
Ms D	10/05/2008	25/02/2013 - 1/03/2013 & 5-8/8/2013	Suicide	17/10/2013
VOS, Glenis June	24/04/2000	19/12/2013	Natural Causes	20/12/2013
IBBOTSON, Graeme Ross	5/04/2000	19/12/2013	Natural Causes	23/12/2013
ZAPPACOSTA, Palermo	16/02/2012	16/12/2013	Natural Causes	23/12/2013
MacKENZIE, Alexander Ronald	20/10/2012	16/12/2013	Natural Causes	23/12/2013
TINKER, Amy	15/09/2010	15-16/01/2014	Natural Causes	31/01/2014
PORTELLI, Bill	22/03/2012	6/02/2014	Natural Causes	24/02/2014
AXTELL, Anthony Nigel	13/09/2012	4/03/2014	Natural Causes	20/03/2014
GORDON, Ritchie	12/07/2005	27/08/2012, 17-18 & 22/04/2013, & 25/02/2014	Natural Causes	11/04/2014
SCOTT, Robert Kenneth	22/05/2008	28-29/08/2012, 17-18 & 22/04/2013, & 25/02/2014	Suicide	11/04/2014
RUTHERFORD, Sarah Jane	27/12/2009	11/03/2013, 17-18 & 22/04/2013, & 25/02/2014	Suicide	11/04/2014
GILBERT, Amanda Alison	22/01/2010	13 &15/03/2013, 17-18 & 22/04/2013, & 25/02/2014	Natural Causes	11/04/2014

COLLINS, Kevin Maxwell	31/08/2010	18-19/03/2013, 16-18 & 22/04/2013, & 25/02/2014	Natural Causes	11/04/2014
FORKIN, Luke Isaac	30/11/2010	20-22/03/2013, 16-18 & 22/04/2013, & 25/02/2014	Suicide	11/04/2014
HUNT, Gregory Laurence	22/02/2011	25/03/2013, 17-18 & 22/04/2013, & 25/02/2014	Suicide	11/04/2014
PRISGROVE, Aaron Luke	12/07/2011	27-28/03/2013, 2/04/2013, 17-18 & 22/04/2013, & 25/02/2014	Suicide	11/04/2014
FOSKI, Tom	06/05/2012	3-4/04/2013, 17-18 & 22/04/2013 & 25/02/2014	Natural Causes	11/04/2014
WILLIAMS, Antoinette	13/10/2012	5,8-12/04/2013, 17-19/04/13. 22/04/2013 & 25/02/2014	Misadventure	11/04/2014
KIMOTO, Ayumi	21/03/2010	5/05/2014	Suicide	23/05/2014
DONE, Marjorie Mary	3/12/2010	13/05/2014	Natural Causes	26/05/2014
CHURCH ,Lynn Desmond Ernest	6/07/2010	28-29/04/2014	Suicide	3/06/2014
COOK-HILL, Daniel Jarvis	12/10/2008	3/06/2014	Accident	11/06/2014

Persons held in care – specific reports

Bac Lam BANH
Inquest held in Perth 25 June 2013, investigation finalised 3 July 2013

Mr Bac Lam Banh (the deceased) died on 5 September 2012 at Albany Regional Hospital. The coroner found the manner of death was natural causes. The cause of death was early bronchopneumonia complicating subarachnoid haemorrhage due to a ruptured berry aneurysm. He was 40 years old.

Immediately before death the deceased was a person held in care pursuant to the Prisons Act because he was sentenced prisoner serving his sentence at the Walpole Work Camp operated by the Department of Corrective Services.

During the evening of 3 September 2012 the deceased played badminton in the local community hall. On returning to the work camp he rang his wife and complained of a headache. The following morning the deceased appeared in good health and spirits and did not make reference to having a headache. At about 8.15am the deceased was repairing a faulty drainpipe connection under some decking. Whilst unattended the deceased lay on his stomach and examined the connection through a hole in the decking. Whilst in this position the berry aneurysm in his brain ruptured and he began to suffer the effects of his severe subarachnoid haemorrhage. He collapsed and became unresponsive.

Very shortly afterwards a prison officer and two other prisoners tried to resuscitate the deceased. A nurse practitioner working for Walpole Silver Chain also assisted in the resuscitation efforts. An ambulance was called and arrived shortly afterwards. The deceased was transferred by ambulance to Walpole Health Clinic who had been alerted to the emergency and had a doctor waiting. After examination the deceased was transferred to Albany Regional Hospital due to the severity of his condition.

Urgent medical investigations showed the deceased's condition was not survivable. Life support systems were turned off and the deceased passed away on 5 September 2012.

The coroner commented that in general terms the quality of the supervision, treatment and care given to the deceased by the Department of Corrective Services was good and that the deceased had access to quality health services which were at least equal to those available to members of the Walpole community. The coroner commented that the deceased's prospects of recovery from the ruptured berry aneurysm were not negatively affected by the fact of his incarceration.

The coroner made two recommendations. The coroner recommended that the Department of Corrective Services consider implementing changes to facilitate hard copies of the EcHO files of prisoners at the Walpole Work Farm be provided to their local, community based physician. The coroner also recommended that the EcHO files be regularly reviewed by a physician employed by the Department and outlined reasons for that. The Commissioner, Office of the Commissioner, Department of Corrective Services responded by letter dated

16 September 2013. In respect of the coroner's first recommendation, the Commissioner responded that Departmental policy dictated that community GP's received a Health Summary pending consent of the patient, consistent with the common practice in the community where a GP refers a patient to a specialist doctor, but that it was not practical or necessary to provide the whole medical file to the community based practitioner. In respect of the coroner's second recommendation, the Commissioner responded that the Department is actively working on a solution, but also referred to medico legal considerations. The response from the Department of Corrective Services is reproduced at Annexure A at page 64 of this Report.

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

Robert Charles BROPHO
Inquest held in Perth 27-28 June 2013, investigation finalised 19 July 2013

Mr Robert Bropho (the deceased) died on 24 October 2011 in Royal Perth Hospital. The coroner found the manner of death was natural causes. The cause of death was acute myocardial infarction in association with coronary artery atherosclerosis. He was 81 years old.

Immediately before death the deceased was a person held in care pursuant to the Prisons Act because he was a sentenced prisoner in Casuarina Prison.

At the inquest the deceased's daughter relayed a number of concerns relating to the deceased's treatment and care while in prison and about failures by the Department of Corrective Services to notify the deceased's family of his condition and his death.

When the deceased began his sentence of imprisonment on 28 February 2008, he had a number of serious medical conditions including longstanding insulin dependent diabetes mellitus, hypertension, chronic renal failure, severe ischaemic heart disease with angina, regular cardiac failure, underactive thyroid and depression. He was on a complicated insulin regime and was prescribed more than ten separate medications.

On 9 August 2010 the deceased was registered as a Phase 1 terminally ill prisoner under the Department's Policy Directive 8. The criterion for Phase 1 was a high probability of death. He was moved from the prison's mainstream population into the infirmary and his condition was to be continuously monitored.

On 23 November 2010 the deceased's status as a terminally ill prisoner was changed to Phase 2, whereby his death was considered imminent. Steps were then taken to ascertain his suitability for exercise by the Governor of the Royal Prerogative of Mercy.

On 19 July 2011 the Department provided the Attorney General with recommendations as to the deceased's suitability for the exercise by the Governor of the Royal Prerogative of Mercy. On 12 September 2011, the Attorney General decided not to recommend to the Governor that the prerogative be exercised.

At 7.30am on 24 October 2011 a nurse employed at the prison noted that the deceased had failed to attend the diabetic parade, so she went to his cell where she administered insulin and carried out standard medical observations.

At 8.45am the deceased was found collapsed on the floor of his cell. He had not lost consciousness and had no chest pain.

About half an hour later, the deceased was accompanied by a nurse back to the day room in the infirmary when he again collapsed. Nurses administered oxygen and took observations. The on-call doctor arrived and requested a priority one ambulance. A blood test indicated a heart attack.

An ambulance took the deceased to Royal Perth Hospital where upon arrival his condition rapidly deteriorated. He had a cardiac arrest from which he could not be resuscitated.

A forensic pathologist conducted a post mortem examination and found widespread areas of severe stenosis in the blood vessels of the heart, acute myocardial infarction and severe coronary artery atherosclerosis. The kidneys showed changes consistent with diabetes and hypertension and there were areas of calcification in the lungs. In his opinion the cause of death was acute myocardial infarction in association with coronary artery atherosclerosis.

Following the deceased's death, an eminent specialist in Aboriginal and rural health provided an independent medical report based on his review of seven folders of prison medical records relating to the deceased's condition from 2006 to October 2011.

The specialist's report contained the following summary:

Mr Bropho suffered from atherosclerosis. He also had several metabolic disorders that contributed to coronary artery occlusion. It is remarkable that he nearly reached 82 years of age. His medical, and particularly his nursing care in prison was compassionate and competent...[extract]

As to the concerns expressed by the deceased's daughter, the coroner was satisfied that they were based on information that was either exaggerated or baseless. The coroner was further satisfied that the quality of the supervision, treatment and care of the deceased while in the custody was high.

The coroner however noted that there was a failure by Departmental officers to follow the policy of notifying the deceased's family of the fact that the deceased had been moved to Royal Perth Hospital in an emergency situation.

The coroner made a recommendation that the Department of Corrective Services take certain steps regarding notification to be given to prisoners that are classified as having a Phase 1 or Phase 2 terminal illness. As to the deceased's daughter's complaint that the deceased's family had not been notified of the deceased's death promptly, the coroner made comment directed to the importance of notification of families of persons who die while in custody. The coroner

also made comment about reviewing the procedure regarding the use of restraints during external escorts in the particular context of the hospitalisation of the deceased, to reduce instances where restraints are applied in clearly inappropriate situations.

The Commissioner, Office of the Commissioner, Department of Corrective Services responded by letter dated 16 September 2013. In respect of the coroner's recommendation, the Commissioner outlined the existing procedure requiring the prison general practitioner to explain to the prisoner that they have been added to the terminally ill list and advised that steps are to be undertaken concerning the notification of the next of kin where a prisoner has a terminal illness and provides consent. In respect of the coroner's comments, the Commissioner outlined the steps to be undertaken regarding the provision of alternative contact details to facilitate notification of families of persons who die while in custody where the next of kin cannot be located or contacted and the Commissioner also outlined the procedures regarding the use of restraints during external escorts. The response from the Department of Corrective Services is reproduced at Annexure A at page 66 of this Report.

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

Ms D
Inquest held in Perth 25 February-1 March & 5-8 August 2013,
Investigation finalised 17 October 2013

Ms D [name suppressed] (the deceased) died on 10 May 2008 at Hospital Angeles, Tijuana, Mexico, Central America. The Deputy State Coroner found the manner of death was suicide. The cause of death was septic shock, nosocomial pneumonia in a woman with acute respiratory distress syndrome. She was 39 years old.

Immediately before death the deceased was a person held in care because she was subject to a community treatment order under the Mental Health Act and therefore an involuntary patient. The deceased was ordinarily residing in Western Australia at the time of death.

The events leading up to Ms D's death were complex and she had received a range of input from the Mental Health Services in WA to which she was generally very resistant. The Deputy State Coroner accepted the diagnosis of a depressive illness in conjunction with Cluster B personality traits and suspected that those issues were factors with which the deceased had struggled for much of her adult life.

Following the deceased's death in Mexico her management was reviewed by the Chief Psychiatrist and he made numerous recommendations with respect to the Mother and Baby Unit at King Edward Memorial Hospital and Alma Street Centre in Fremantle to improve issues around consent and confidentiality and care in the community.

However the Deputy State Coroner did not consider any of those improvements would have led to a different outcome in the case of the deceased. There was nothing in the Chief Psychiatrist's review which indicated the deceased's care did not fall within acceptable levels at either facility.

Following the decision of the Mental Health Review Board to discharge the deceased from involuntary status, the clinicians at the Mother and Baby Unit were faced with a the difficult challenge of ascertaining the best way to proceed for the safety of the deceased. The clinicians were also concerned with the safety of the deceased's youngest child from whom she was only separating as a result of actions taken by the Mother and Baby Unit clinicians.

From the position of the Mental Health Review Board there was little to support the deceased's involuntary status under the Mental Health Act on her arguments and presentation to the hearing. She was able to present herself very reasonably and that alone emphasised the difficulty for her treating clinicians as to whether the restrictions they had imposed on her by involuntary status were in fact contributing to her lack of improvement whilst at the Mother and Baby Unit. That concern explained the decision to try another means of treatment which involved extending her involuntary status to an outpatient environment by use of a Community Treatment Order (CTO).

The deceased appeared to be compliant with the CTO's conditions and the community mental health nurses had some difficulty understanding why it was in place. Nevertheless they continued to attempt to engage with her and visit her twice a week to ensure she was complying with conditions.

The number of patients dealt with by the Alma Street Centre made earlier psychiatric review very difficult and there was nothing perceived by way of a crisis which would warrant an emergency assessment. The Deputy State Coroner found that it was likely that even with an emergency assessment the deceased's presentation would have been such there was still no apparent reason to require her return to inpatient status. On the little of her life she allowed the community health nurses to see things appeared to be moving well. The deceased had specifically excluded contact with particular family members.

The Deputy State Coroner found that while the deceased's supervision, treatment and care whilst in the community was not optimal, it would seem that was more due to the systems available for community supervision and resourcing issues, than a lack of care. There was nothing to suggest the care provided was below accepted practise at that time.

The Deputy State Coroner made observations on matters concerning patient confidentiality. The Deputy State Coroner did not make any recommendations.

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

Glenis June VOS
Inquest held in Perth 19 December 2013, investigation finalised 20 December 2013

Ms Glenis June Vos (the deceased) died on 24 April 2000 at Graylands Hospital. The Deputy State Coroner found that the manner of death was natural causes. The cause of death was focal pneumonia in a woman with emphysema and ischaemic heart disease. She was 60 years old.

Immediately before death the deceased was a person held in care because she was an involuntary patient, within the meaning of the Mental Health Act, at Graylands Hospital, having become such in March 1995.

The deceased had struggled with mental health issues from 21 years of age when she was diagnosed as suffering from schizophrenia. This was later diagnosed as bipolar affective disorder. The deceased spent large periods of her life at Graylands Hospital, as well as other medical institutions. She had effectively become institutionalised due to the amount of time in medical and mental health facilities.

From January 2000 until her death in April 2000 the deceased was frequently transferred to Sir Charles Gairdner Hospital for treatment for seizures and infections. A CAT scan in February 2000 revealed generalised cerebral atrophies. An attempt was made to care for her in a nursing home but due to her behavioural problems this was unachievable and she was returned to Graylands Hospital as an involuntary patient.

By April 2000 her physical health had declined to the extent she was frail and needed to walk with the aid of a zimmer frame or wheel chair. Her medical history consisted of strokes, aspiration pneumonia, seizures, respiratory arrest resulting in hypoxic brain injury and residual upper right limb weakness. She also suffered repeatedly from bronchitis and pneumonia.

In the weeks immediately preceding her death the deceased became unsettled and it is likely this was part of her deterioration due to pneumonia and emphysema. Overnight from 24-25 April 2000 she was extremely unsettled and needed to be sedated in a locked ward to ensure her rest. She was located, deceased, in the morning.

The Deputy State Coroner found that the deceased had received extensive input for her mental health issues and her medical conditions. The deceased's behaviour was such she was not able to be cared for in a conventional nursing home and therefore required the type of care which could only be provided to her as an involuntary patient at Graylands Hospital.

In all the circumstances the Deputy State Coroner found the deceased had been provided with sufficient treatment and her care had been adequate.

The Deputy State Coroner did not make any recommendations.

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

Graeme Ross IBBOTSON
Inquest held in Perth 19 December 2013, investigation finalised 23 December 2013

Mr Graeme Ross Ibbotson (the deceased) died on 5 April 2000 at Mill Street Centre, Bentley Hospital. The Deputy State Coroner found that the manner of death was natural causes. The cause of death was ischaemic heart disease. He was 57 years old.

Immediately before death the deceased was a person held in care because he was an involuntary patient, within the meaning of the Mental Health Act, at Mill Street Centre.

The deceased had an extensive medical history and had been diagnosed with bipolar affective disorder in 1974. On 27 February 2000 the deceased admitted himself to the Mill Street Centre for treatment of his bipolar affective disorder. He was transferred to Royal Perth Hospital on 8 March 2000 due to his developing clinical symptoms relating to a shortness of breath associated with a productive cough and confusion. He was transferred back to Mill Street Centre but again taken to the emergency department at Royal Perth Hospital due to a worsening of his medical symptoms. Thereafter the deceased was transferred between Mill Street Centre and Royal Perth Hospital each time his medical symptoms deteriorated. Eventually on 5 April 2000, as he was being transferred again to Royal Perth Hospital, he suffered a respiratory arrest and could not be revived.

The Deputy State Coroner found the deceased had been appropriately monitored and maintained while an involuntary patient with transfers to a tertiary institution when required due to the exacerbation of his medical symptoms.

The Deputy State Coroner was satisfied that the supervision, treatment and care of the deceased while an involuntary patient at the Mill Street Centre was reasonable and appropriate.

The Deputy State Coroner did not make any recommendations.

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

Palmerino ZAPPACOSTA
Inquest held in Perth 16 December 2013, investigation finalised 23 December 2013

Mr Palmerino Zappacosta (the deceased) died on or about 16 February 2012 at Royal Perth Hospital. The Deputy State Coroner found that the manner of death was natural causes. The cause of death was sepsis associated with a pericolic abscess, complicated by terminal large intestinal haemorrhage. He was 86 years old.

Immediately before death the deceased was a person held in care pursuant to the Prisons Act because he was a sentenced prisoner. He was serving his sentence at Casuarina Prison, where he had primarily stayed in the prison infirmary due to his ongoing health issues. He had been incarcerated since December 1999.

The deceased had a significant medical history prior to his imprisonment which included mental health issues.

Although the deceased was recorded as being terminally ill in 2001, he survived until 2010, without his condition being escalated to imminent death until 2010. Even then the deceased, with the care and treatment to which he was fairly resistant, remained in Casuarina infirmary until 10 February 2012 when he was transferred to Royal Perth Hospital for the last time. He was treated palliatively and died on 16 February 2012 as a result of his combined medical conditions.

The Deputy State Coroner commented that the treatment the deceased received while in custody was significant in maintaining his life expectation despite his frequent lack of compliance and cooperation with those trying to treat him.

The Deputy State Coroner was satisfied on the whole of the evidence that the deceased had multiple medical problems for which he was treated. He was reviewed by external medical facilities for his specialist medical needs and provided with ongoing treatment and care on their advice. He was provided with ongoing medical assessment and nursing care once his condition necessitated he be assisted with daily living requirements.

The Deputy State Coroner found that the deceased's supervision, treatment and care while in the custody of the Department of Corrective Services, and collocated in Royal Perth Hospital, was appropriate.

The Deputy State Coroner did not make any recommendations.

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

Alexander Ronald MacKENZIE
Inquest held in Perth 16 December 2013, investigation finalised 23 December 2013

Mr Alexander Ronald MacKenzie (the deceased) died on 20 October 2012 at Sir Charles Gairdner Hospital. The Deputy State Coroner found that the manner of death was natural causes. The cause of death was pneumonia in a man with advanced metastatic angiosarcoma. The deceased was 60 years old.

Immediately before death the deceased was a person held in care pursuant to the Prisons Act because he was a sentenced prisoner. He was serving a 25 year term of imprisonment at Casuarina Prison that had been imposed on 25 March 2003. The deceased had been both diagnosed, and treated for, his conditions whilst in the care of Casuarina Prison until transferred to the palliative care unit at Sir Charles Gairdner Hospital on 6 September 2012.

The Deputy State Coroner found that the deceased had received substantial and reasonable management for his various medical problems, instigated by the prison doctors and directed by external specialists and consultants. While accepting that clues to the deceased's rare conditions may have alerted a single clinician to the fact of his illnesses earlier, there was no evidence that would have extended his life any more significantly than occurred with the treatment he did receive.

The Deputy State Coroner found the deceased's supervision, treatment and care was appropriate to the conditions in an institution caring for many prisoners, some of whom have extremely intricate medical histories.

The Deputy State Coroner did not make any recommendations.

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

Amy TINKER
Inquest held in Perth 31 January 2014, investigation finalised 31 January 2014

Ms Amy Tinker (the deceased) died on 15 September 2010 at Royal Perth Hospital. The coroner found the manner of death was natural causes. The cause of death was multiple organ failure complicating likely sepsis and cirrhosis of the liver. She was 33 years old.

Immediately before death the deceased was a person held in care pursuant to the Prisons Act because she was a sentenced prisoner at Greenough Regional Prison.

In October 2004 the deceased had been treated for acute alcoholic hepatitis and was found to have decompensated liver failure.

On 18 December 2006 the deceased underwent an initial health screen when she was admitted to Roebourne Regional Prison. She denied that she had ever been admitted to hospital for a serious illness.

The deceased was again in prison from March 2010. In April 2010, a prison doctor requested that liver function tests be done. There were no liver function test results in the Department of Corrective Services' medical records for the deceased.

On 12 August 2010 a prison doctor reviewed the deceased's previous liver function test results which showed abnormal liver function. Fasting blood tests were scheduled for 27 August 2010, the same day the deceased was transferred to Greenough Regional Prison. It is not known if blood samples were taken because no results were provided by a pathology laboratory and, because of a lack of process, the Department did not follow them up.

Over the next two weeks at Greenough Regional Prison the deceased became ill. On 13 September 2010 she was taken to Geraldton Regional Hospital. Her liver function test results were normal. She was transferred into Royal Perth Hospital where she died on 15 September 2010.

The inquest focused primarily on the care provided to the deceased and on possible improvements that could be made to the standard of primary medical care provided to prisoners, particularly in relation to liver disease. The coroner found the deceased's sepsis was caused to some degree by chronic liver disease associated with alcohol abuse and lack of proper nutrition. Whilst the investigation did not explore the reasons for the deceased's chronic alcohol abuse, the coroner commented that the ongoing social catastrophe related to

alcohol abuse in the State's northwest, of which the deceased was a victim, is well documented.

The coroner found that improvements had been made to the Department of Corrective Services' procedures to ensure that pathology test results are followed up appropriately and that the Department had taken appropriate steps to address issues relevant to the treatment and care of the deceased in 2010.

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

The coroner did not make any recommendations.

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

Bill PORTELLI
Inquest held in Perth 6 February 2014, investigation finalised 24 February 2014

Mr Bill Portelli (the deceased) died on 22 March 2012 at Fremantle Hospital. The coroner found the manner of death was natural causes. The cause of death was bronchopneumonia while receiving palliative care for terminal carcinoma of the rectum. He was 64 years old.

Immediately before death the deceased was a person held in care because he was an involuntary patient, within the meaning of the Mental Health Act, at the Alma Street Centre, having been diagnosed with chronic paranoid schizophrenia. He had first been diagnosed with this mental illness in 1975. In 2011 the deceased had been diagnosed with likely colorectal cancer with liver metastasis.

For many years the deceased was living at home and receiving support for his mental illness from his doctor, Silver Chain and the Alma Street Centre. By 12 March 2012 the Alma Street Centre and Silver Chain were no longer able to support the deceased at home, due to the state of his physical and mental health.

On 13 March 2012 the deceased was admitted into Alma Street Centre for palliative treatment as an involuntary patient. At the Alma Street Centre the deceased was placed on 15 minute observations and a 'not for resuscitation' order. A palliative care nurse saw him daily to review and alter his pain management.

On 20 March 2012 the deceased's condition deteriorated rapidly and he died in the early hours of 22 March 2012.

The coroner found that the supervision, treatment and care provided to the deceased by Alma Street Centre while he was an involuntary patient were exemplary.

The coroner did not make any recommendations.

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

Anthony Nigel AXTELL
Inquest held in Perth 4 March 2014, investigation finalised 20 March 2014

Mr Anthony Nigel Axtell (the deceased) died on 13 September 2012 at Royal Perth Hospital. The coroner found the manner of death was natural causes. The cause of death was consistent with heart failure in a man with dilated cardiomyopathy and focal severe coronary artery atherosclerosis. He was 38 years old.

Immediately before death the deceased was a person held in care pursuant to the Prisons Act because he was a remand prisoner at Casuarina Prison.

The inquest focused primarily on the care provided to the deceased while a prisoner, both within the custodial environment and while admitted at Royal Perth Hospital. The deceased had a long history of cardiac disease, exacerbated by illicit drug use and non-compliance with medical advice.

No issues arose in the evidence relevant to the quality of the supervision of the deceased.

As to the quality of treatment and care of the deceased, on the whole the coroner found the treatment and care of the deceased was appropriate and of a high standard. The only issue that could have been done better related to the prescribing of the deceased's medications and recording of their administering while in custody. However, the expert opinion provided at the inquest was that this issue would not have had a major impact on the deceased's deteriorating health.

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

The coroner did not make any recommendations.

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

Ritchie GORDON
Inquest held in Perth 27 August 2012, 17-18 April 2013, 22 April 2013 and 25 February 2014, investigation finalised 11 April 2014

Mr Ritchie Gordon (the deceased) died on 12 July 2005 at Graylands Hospital. The coroner found that the manner of death was by natural causes. The cause of death was unascertainable, though the forensic pathologist advised that given her findings and her understanding of the circumstances surrounding the deceased, the possible explanations for a cause of death would include epileptic seizure, cardiac arrhythmia and paralytic ileus/bowel obstruction. He was 49 years old.

Immediately before death the deceased was a person held in care pursuant to the Mental Health Act. He had been a long term involuntary patient at Graylands Hospital since 6 August 2002. He suffered from chronic schizophrenia and organic brain syndrome from a childhood head injury and also from a history of alcohol and drug abuse.

As time went on, the deceased suffered from mild chronic obstructive pulmonary disease and ischaemic heart disease.

On the evening of 12 July 2005 the deceased was found dead on a veranda of his ward after not being seen for some hours. He had no apparent injuries.

The coroner found that the deceased was provided with an acceptable level of supervision, treatment and care. The coroner found there was no basis for a conclusion that any shortcomings with the infrastructure at Graylands Hospital at the material times had any negative effect on the deceased's treatment and care.

The coroner did not make any recommendations.

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

Robert Kenneth SCOTT
Inquest held in Perth 28-29 August 2012, 17-18 April 2013, 22 April 2013 and 25 February 2014, investigation finalised 11 April 2014

Mr Robert Kenneth Scott (the deceased) died on 22 May 2008 while absconding from Graylands Hospital. The coroner found the manner of death was suicide. The cause of death was ligature compression of the neck (hanging). The deceased was 28 years old.

Immediately before death the deceased was a person held in care because he was an involuntary patient, within the meaning of the Mental Health Act, at Graylands Hospital. The deceased was first diagnosed with a psychiatric condition in 1997. He was admitted to Graylands Hospital and treated on and off over the next two years as an involuntary patient.

The deceased was not admitted to Graylands again until March 2007 following a relapse of schizophrenia because of poor compliance with medications. In January 2008 he was admitted to Graylands with another relapse of schizophrenia and was discharged on 13 February 2008.

On 5 April 2008 the deceased was admitted to Graylands Hospital for the last time. His condition fluctuated until late May 2008 when he began to be considered for discharge. On 21 May 2008 the deceased absconded from Graylands Hospital and went to his uncle's home in Midland. The next day, he hanged himself there while his uncle was at work.

The coroner was satisfied that the quality of the supervision, treatment and care of the deceased was appropriate. The coroner commented that the deceased received a significant amount of treatment and care at Graylands Hospital and that each admission to that hospital bar the last one resulted in the deceased being discharged following successful treatment. As to the deceased's supervision in light of the deceased's unescorted ground access, before his transition to open ward care, the coroner commented that the evidence of the deceased's mental state progress, his needs and his risk management suggest that that decision was reasonable.

The coroner found there was no evidence to suggest that any act or omission of a Graylands Hospital staff member in any way contributed to the deceased's death.

The coroner did not make any recommendations.

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

Sarah Jane RUTHERFORD
Inquest held in Perth 11 March 2013, 17-18 April 2013, 22 April 2013 and 25 February 2014, investigation finalised 11 April 2014

Ms Sarah Jane Rutherford (the deceased) died on 27 December 2009 after falling onto the Mitchell Freeway in Hamersley while on leave from Graylands Hospital. The coroner found that the manner of death was suicide. The cause of death was multiple injuries. The deceased was 28 years old.

Immediately before death the deceased was a person held in care because she was an involuntary patient, within the meaning of the Mental Health Act, at Graylands Hospital.

The deceased began to suffer mental problems in 1999. When she was about 23 years old, the deceased went to Korea where she experienced a mental breakdown. She was returned to Australia and was diagnosed with bipolar affective disorder and psychotic features. Over the next few years she was treated by psychiatrists.

In late May 2007 the deceased was admitted to Graylands Hospital and diagnosed with paranoid schizophrenia with catatonic features. She was discharged after a month and managed to cope in the community for two years.

On 2 December 2009 the deceased was diagnosed with a relapse of schizophrenia due to non-compliance with medication. She was transferred back to Graylands Hospital where she was made an involuntary patient and put back on her medication.

After a trial leave, the deceased was given leave from Graylands to spend Christmas with her family. On 24 December 2009 the deceased and her family travelled south to spend Christmas Day with her older sister. They returned on 26 December 2009. That night the deceased fell from a pedestrian bridge over the Mitchell Freeway and suffered non-survivable injuries.

The coroner found that the death occurred by way of suicide. The coroner heard evidence regarding the management of the deceased's medication, and her progression from escorted ground access to an open ward, overnight leave, weekend leave and then the final period of leave with her family (including a seven day prescription for risperidone, with which she had been compliant).

The coroner was satisfied that the quality of the treatment and care received by the deceased at Graylands Hospital was reasonable and appropriate.

The coroner did not make any recommendations.

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

Amanda Alison GILBERT
Inquest held in Perth 13 and 15 March 2013, 17-18 April 2013, 22 April 2013 and 25 February 2014, investigation finalised 11 April 2014

Ms Amanda Alison Gilbert (the deceased) died on 22 January 2010 at Graylands Hospital. The coroner found the manner of death was natural causes. The cause of death was bronchopneumonia on a background of ischaemic heart disease, chronic renal failure and past hypoxic brain injury. The deceased was 47 years old.

Immediately before death the deceased was a person held in care because she was an involuntary patient, within the meaning of the Mental Health Act, at Graylands Hospital.

The deceased was first admitted to Graylands Hospital as an involuntary patient in 1980 with psychotic symptoms. Her symptoms continued. In 1985 she suffered hypoxic brain damage from an attempted suicide by hanging.

At the time there was a lack of facilities for brain damaged young adults in Western Australia; Graylands Hospital was the only alternative. Other options were explored but were unsuitable in the long term.

In June 1987 the deceased was admitted into a mixed-gender long-stay unit in Graylands Hospital where for several years she suffered frequent and regular assaults from other patients. The deceased was also found in sexually compromising situations with male patients while in Graylands Hospital. The coroner commented that the fact it was likely the deceased provoked or instigated many of these assaults was, of course, not relevant as she needed protection from the effects of her own psychotic or disinhibited behaviour.

Over time, the deceased also began to suffer from falls due to an unsteady gait from her brain damage. The first serious injury from a fall was in August 1994.

Funding for a one-to-one special nurse for the deceased was finally provided in 1997, which ended the assaults and she could be accommodated in an open ward.

By May 1998 the deceased's creatinine levels were rising, so her lithium medication was stopped since it was known to be a risk of causing renal failure.

On 19 August 1998 the deceased was admitted to Sir Charles Gairdner Hospital with aspiration pneumonia. While there she developed malignant hypertension, acute renal failure and diabetes insipidus. The renal failure and the diabetes insipidus were thought to have been caused by the previous lithium prescription.

Following that episode, the deceased's cognitive and personality functions deteriorated further. She remained at Graylands Hospital as there was nowhere else for her. From 1999 the deceased's renal function deteriorated.

By the beginning of 2008 the deceased's renal condition was terminal. Graylands Hospital continued to care for the deceased in liaison with the renal unit at Sir Charles Gairdner Hospital. Her physical health declined progressively until she died on 22 January 2010.

The coroner found that Graylands Hospital was not an appropriate facility for the deceased at the time, but that the staff there did what they could to manage the deceased appropriately with the resources available to them. At the material time, there was no facility in Western Australia that could provide suitable care for a young person suffering from mental illness and brain damage.

The coroner found that the treatment and care of the deceased at Graylands Hospital with respect to her mental illness, her mental disability and her chronic renal failure was appropriate in the circumstances.

The coroner commented that the evidence at the inquest indicated that the situation for young people suffering mental illness and organic brain damage has improved somewhat since the deceased was admitted to Graylands Hospital, noting the evidence of segregated wards, more wards and increases in staff, availability of one-to-one nursing care and a range of placement options.

The coroner did not make any recommendations.

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

Kevin Maxwell COLLINS
Inquest held in Perth 18-19 March 2013, 16-18 April 2013, 22 April 2013 and 25 February 2014, investigation finalised 11 April 2014

Mr Kevin Maxwell Collins (the deceased) died on 31 August 2010 at Graylands Hospital. The coroner found the manner of death was natural causes. The cause of death was bronchitis as a feature of pandemic influenza A/H1N1 2009 (swine flu) in the context of chronic obstructive pulmonary disease. The deceased was 50 years old.

Immediately before death the deceased was a person held in care because he was an involuntary patient, within the meaning of the Mental Health Act, at Graylands Hospital.

The deceased had suffered from schizophrenia from about 1985. He also suffered from chronic pulmonary disease, obesity and sleep apnoea. He was first admitted into Graylands Hospital in 1986 and was admitted another 16 times. He spent most of 2008 and 2009 at Graylands Hospital. He refused to use a BiPAP machine for the sleep apnoea and he was a heavy smoker.

The deceased began his last admission at Graylands Hospital on 24 March 2010.

In the early morning of 31 August 2010 the deceased stopped breathing in his sleep. Resuscitation efforts were unsuccessful.

The coroner found that the deceased had received a considerable amount of high level treatment and care for several years at Graylands Hospital and that the quality of all facets of the treatment and care was reasonable and appropriate.

The coroner did not make any recommendations.

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

Luke Isaac FORKIN
Inquest held in Perth 20-22 March 2013, 16-18 April 2013, 22 April 2013 and 25 February 2014, investigation finalised 11 April 2014

Mr Luke Isaac Forkin (the deceased) died on 30 November 2010 while he was absent without leave from Graylands Hospital. The coroner found that the manner of death was suicide. The cause of death was ligature compression of the neck (hanging). The deceased was 28 years old.

Immediately before death the deceased was a person held in care because he was an involuntary patient, within the meaning of the Mental Health Act, at Graylands.

The deceased had a history of amphetamine and cannabis abuse, schizophrenia and suicide attempts.

In April 2010 the deceased was convicted of aggravated robbery and sentenced to imprisonment for 24 months suspended for 18 months. On 5 July 2010 the deceased was admitted to Graylands Hospital suffering from psychosis and suicidal ideation. Once the psychosis had passed, he absconded and in light of the opinion of his psychiatrist he was discharged.

On 5 November 2010 the deceased became psychotic at his mother's home and was admitted to Graylands Hospital as an involuntary patient. The deceased had also been charged with assault occasioning bodily harm in relation to an incident on 22 October 2010. The first court appearance was to be 7 December 2010.

On 29 November 2010 the deceased absconded from Graylands while on unescorted ground access. He went to a friend's home where he hanged himself when the friend and his wife went to work the next day.

The coroner was satisfied that the care and treatment the deceased received was reasonable and appropriate. The coroner commented that there was no reasonable basis for any criticism of the risk assessment of the deceased before allowing him unescorted ground access and that had he not been granted access there would have been legitimate criticisms that his treatment was unreasonably restrictive. The coroner also heard evidence about the Chief Psychiatrist's development of a Mental Health Act orientation and training package that was to be rolled out in September and October 2013 for all consultant psychiatrists.

The coroner did not make any recommendations.

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

Gregory Laurence HUNT
Inquest held in Perth 25 March 2013, 17-18 April 2013, 22 April 2013 and 25 February 2014, investigation finalised 11 April 2014

Mr Gregory Laurence Hunt (the deceased) died on 22 February 2011 at Graylands Hospital. The coroner found that the manner of death was suicide. The cause of death was ligature compression of the neck (hanging). The deceased was 53 years old.

Immediately before death the deceased was a person held in care because he was an involuntary patient, within the meaning of the Mental Health Act, at Graylands Hospital.

In 1976 the deceased had been diagnosed with schizophrenia. The deceased had been admitted to Graylands Hospital about 40 times before his death. His condition did not significantly improve despite the use of various combinations of antipsychotic medications at Graylands Hospital and other mental health facilities, but there was no proven history of suicide attempts or deliberate self-harm.

When not admitted to a mental health facility, the deceased lived an itinerant lifestyle characterised by homelessness and low level criminal activity.

The deceased was last admitted to Graylands Hospital after being transferred to the Franklyn Centre from prison in late March 2010. When his prison sentence was completed, he remained in Graylands Hospital as an involuntary patient.

In the early morning of 22 February 2011 the deceased hanged himself with a shower hose connected to a bathroom wall. Having regard to the evidence, the coroner commented that there was no basis for the staff at Graylands Hospital to have considered the deceased to be at risk of suicide.

The coroner found that the deceased received appropriate levels of supervision, treatment and care while at Graylands Hospital during his last admission.

The coroner commented that after the deceased's death the shower hose in that shower was removed and not replaced and that Graylands Hospital should continue to attempt to identify and, if reasonably practicable, remove potential ligature points as an ongoing improvement of the facility.

The coroner did not make any recommendations.

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

Aaron Luke PRISGROVE
Inquest held in Perth 27-28 March 2013, 2 April 2013, 17-18 April 2013, 22 April 2013 and 25 February 2014, investigation finalised 11 April 2014

Mr Aaron Luke Prisgrove (the deceased) died on 12 July 2011 at Graylands Hospital. The coroner found the manner of death was by suicide. The cause of death was ligature compression of the neck (hanging). The deceased was 32 years old.

Immediately before death the deceased was a person held in care because he was an involuntary patient, within the meaning of the Mental Health Act, at Graylands Hospital.

The deceased had attempted suicide in 2001 or 2002 while a young man in Melbourne. He was diagnosed with depression. In 2008 he was diagnosed with acromegaly and was treated by an endocrinologist.

In 2011 the deceased was working in the Pilbara as a fly-in fly-out worker. He became depressed and was admitted into Tom Price Hospital before being transferred to Royal Perth Hospital. After attempting suicide by hanging at Royal Perth Hospital, on 12 July 2011 he was transferred to Graylands Hospital.

At Graylands Hospital the deceased was allowed to go to his room while awaiting assessment by the duty doctor. Despite monitoring, he hanged himself on a cupboard in his room with the handles of a holdall bag.

The coroner commented that the decision to place the deceased on 15 minute observations was reasonable at the time, but that the circumstances changed somewhat once the deceased had been allowed to go to a room that was difficult to monitor from the nursing station. Following the deceased's death, Graylands Hospital implemented a policy of keeping newly admitted patients on the same level of observations as was in place at the transferring hospital.

The coroner found that, with the benefit of hindsight, it was possible to identify decisions made at Graylands Hospital which, had they been different, could have resulted in a different outcome, but that the quality of supervision, treatment and care of the deceased was reasonable in the circumstances.

The coroner encouraged those who decide the nature and the level of resources that are allocated to mental health services in Western Australia to give this area of public health the priority it requires.

The coroner did not make any recommendations.

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

Tom FOSKI
Inquest held in Perth 3-4 April 2013, 17-18 April 2013, 22 April 2013 and 25 February 2014, investigation finalised 11 April 2014

Mr Tom Foski (the deceased) died on 6 May 2012 at Graylands Hospital. The coroner found the manner of death was natural causes. The cause of death was congestive cardiac failure in association with ischaemic and hypertensive heart disease. The deceased was 51 years old.

Immediately before death the deceased was a person held in care because he was an involuntary patient, within the meaning of the Mental Health Act, at Graylands Hospital.

The deceased had been admitted to Graylands 21 times prior to his final admission. He suffered from chronic paranoid schizophrenia, congestive heart failure, ischaemic heart disease and a large incisional abdominal hernia which he refused to have treated.

The deceased remained at Graylands from 2003 until his death, apart from a period in late 2010 and February 2011 when he was trialled unsuccessfully at a new high support psychiatric accommodation available in the community.

On 6 May 2012 the deceased was found collapsed on the floor in his ward at Graylands Hospital and could not be revived.

The coroner was satisfied that the treatment and care of the deceased with respect to his psychiatric and medical conditions was reasonable and appropriate.

However, the coroner noted that, while an involuntary patient at Graylands Hospital, the deceased was unable to use his own funds to improve his quality of life. The funds were managed by the Public Trustee.

The coroner recommended that case managers of long term mental health patients whose finances are controlled by the Public Trustee's Office consult with that entity with a view to using funds held on behalf of such patients to improve their quality of life. The Honourable Attorney General; Minister for Commerce responded by letter dated 20 June 2014 outlining the steps that have been undertaken to improve accessibility to the money of long term mental health patients. That letter is reproduced at Annexure A at page 68 of this Report.

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

Antoinette WILLIAMS
Inquest held in Perth 5 April 2013, 8-12 April 2013, 17-19 April 2013, 22 April 2013 and 25 February 2014, investigation finalised 11 April 2014

Ms Antoinette Williams (the deceased) died on 13 October 2012 at Graylands Hospital. The coroner found the manner of death was misadventure. The cause of death was combined drug effect and myocarditis. The deceased was 19 years old.

Immediately before death the deceased was a person held in care because she was an involuntary patient, within the meaning of the Mental Health Act, at Graylands Hospital.

On 10 October 2012 the deceased attempted suicide by hanging while affected by alcohol and cannabis. She was admitted into Broome Hospital and was discharged the next day.

On 11 October 2012 the deceased again attempted to hang herself. Doctors at Broome Hospital determined that she should be transferred to Graylands for psychiatric assessment.

On 12 October 2012, the deceased was sedated with haloperidol and midazolam at Broome Hospital until the Royal Flying Doctor Service (RFDS) arrived at about 6.30pm. At the RFDS doctor's request, a large quantity of haloperidol was prepared for use during the flight.

During the flight, the RFDS nurse administered a significant overdose of haloperidol to the deceased, potentially affecting her cardiac rhythm.

The nurse told the RFDS doctor about her mistake and recorded the dose in the relevant patient record. The RFDS doctor told the RFDS clinical co-ordinator that the deceased was heavily sedated, but he did not say that there had been an overdose.

Graylands Hospital accepted the deceased when other hospitals were reluctant to do so. The duty doctor at Graylands Hospital contacted the RFDS doctor, who did not mention that there had been an overdose.

Once in Perth, the RFDS nurse told ambulance personnel of the overdose. When ambulance officers delivered the deceased to Graylands Hospital early on 13 October 2012, they not inform the staff at Graylands Hospital of what the nurse had said.

At Graylands Hospital the deceased was initially agitated. Her heart rate and blood pressure were normal.

The deceased was placed in a bedroom and was monitored every 15 minutes for self-harm.

During the afternoon shift on 13 October 2012 the nurse tasked to monitor the deceased checked her for self-harm from the doorway of her room. The nurse did not conduct respiration checks as required. At 5.00 pm that same day, nurses discovered that the deceased was cold and unresponsive. She could not be revived.

A forensic pathologist conducted a post mortem examination and found widespread myocarditis. In his opinion, the cause of death was consistent with a combination of drug effect and myocarditis. A clinical toxicologist agreed.

The coroner found that the manner of death was misadventure since the myocarditis should not have been fatal but for the overdose of haloperidol.

The coroner commented that the deceased's treatment and care was well below that which Western Australians have justifiably come to expect from its health services. A copy of his

finding was provided to the Australian Health Practitioner Regulation Agency for review pursuant to section 50 of the Coroners Act.

Following the death of the deceased, a number of improvements were made to procedures in the RFDS, regional hospitals and Graylands to reduce the likelihood of a similar incident. Accordingly, the coroner did not make any recommendations.

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

Ayumi KIMOTO
Inquest held in Perth 5 May 2014, investigation finalised 23 May 2014

Mr Ayumi Kimoto (the deceased) died on 21 March 2010 at Hakea Prison. The coroner found the manner of death was suicide. The cause of death was ligature compression of the neck (hanging). The deceased was 32 years old.

Immediately before death the deceased was a person held in care because he was a prisoner under the Prisons Act.

The deceased was a photographer who lived overseas. He flew to Perth to attend a photography exhibition and was arrested at Perth International Airport for allegedly being in possession of child pornography. He denied knowledge of the material. He was refused bail and remanded in custody at Hakea Prison.

The deceased was found suspended from a hand basin in his cell three days later.

The inquest focused primarily on the admission of the deceased into prison and the assessment of his risk of self-harm at that time, as well as the steps taken by the Department of Corrective Services to minimise risk of suicide by hanging in the prison environment since the death of the deceased.

The coroner found on the whole the supervision, treatment and care of the deceased was appropriate and was satisfied that there was nothing that the Department of Corrective Services did or failed to do that contributed to the deceased's death.

The coroner commented on the desirability of the Department of Corrective Services continuing to fund the implementation of the ligature minimisation program in the prisons.

The coroner did not make any recommendations.

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

Marjorie Mary DONE
Inquest held in Perth 13 May 2014, investigation finalised 26 May 2014

Ms Marjorie Mary Done (the deceased) died on 3 December 2010 at the Ursula Frayne Unit of the Mercy Hospital in Mount Lawley. The coroner found the manner of death was natural causes. The cause of death was unascertained. The deceased was 84 years old.

Immediately before death the deceased was a person held in care because she was an involuntary patient, within the meaning of the Mental Health Act, Ursula Frayne Unit of the Mercy Hospital in Mount Lawley.

The deceased had suffered from mental health problems since she was a young adult. Her psychiatric problems increased as she got older. By October 2005, she had also begun to suffer from recurrent falls.

In 2002, the deceased moved into an aged care facility in Mount Lawley where she remained until August 2010.

In August 2010 the deceased was admitted to Royal Perth Hospital after she fractured her hip in a fall. She was treated surgically and was transferred to the rehabilitation site at Shenton Park.

The deceased was admitted into the Ursula Frayne Unit on 6 September 2010 and was made an involuntary patient under the Mental Health Act on 16 October 2010. She was treated with anti-psychotic and anti-depressant medication. Her general health was frail.

On 3 December 2010 the deceased was sitting in a chair in the company of other patients when she died peacefully.

The cause of death could not be ascertained but may have included cardiac arrhythmia, myocardial infarction, stroke or pulmonary thromboembolism.

The coroner found that the supervision, treatment and care of the deceased was of a reasonable quality.
The coroner did not make any recommendations.

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

Lynn Desmond Ernest CHURCH
Inquest held in Perth 28-29 April 2014, investigation finalised 3 June 2014

Mr Lynn Desmond Ernest Church (the deceased) died on 6 July 2010 at the Joondalup Health Campus Mental Health Unit. The coroner found the manner of death was suicide. The cause of death was plastic bag asphyxia. The deceased was 64 years old.

Immediately before death the deceased was a person held in care because he was an involuntary patient, within the meaning of the Mental Health Act at Joondalup Health Campus Mental Health Unit.

The deceased suffered from migraine-like headaches and depression. He was prescribed tramadol for his headaches.

In 2006 the deceased was diagnosed with personality disorder, hypochondriasis and abnormal illness behaviour, chronic paranoid schizophrenia, depression and medication abuse. By 2010 he was constantly in pain. He was slowly deteriorating and he was continually expressing suicidal ideations.

On 26 June 2010 the deceased was admitted into Joondalup Health Campus Mental Health Unit as an involuntary patient due to his being a significant suicide risk. After assessment he absconded and went home.

Police returned him to the Joondalup Health Campus Mental Health Unit where he was assessed with a high risk of suicide and placed in the closed ward. There were also concerns of a possible serotonin syndrome from excessive tramadol intake.

On Sunday 4 July 2010 the deceased called his daughter and told her of his desire to suicide. His daughter called the Joondalup Health Campus Mental Health Unit to express her concerns. She was finally able to speak to a doctor on the afternoon of 5 July 2010.

On Monday 5 July 2010 the deceased was moved into an open ward where he was monitored every 15 minutes. That night he used bedding to make a bulge on his bed to create the impression that he was asleep in the bed while he asphyxiated himself in his ensuite bathroom with a plastic bag.

The coroner found that the relevant supervision, treatment and care provided to the deceased was reasonable in the circumstances.

As to the deceased's use of tramadol, the coroner expressed concern that serotonin syndrome's causes and effects are not more widely known in the general medical field.

Because Joondalup Health Campus Mental Health Unit had changed the protocol for observations to require that a patient on 15 minute observations be sighted at close proximity to confirm that the patient is breathing, the coroner made no recommendation about observation procedures.

Because all plastic bags were removed from the open ward and replaced with paper bags, the coroner made no recommendations about the use of plastic bags in the Joondalup Health Campus Mental Health Unit.

The coroner recommended that Joondalup Health Campus Mental Health Unit investigate its procedures of managing communications with the families of patients with a view to ensuring that information is relayed to the relevant health professional. The Honourable Minister for Mental Health responded by letter dated 11 July 2014 advising of initial steps that had been undertaken by the Office of the Chief Psychiatrist. The response status is ongoing and that letter is reproduced at page 70 of this Report.

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

Daniel Jarvis COOK-HILL
Inquest held in Perth 3 June 2014, investigation finalised 11 June 2014

Master Daniel Jarvis Cook-Hill (the deceased) died on the morning of 12 October 2008. The coroner found the manner of death was accident. The cause of death was as a result of smoke inhalation and burns. He was three years old.

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

The deceased had been placed with his maternal grandmother and was living with her at Wakathuni Aboriginal Community. The inquest focused primarily on the care of the deceased in the period leading up to his death as well as the circumstances of his death.

The coroner found that the deceased was happy and being well cared for by his grandmother, with appropriate supervision by the Department for Child Protection and Family Services. On the day of his death the deceased and another child were playing in the caravan when a fire ignited. They became trapped in the caravan and could not be rescued due to the intensity of the fire. The coroner found that the death occurred by way of accident.

The coroner found that the tragic events that occurred on 12 October 2008 did not have any connection with the reasons why the deceased was taken into care by the Department for Child Protection and Family Services and there was no action that the Department could have taken that might have prevented his death.

The coroner did not make any recommendations.

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

ANNEXURE A
RESPONSES TO CORONIAL RECOMMENDATIONS

Government of Western Australia
Department of Corrective Services

Office of the Commissioner

Author: Monica Csaba
Contact: 9264 1959
Email: criticalreviews@correctiveservices.wa.gov.au

Reference: AF38371

Ms E Vicker
State Coroner
Coroner's Court of Western Australia
Level 10, Central Law Courts
501 Hay Street
Perth WA 6000

Dear Ms Vicker,

DEPARTMENT OF CORRECTIVE SERVICES' RESPONSE TO THE FINDINGS OF THE CORONER INTO THE DEATH OF BAC LAM BANH

The Department of Corrective Services (the Department) acknowledges the receipt of the findings contained in the Record of Investigation into the Death of Mr Banh.

The Department provides the following response to the recommendations made by the Coroner in his findings.

Recommendation 1

The Commissioner of the Department of Corrective Services consider implementing changes to the healthcare arrangements of prisoners at the Walpole Work Farm, so they can provide written permission for a hard copy of their EcHO file to be provided to their local, community based physician.

The Department supports this recommendation in principle. Current Departmental policy dictates that community General Practitioners providing care to Work Camp patients will receive a Health Summary pending consent of the patient. This shared care model is consistent with common practice in the community when a General Practitioner refers to a patient to a specialist doctor. However, it is not practical or necessary to provide the whole medical file to the community based practitioner.

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ABN 25 103 389 163

Recommendation 2

The Commissioner of the Department of Corrective Services consider implementing changes to the healthcare arrangements of prisoners at the Walpole Work Farm, so their EcHO file is regularly reviewed by a physician employed by the Department, with a view to determining whether an unwelcome pattern of ill-health has developed which invites further medical investigation or treatment.

The Department supports this recommendation in principle and it's actively working on a solution to resolve this problem. Various medicolegal issues would arise if a General Practitioner, employed by the Department, reviewed and acted on matters contained within the medical file without having assessed the patient in person. Ideally, the community practitioner would have total governance over the Work Camp patients and would therefore source their prescriptions locally, however the Department would have to fund the prescriptors.

Yours sincerely

Heather Harker
Commissioner

16 September 2013

Government of Western Australia
Department of Corrective Services

Office of the Commissioner

Author: Monica Csaba
Contact: 9264 1959
Email: criticalreviews@correctiveservices.wa.gov.au

Reference: AF13808

Ms E Vicker
State Coroner
Coroner's Court of Western Australia
Level 10, Central Law Courts
501 Hay Street
Perth WA 6000

Dear Ms Vicker,

DEPARTMENT OF CORRECTIVE SERVICES' RESPONSE TO THE FINDINGS OF THE CORONER INTO THE DEATH OF ROBERT CHARLES BROPHO

The Department of Corrective Services (the Department) acknowledges the receipt of the findings contained in the Record of Investigation into the Death of Mr Bropho.

The Department provides the following responses to the recommendation and comments made by the Coroner in his findings.

Recommendation 1

The Department of Corrective Services consider amending its Policy Directive 8 to require that a person classified as having a Phase 1 or Phase 2 terminal illness be notified of the classification and the ramifications thereof as soon as practicable after the classification occurs.

The Department supports this recommendation in principle. Current Departmental process requires the prison General Practitioner to explain to the prisoner that they have been added to the terminally ill list. This medical consultation involves some discussion in regard to their illness and prognosis however the prisoner is not specifically advised as to their phase classification. This is purely an internal administrative term which initiates the Royal Prerogative of Mercy (RPOM) process undertaken by the Department's Adult Custodial division.

Policy Directive 8 'Prisoners with a Terminal Illness' will be reviewed to allow for the notification of the next of kin where a prisoner has a terminal illness and provides consent.

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In addition, Policy Directive 82 (PD 82) 'Prisoner Movements' allows for the notification of the next of kin in the event a prisoner's health deteriorates after hospitalisation, to the extent that medical staff determine a serious and imminent threat to life, and are therefore deemed terminally ill. Furthermore, in the event the prisoner diagnosed as terminally ill requests a person(s) other than their next of kin be notified of their diagnosis/hospitalisation, the Superintendent will initiate this process subject to the provisions of PD 82.

Comment - Notification of Next of Kin

If such a procedure does not already exist the Department of Corrective Services and the WA Police should implement a procedure to ensure so far as practicable that families of persons who die while in the custody of the Department are notified without delay notwithstanding that a person nominated as next of kin is not able to be contacted.

Policy Directive 30 (PD 30) 'Death of a Prisoner' dictates that WA Police are responsible for notifying the next of kin in the event of a death in custody. The Department will amend PD 30 to reflect the necessity to provide WA Police with alternative contact details, registered at the time of the prisoner's reception, if the primary next of kin cannot be located or contacted.

Comment – Use of Restraints

The Department should consider reviewing the procedure under Policy Directive 8 to reduce instances where restraints are applied in clearly inappropriate situations.

In respect to the use of restraints during external escorts, the Department is cognizant of a prisoner's medical needs and current procedures are considered to be appropriate. Policy Directive 82 'Prisoner Movements' allows for restraints to be used whereby risk is low or in cases of medical deterioration, pending the completion of an External Movement Risk Assessment. Furthermore, restraints shall be checked at a minimum of every hour during the escort. Escorting officers are permitted to exercise discretion and remove the restraints if a prisoner is believed to be seriously ill to the extent that it is apparent that security will not be breached.

Yours sincerely

Heather Harker
Commissioner

16 September 2013

ATTORNEY GENERAL; MINISTER FOR COMMERCE

Our Ref: 44-10494
Your ref: 55/12

25 JUN 2014

RECEIVED

Ms Ros Fogliani
State Coroner
Office of the State Coroner
Central Law Courts
Level 10 501 Hay Street
PERTH WA 6000

Dear Ms Fogliani

IMPLEMENTATION OF RECOMMENDATION MADE IN CORONER'S RECORD OF INVESTIGATION INTO DEATH OF MR TOM FOSKI 55/12

I refer to correspondence from your office dated 2 May 2014 regarding the record of investigation dated 11 April 2014 and Coroner King's recommendation regarding the Public Trustee's plenary administration of clients who are Graylands Hospital (Graylands) inpatients.

Senior Public Trustee staff recently met with Graylands staff to formulate an agreed approach to improving accessibility to the money of long-term inpatients.

It was agreed that Graylands will provide the Public Trustee with a list of the names of Welfare Officers/Social Workers who are authorised to make enquiries about the financial position of these patients.

The Public Trustee will also provide Graylands with a regularly updated list of Trust Manager details, which includes direct telephone numbers and email addresses.

Upon receipt of an enquiry, the relevant Trust Manager will advise of the approximate amount of money held in trust on behalf of its client.

Where appropriate, Graylands staff may also enquire if there are sufficient funds available to fund the cost of a client-specific program that will improve the quality of a patient's life. The Public Trustee has undertaken to approve these requests, provided funds are available and the request is supported.

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The Public Trustee has encouraged Graylands staff to enquire about the availability of all patient funds whenever required or appropriate.

Thank you for bringing this matter to my attention.

Yours sincerely

Hon. Michael Mischin MLC
ATTORNEY GENERAL; MINISTER FOR COMMERCE
20 JUN 2014

Minister for Mental Health; Disability Services; Child Protection

Our Ref: 43-13031

PERTH CORONERS COURT
16 JUL 2014
RECEIVED

Ms Dawn Wright
Manager Listings
Office of the State Coroner
Level 10, Central Law Courts
30 St George's Terrace
PERTH WA 6000

Dear Ms Wright

Thank you for your letter of 6 June 2014 in relation to the inquest finding for Lynn Desmond Ernest CHURCH which informed me of the recommendation made by the Coroner.

Given the short timeframe from the release of the inquest findings (3 June 2014), it is too soon to comment on specific actions that have been taken in response to the Coroner's recommendation.

I can advise that the Office of the Chief Psychiatrist has engaged with Ramsay Health (Joondalup Health Campus) about this case in order to facilitate discussion about any appropriate corrective actions and is currently awaiting a response.

The Department of Health's Coronial Liaison Unit coordinates the department's response to the State Coroner on action taken with respect to the recommendations arising from coronial inquests. Any actions taken by WA Health services in relation to the recommendation will be included in the Coronial Liaison Unit's routine six-monthly reports to the State Coroner; the next one being due in August 2014.

Furthermore, the Department of Health's Coronial Review Committee will be reviewing the findings at a meeting scheduled later this month. Based on this discussion, appropriate WA Health stakeholders will be asked to consider the inquest findings and provide a response.

I trust that this information, and that provided in the ongoing six-monthly reports, will assist the Coroner to fulfil the annual reporting requirements to the Attorney General.

Thank you for bringing this matter to my attention.

Yours sincerely

Helen Morton

11 JUL 2014

Helen Morton MLC
MINISTER FOR MENTAL HEALTH

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