ANNUAL REPORT 2022-2023

Office of the State Coroner for Western Australia

STATE CORONER'S CHAMBERS
CORONER'S COURT OF WESTERN AUSTRALIA
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Our ref: Annual Report

Hon John R Quigley LLB JP MLA
Attorney General
11th floor, Dumas House
2 Havelock Street
WEST PERTH WA 6005

Dear Attorney

ANNUAL REPORT 2022-2023

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 2023.

Yours sincerely

R V C FOGLIANI
STATE CORONER

30 October 2023

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ACKNOWLEDGEMENT OF COUNTRY

The Coroner's Court of Western Australia acknowledges the Traditional Owners and Custodians of the lands and waterways across the State of Western Australia. The Court pays its respects to Elders past, present, and emerging. We value the culture and traditions of Aboriginal and Torres Strait Islander people, and their contributions to our communities.

The Court commits itself to working with Aboriginal and Torres Strait Islander people in Western Australia to improve access to the Court's services and to ensure that those services are culturally sensitive and culturally safe.

2022 Aboriginal Artwork Design Story
Artist: Acacia Collard, *Balladong Noongar, Badimia Yamatji*

This design represents the journey of the deceased person – like a river sitting below the surface, the water travels towards its destination. Depicted in the design is the Coroner and the important role they play for the deceased person and their family. Each circular shape represents the delicate pieces that need to be put together in order to reach the Court's outcomes.

Along the riverbank – like a drop of water, the ripples flow outwards and touch the others. This symbolises the effects the person has had on others throughout their lives – being comforted by the many people in their life.

WARNING: Please be advised some content in this report may be distressing to readers. Aboriginal and Torres Strait Islander people are advised that this report contains the names of people who have passed away.

NOTE: The data in this Annual Report is drawn from the ICMS case management system.

STATE CORONER'S OVERVIEW

- **there were 3,577 cases finalised by Coroners this reporting year, with 98.8% of them being finalised by way of administrative finding, and the balance of 1.2% being finalised by inquest**
- **clearance rate, being the number of incoming reportable deaths compared to the number of finalisations of coronial investigations, sits at a high of 108.6%**

The State coronial system is a multidisciplinary system, operating with the support of external agencies, primarily the Western Australia Police Force (with every member of the Police Force being a coroner's investigator), PathWest Laboratory Medicine WA (through the services of the forensic pathologists, neuropathologists and forensic biologists who prepare reports for the Coroner) and ChemCentre (through the services of the toxicologists who prepare reports for the Coroner).

As an independent judicial officer, the Coroner reviews the reports and evidentiary material, considers whether further evidence should be gathered, and makes findings, if possible, on how death occurred, and the cause of the death.

A coronial investigation is a fact-finding exercise, aimed not at apportioning blame, but at establishing the circumstances surrounding the death. It is in the public interest for there to be a careful and thorough review of the information so that reportable deaths are properly investigated, and the cause and manner of each death is properly found and recorded.

The Coronial Counselling and Information Service is able to provide initial support and counselling to persons coming into contact with the coronial system and provides information to families about the progress of their loved one's case through the coronial system. The involvement of the Coroner often comes at a time when family members are experiencing feelings of intense grief and loss. The officers of the Coronial Counselling and Information Service aim to impart clear and accurate information, with compassion.

As with previous years, the focus of the work of the Coroner's Court has been on the backlog cases. The backlog cases are determined by reference to the date that a reportable death is reported to the Coroner. When the date of that report is more than 12 months old, that case enters backlog and becomes a priority. The backlog is a dynamic figure because cases are constantly being finalised and equally, at the 12 month anniversary, cases are also coming into backlog, on a daily basis.

The Coroner is reliant upon the conduct of investigations by external agencies such as the police (who attend at the scene of death and obtain information for the Coroner) and the forensic pathologists (who perform the post mortem examinations and provide an opinion on the cause of death for the Coroner). The provision of this information assists the Coroner in making the findings.

The overall backlog has decreased from 1315 cases (2021/2022) to 1120 cases (2022/2023). Police, through their concerted efforts, have submitted a greater number of reports to the Coroner, and this has been a significant factor in the reduction of the overall backlog.

While the overall backlog has decreased, the backlog of cases pending analysis at the Coroner's Court has increased from 288 as at the end of the last reporting year (2021/2022) to 503 as at the end of this reporting year (2022/2023). In discussion with the Department of Justice, steps have been taken and continue to be taken, to increase the resourcing of the Coroner's Court to address the accumulated backlog that now rests with the court.

STATE CORONER'S OVERVIEW
(continued)

As with previous years, the Coroners and staff members at the Coroner's Court, and the regional Magistrates (who are contemporaneously coroners) and their registrars have worked carefully and assiduously to review and finalise coronial investigations in as timely a manner as is possible.

I am able to report that the clearance rate, that compares the number of incoming reportable deaths to the number of finalisations of coronial investigations, sits at a high of 108.6%. This means that more cases have been finalised, than have been reported to the Coroner.

Overall, there were 3,577 cases finalised by Coroners this reporting year, with 98.8% of them being finalised by way of administrative finding. These are findings made by Coroners in chambers, they are provided to the next of kin, but are otherwise confidential. The balance of the total cases finalised, being 1.2% were finalised by inquest. An inquest is a court hearing, presided over by a Coroner, that examines the circumstances surrounding the death. Inquests are conducted in accordance with the principles of open justice and procedural fairness and are generally open to the public. Inquest findings together with any Ministerial responses to Coroner's recommendations are published on the website of the Coroner's Court of Western Australia.

It is said that the role of the Coroner is to speak for the dead and to protect the living. Within the context of an inquest, Coroners may make recommendations directed towards avoiding deaths in similar circumstances. Coroners made a total of 52 recommendations this reporting year. Responses to coronial recommendations are published on the website of the Coroner's Court of Western Australia.

Throughout this reporting year, in addition to their work on the coronial investigations, staff members of the Coroner's Court have worked on a number of projects that support the Coroner's death prevention role. These are outlined in my Report.

The first part of my Report provides statistical and other information on the operations of the Office of the State Coroner in the reporting year ended 30 June 2023.

The second part of this Report contains the specific reports that I am required to provide on the death of each person held in care under s 27(1) of the *Coroners Act 1996*. The legislative requirement to provide a specific report on the death of each person held in care reflects the community's concern with the quality of the supervision, treatment and care of persons who have been taken into care and/or persons whose freedoms have been removed by operation of law. They include prisoners, persons under the custody of police, children the subject of protection orders and involuntary mental health patients.

I acknowledge the dedication and the efforts of the Deputy State Coroner Sarah Linton, Coroner Michael Jenkin and Coroner Philip Urquhart.

The reduction of the overall backlog, and the increase in the clearance rate, is a credit to the Coroners and staff of the Coroner's Court, the regional Magistrates and their registrars, all of the coroner's investigators, including the police at the Coronial Investigation Squad, the forensic pathologists, neuropathologists, forensic biologists and other PathWest staff, and the toxicologists and other ChemCentre staff. I take this opportunity to express my gratitude to these officers and staff members in all of these agencies that ably assist the Coroner's Court on a daily basis.

I am pleased to present the 2022/23 Annual Report of the Office of the State Coroner.

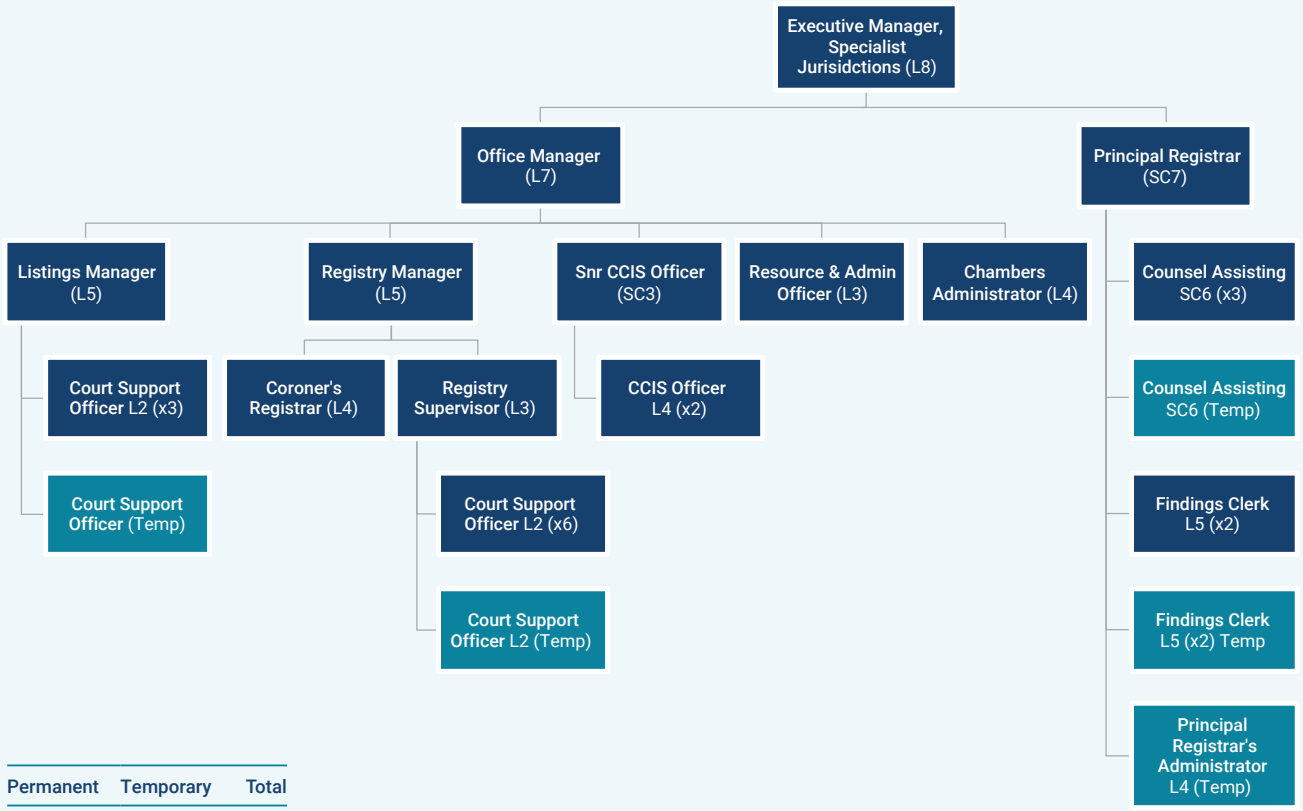
R V C FOGLIANI
STATE CORONER

OFFICE STRUCTURE

The Coroner's Court of WA comprises the State Coroner, Deputy State Coroner, two Coroners and funding for 25 non-judicial full-time employees.

In order to address the backlog within the control of the Court and provide a more efficient service to the community, the Department of Justice has provided funding for six additional fixed term positions to the Court. This includes an additional Counsel Assisting position, two additional Findings Clerks, two additional Court Support Officer positions, and an Administrator to the Principal Registrar.

These fixed term positions have been gradually added and filled and are differentiated on the Table below. It is expected that, with the addition of these fixed term positions, the backlog of cases will be more efficiently addressed.



Permanent	Temporary	Total
SC7 x 1		1
SC6 x 3	SC6 x 1	4
SC3 x 1		1
L7 x 1		1
L5 x 4	L5 x 2	6
L4 x 4	L4 x 1	5
L3 x 2		2
L2 x 9	L2 x 2	11
25	**6**	**31**

OUTCOMES

Under section 8 of the *Coroners Act 1996* (WA) (Coroners Act) one of my functions is to ensure that the State Coronial system is administered and operates efficiently. The Tables showing outcomes for the Office of the State Coroner for 2022/23 appear below.

CASES RECEIVED AND CASES COMPLETED

The following Table provides an overview of the work of the Coroner's Court in the 2022/23 year, by reference to incoming reports of death, cases completed by the coroner, overall backlog and overall number of cases on hand:

Cases received	Perth	Country	Total
Full Investigation	**2464**	**830**	**3294**
Death Certificates	**1386**	**255**	**1641**

Cases completed	Perth	Country	Total
Finalised by Inquiry	2796	739	3535
Finalised by Inquest	38	4	42
TOTALS	**2834**	**743**	**3577**

Backlog	Perth	Country	Total
	981	**139**	**1120**

Cases on hand	Perth	Country	Total
	2705	**673**	**3378**

INQUIRY/INQUEST FINALISATION RATIO

The following Table shows the breakdown as between cases finalised by administrative finding (Inquiry) and the cases finalised by Inquest for the 2022/2023 year.

Finalised By Inquiry	**3535**	**98.8%**
Finalised By Inquest	**42**	**1.2%**

CASES CLOSED BY REFERENCE TO AGE OF CASE

The following Table shows the age of a coronial file when closed calculated from the date of death, for the 2022/2023 year.

It will be seen that 54% (1938) of files were closed in under 12 months and 46% (1639) of files were over 12 months old at closure (i.e. backlog files).

	INQUIRY		INQUEST	
Timelines	**Perth**	**Country**	**Perth**	**Country**
< 3 mths	293	148	0	0
3-6 mths	138	30	1	0
6-12 mths	1019	308	1	0
12-18 mths	559	113	2	0
18-24 mths	405	65	8	1
>24 mths	382	75	26	3
TOTALS	**2796**	**739**	**38**	**4**

CASES REPORTED AND COMPLETED BY REFERENCE TO PERTH AND REGIONAL WA

The following table shows cases reported to the Coroner and cases and completed by the Coroner as between Perth and Regional WA, including whether they were finalised by administrative finding (Inquiry) or by Inquest, for the 2022/2023 year.

Metropolitan deaths	2464
Regional deaths	830
TOTAL NUMBER OF REPORTABLE DEATHS	**3294**

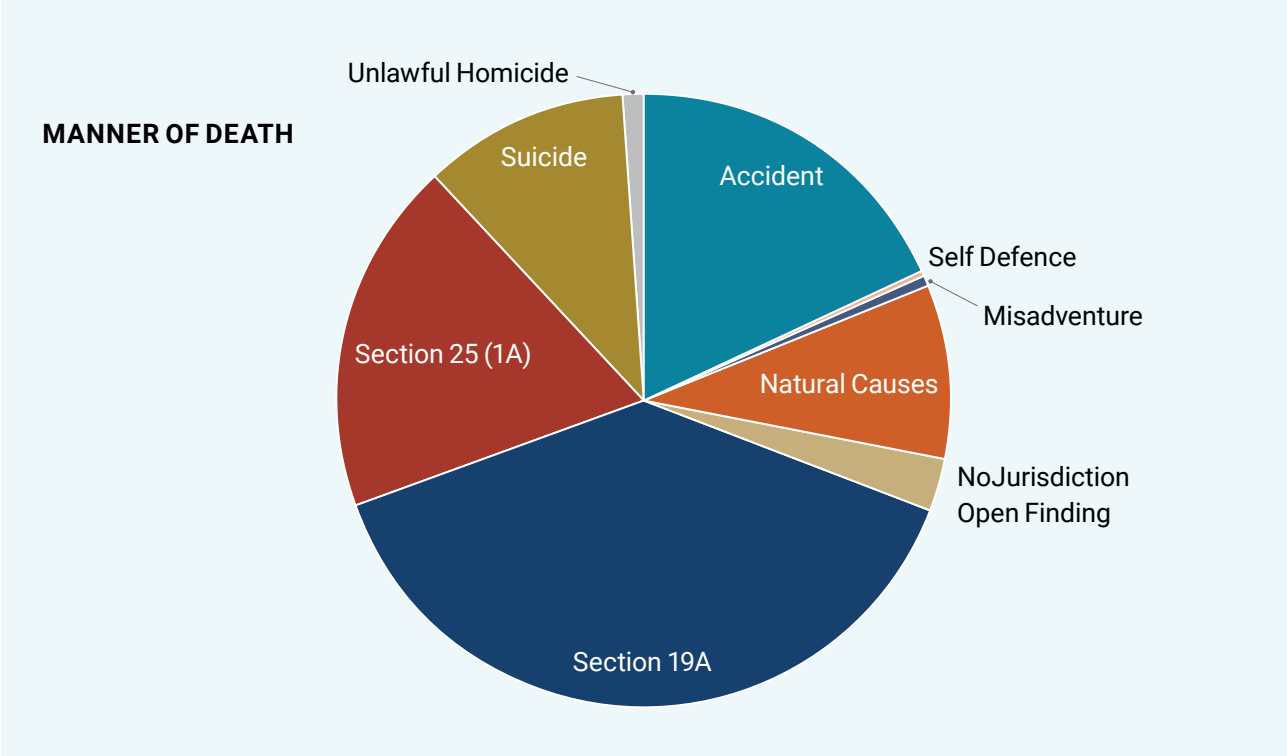
Cases completed	**Perth**	**Country**	**Total**
Finalised by Inquiry	2796	739	3535
Finalised by Inquest	38	4	42
TOTALS	**2834**	**743**	**3577**

CASES CLOSED BY MANNER OF DEATH

Under s 25(1)(b) of the Coroners Act, a Coroner investigating a death must find if possible, how death occurred. This is the Coroner's finding on manner of death.

The following Table and Chart show the data relating to the coroner's findings on manner of death for the 2022/2023 year.

Manner of death	2022-23
Accident	653
Misadventure	24
Natural Causes	328
No Jurisdiction	8
Open Finding	86
Self Defence	8
Suicide	387
Unlawful Homicide	35
Section 19A (Natural Causes)	1385
Section 25 (1A)	663
TOTALS	**3577**



POST MORTEM EXAMINATIONS

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

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

NUMBER OF POST MORTEM EXAMINATIONS

The following Table shows the number of post mortem examinations performed for the 2022/2023 year.

Immediate post mortem	51
No objection to post mortem	2467
Objection to post mortem	720
No post mortem conducted (missing person, death certificate originally issued or by order of coroner etc)	56
NUMBER OF REPORTED DEATHS	**3294**

OBJECTIONS TO POST MORTEM EXAMINATIONS

The following Table shows the number of objections to post mortem examinations and their outcomes, for the 2022/2023 year:

Objection accepted	686
Objection withdrawn	34
Objection Overruled	0
TOTAL OBJECTIONS TO POST MORTEMS	**720**

PATHOLOGISTS RECOMMENDED EXTERNAL POST MORTEM EXAMINATIONS (PRE'S)

Consistent with s 34(1) of the Coroners Act, and the adoption of the least invasive post mortem procedure that is available and appropriate in the circumstances, the forensic pathologist may recommend to the Coroner that an external post mortem examination together with a review of available medical records and/or toxicological information is sufficient to enable them to form an opinion on cause of death. In each instance the senior next of kin is consulted, and the Coroner makes a decision as to whether to approve the forensic pathologist's recommendation for an external examination.

The following Table shows the number of pathologist recommended external post mortem examinations approved by the Coroner, and the number of instances where the Coroner has directed a full internal post mortem examination.

PRE recommended by Pathologist	1082
PRE approved by Coroner	1036
PRE not approved by Coroner - Full PM	40
PRE rejected by next of kin - Full PM	0
PRE approved – Partial PM	6
TOTAL PATHOLOGIST RECOMMENDED EXTERNAL	**1082**

BACKLOG

The backlog cases are determined by reference to the date that a reportable death is reported to the Coroner. When the date of that report is more than 12 months old, that case enters into backlog and becomes a priority.

The backlog is a dynamic figure because cases are constantly being finalised and equally, at the 12 month anniversary, cases are also coming into backlog, on a daily basis.

The following Table shows the total backlog of cases for the 2021/2022 and 2022/2023 years, divided as between inquest cases, and non-inquest cases, and also divided as between cases as follows:

- Cases where no further finalisations were possible at the Coroner's Court as at the end of the relevant reporting year, because the Coroner was awaiting reports from External Entities; and
- Cases that were pending analysis at the Coroner's Court prior to finalisation, as at the end of the relevant reporting year.

	2021/22	2022/23	% Change Last 12 Months
Inquest Cases	59	65	10.2%
Pending Reports (External Entities)	968	552	-42.9%
Pending Analysis Prior to Finalisation (Coroner's Court)	288	503	74.6%
TOTAL BACKLOG	**1,315**	**1,120**	**-14.8%**

SUMMARY OF FINALISATIONS

The following Table shows the summary figures for the finalisations of cases for the 2021/2022 and 2022/2023 years, divided as between inquest cases and non-inquest cases, and also divided as between backlog cases and non-backlog cases.

		2021/22	2022/23	% Change Last 12 Months
By Administrative Finding	Non-Backlog	1,329	1,936	45.7%
	Backlog (12+Months)	971	1,599	64.7%
By Inquest	Non-Backlog	4	2	-50.0%
	Backlog (12+Months)	55	40	-27.3%
TOTAL FINALISATIONS		**2,359**	**3,577**	**51.6%**

KEY DATA OVER THE LAST FIVE YEARS

The following tables show key data over the last five years, for comparison purposes.

CORONER'S COURT REPORTABLE DEATHS & DEATH CERTIFICATES ACCEPTED

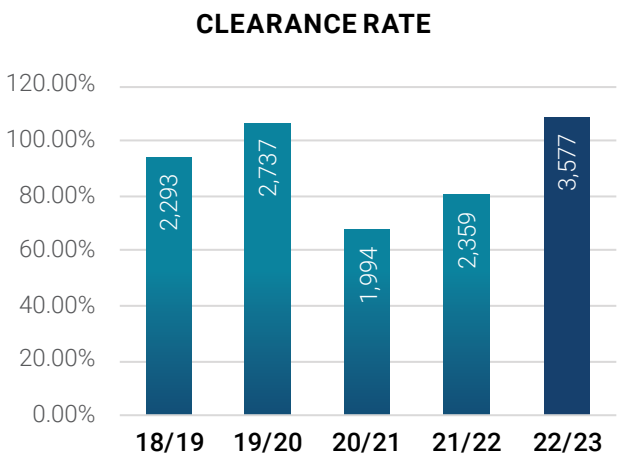
The following tables show the number of deaths reported to the coroner and the number of death certificates accepted by the coroner over the last five years, with the percentage change from the previous year.

	Reportable Deaths	% Change from previous year	Death Certificate Accepted	% Change from previous year
2018/19	2,452	7.0%	1,458	13.9%
2019/20	2,573	4.9%	1,129	-22.6%
2020/21	2,942	14.3%	1,425	26.2%
2021/22	2,944	0.1%	1,614	13.3%
2022/23	3,294	11.9%	1,634	1.2%

CLEARANCE RATE

The clearance rate represents the number of deaths reported to the coroner for the relevant financial year, as compared to the number of finalisations for the same year, expressed as a percentage. The following table shows the clearance rates over the last five years.

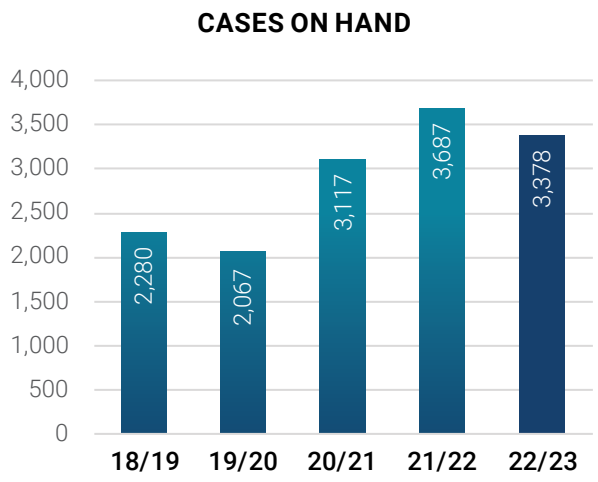
	Reportable Deaths	Finalisations	Clearance Rate
2018/19	2,452	2,293	93.5%
2019/20	2,573	2,737	106.4%
2020/21	2,942	1,994	67.8%
2021/22	2,944	2,359	80.1%
2022/23	3,294	3,577	108.6%



CASES ON HAND

The cases on hand are the number of active coronial cases within the coronial system that are under investigation as at the end of the relevant financial year.

		% Change from previous year
2018/19	2,280	7.2%
2019/20	2,067	-9.3%
2020/21	3,117	50.8%
2021/22	3,687	18.3%
2022/23	3,378	-8.4%



CORONIAL COUNSELLING AND INFORMATION SERVICE

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

The CCIS provides initial support and counselling to those affected by sudden death. The CCIS explains the coronial process, including the process of objecting to a post mortem examination, provides associated information to the next of kin concerning the progression of the case through the coronial system, and also facilitates connections to agencies that may assist with other aspects of the bereavement process. The CCIS is available Monday to Friday during normal Court business hours.

The discussions with the CCIS are targeted to and supportive of the client's immediate needs. Referrals for longer term counselling options may be explored with clients as required.

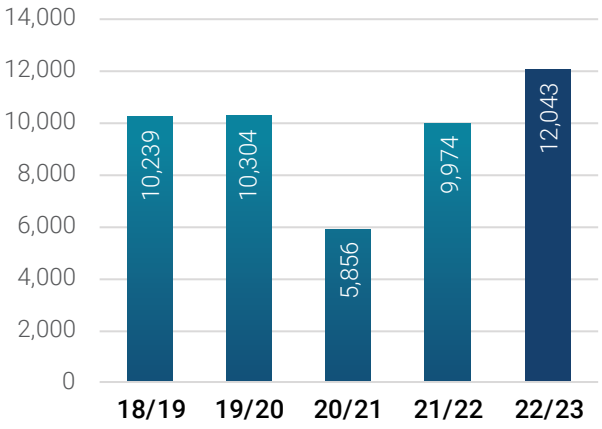
Support options for the next of kin are available from the CCIS in relation to inquest matters. The CCIS acknowledges that each family has different needs which may vary. This process involves supporting the next of kin during an inquest as appropriate and being there as a calming presence for them.

The CCIS also facilitates a culturally relevant counselling and information service for Aboriginal and Torres Strait Islander clients and for culturally and linguistically diverse (CALD) clients.

The following Tables show the total number of contacts that the CCIS have had each year for the past five reporting years. Where there have been multiple contacts per case per day, they have been separately counted.

2018/19	10,239
2019/20	10,304
2020/21	5,856
2021/22	9,974
2022/23	12,043

CORONIAL COUNSELLING AND INFORMATION SERVICE CONTACTS



CORONER'S DEATH PREVENTION ROLE

The coroner's death prevention role is an important aspect of a coronial system. This role is carried out in various ways in WA:

INQUEST RECOMMENDATIONS

Under s 25(2) of the Coroners Act, the coroner holding an inquest may comment on any matter connected with the death, including public health, safety or the administration of justice. These comments are often made in the form of recommendations, directed towards avoiding deaths in similar circumstances. The inquest finding and any responses to the recommendations are published on the website of the Coroner's Court of WA.

FROM DEATH WE LEARN

The Office of the State Coroner has a working relationship with the Department of Health, the Patient Safety Surveillance Unit. Their specialist medical consultant reviews inquest findings. The salient points are de-identified and selected summaries are published in the booklet "From Death We Learn" which is then distributed to relevant clinical areas.

THERAPEUTIC GOODS ADMINISTRATION

The Office of the State Coroner has a working relationship with the Therapeutic Goods Administration (TGA) in recognition of the importance of identifying any reportable deaths that may have been associated with the use of medicines, vaccines or medical devices. To assist the TGA with monitoring the safety of therapeutic products, the Office of the State Coroner has developed a notification system whereby relevant information is de-identified and provided to the TGA. There were 195 such notifications to the TGA this reporting year.

SUICIDE PREVENTION

The Office of the State Coroner has a working relationship with the Mental Health Commission (MHC) in relation to the sharing of data about deaths by suicide, where the case has been finalised by the coroner (referred to as a closed suicide case). The MHC has managed and maintained the Western Australian Coronial Suicide Information System (WACSIS) that stores de-identified information specific to a death by suicide in Western Australia. It is expected that improvements in technology, including the process for electronic transfer of coronial data to the MHC will enable the MHC to obtain coronial information specific to recent closed suicide cases at the earliest possible opportunity and more efficiently. This initiative will assist the MHC in continuing to develop its important strategies that work towards suicide prevention in Western Australia, within a significantly improved time frame.

WA CORONIAL ETHICS COMMITTEE

The WA Coronial Ethics Committee was established pursuant to s 58 of the Coroners Act and operates in compliance with the National Health and Medical Research Council's National Statement on Ethical Conduct in Human Research and its associated guidelines. A function of the WA Coronial Ethics Committee includes the review of requests for statistical information from entities conducting research in the areas of health promotion and/or safety in furtherance of the death prevention role, and to ensure that confidentiality and privacy issues are addressed. Tables showing the membership of the WA Coronial Ethics Committee and the projects and requests approved for this reporting year appear below:

Committee Member	Membership Category
Dr Jodi White	Chairperson, Forensic Pathologist, PathWest
Mr Philip Urquhart	Coroner
Ms Caroline Pittman	Until January 2023
Ms Alice Barter	Legal Member
Dr Natalie Gately	Member with relevant research experience
Dr Thomas Hitchcock	Member with relevant research experience
Ms Antoinette Fedele	Until November 2022
Dr Astra Lees	Member with relevant professional experience

Number of Projects Considered	Number of projects approved	Number of projects not approved	Deferred
5	5	0	0
Number of Requests for renewal Considered	**Number of Requests for renewal Approved**	**Number of Requests for renewal Not approved**	**Deferred**
13	13	0	0
Number of Amendments	**Number of amendments approved**	**Number of amendments not approved**	
50	50	0	0

INQUESTS

REPORT ON INQUESTS THAT ARE REQUIRED BY LAW TO BE HELD (MANDATED INQUESTS)

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

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

Overall there were 42 investigations finalised by inquest in the past financial year and of those, a total of 36, being 86%, comprised investigations where an inquest was mandated by law.

The 36 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;
- 8 mandated inquests in relation to the suspected deaths of missing persons;
- 4 mandated inquests where it appeared that the death was caused, or contributed to, by an action of the police force.

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

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

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

In the past financial year there were 24 investigations of deaths of persons held in care finalised by mandated inquest. Of those:

- 17 investigations were finalised by inquest in respect of deaths of persons held in custody under the *Prisons Act 1981*;
- 3 investigations were finalised by inquest in respect of a child who was the subject of a protection order under the *Children and Community Services Act 2004*;
- 4 investigations were finalised by inquest in respect of the death of an involuntary patient within the meaning of the *Mental Health Act 1996*;

In respect of all of the 24 investigations of deaths of persons held in care finalised by mandated inquest this past reporting year, the coroner was required under s 25(3) of the Coroners Act to comment on the quality of the supervision, treatment and care of the person while in that care. In 10 such cases, the Coroner expressed concern about aspects of supervision, treatment and/or care, as follows:

Yeeda, SGV
Mitchell C
Hardie MJ
Shortte, L
Larder WT
Anderson WF
Graham C
Africh EI
Bartlett-Torr, EW

Under s 27(1) of the Coroners Act, the annual report is required to include a specific report on the death of each person held in care. The Table of the 24 investigations into deaths of persons held in care that were finalised by inquest in the past financial year appears at pages 28 to 29 of this report. Following that Table, at pages 31 to 56 are the specific reports on the deaths of each person held in care.

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

There were a total of 4 inquests in this category. In each of the four instances the Coroner found that the police did not cause or contribute to the death.

The Table of the 4 investigations appears at page 25 of this Report.

(c) Mandated inquests – suspected deaths

There were 8 investigations into the suspected deaths of missing persons finalised by mandated inquest.

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

In each instance, the Coroner found that the death of the missing person had been established beyond all reasonable doubt.

The Table of the 8 investigations appears at page 22 of this Report.

REPORT ON INQUESTS THAT ARE HELD PURSUANT TO AN EXERCISE OF DISCRETION BY THE CORONER (DISCRETIONARY INQUESTS)

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

In exercising the discretion under this statutory function the Coroner will have regard to whether an inquest will generate further evidence to assist the Coroner in reaching the findings required to be made, if possible, under s 25(1) of the Coroners Act and/or whether there are reasons for highlighting issues of public health or safety in connection with the death. The Coroner will also take account of the reasons provided by any person who makes a request for an inquest under s 24(1) of the Coroners Act. Of the 42 investigations finalised by inquest in the past financial year, a total of 6, being approximately 14%, comprised investigations where the inquest was discretionary.

TOTAL NUMBER OF INQUESTS

The Table of all of the investigations that were finalised in the 2022/2023 year by inquest (42) appears below as Table A. The six discretionary inquests are marked as such (*) leaving the remainder on the Table (36) as the mandated inquest.

TABLE A

Name of Deceased	Date of Death	Inquest Date(s)	Finding	Date of Finding
KEATING Paul Stephen	12/5/2020	28/6/2022	Natural Causes	6/7/2020
*AL JHELIE Sarwan Hekmat Salman	5/9/2018	18-22/10/2021	Suicide	15/7/2022
YEEDA Seth Gregory Victor	3/5/2018	31/8/2021 to 2/9/2021	Natural Causes	20/7/2022
MITCHELL Callum	21/4/2019	13-14/6/2022	Suicide	22/7/2022
BUCKLAND Ronald Joseph	9/7/2020	28/7/2022	Natural Causes	1/8/2022
ALLEN Henry	14/6/2020	8/6/2022	Natural Causes	2/8/2022
HARDIE Michael James	7/2/2020	14/7/2022	Natural Causes	5/8/2022
TRAN Quoc Xuan	10/4/2019	17/8/2022	Open Finding	17/8/2022
PALKOVICS Roland	On or about 22/7/2020	2/8/2022	Open Finding	21/9/2022
PAVLIDIS Nicholas	Unknown	22/7/2022	Open Finding	18/8/2022
NARRIER Roderick Malcolm	27/10/2019	30/5/2022 to 2/6/2022	Natural Causes	22/8/2022
MATTHEWS Warren Keith	21/10/2020	2/2/2022	Accident	14/9/2022
SHORTTE Leslie	3/3/2020	6/9/2022	Natural Causes	15/9/2022
RICE David Arthur	23/1/2021	28/9/2022	Natural Causes	5/10/2022
*PAINTER Justine	4/6/2020	15-18/3/2022	Open Finding	7/10/2022
ROONEY Jeffery William	1/7/2021	1/11/2022	Natural Causes	3/11/2022
LARDER Wayne Thomas	22/2/2021	18-20/11/2022	Suicide	28/11/2022
CHILD B	27/10/2019	30/5/2022 to 2/6/2022	Natural Causes	22/8/2022
WESTON Lewis Henry	3/11/2020	4/10/2022	Suicide	12/12/2022
ANDERSON William Frederick	24/12/2020	20/9/2022	Natural Causes	13/12/2022
Ms L	4/3/2021	29-30/11/2022	Suicide	23/12/2022
Child F	19/6/2013	12/12/2022	Natural Causes	9/1/2023
FULTON Sharon Elizabeth	18/3/1986	3-5/5/2022	Suspected Homicide	10/1/2023
WINTER Colin Albert	19/12/2019	7/12/2022	Natural Causes	11/1/2023
Child C	27/11/2020	13/12/2022	Unlawful Homicide	24/1/2023

INQUESTS
(continued)

Name of Deceased	Date of Death	Inquest Date(s)	Finding	Date of Finding
GRAHAM Cally	26/2/2017	4-8/4/2022	Natural Causes	31/1/2023
NIXON Roly	28/1/2018	1/2/2023	Open Finding	3/2/2023
SULLEY Philip	27/4/2020	16-18/1/2023	Natural Causes	13/2/2023
*CHAVITTUPARA Aishwarya Aswath	3/4/2021	24/8/2022 to 2/9/2022	Natural Causes	22/2/2023
BRADY Paul James	15/5/2020	21-22/6/2022	Suicide	28/2/2023
WHEILDON Ronald Leslie and FLOCKTON Douglas Ronald	27/5/1976	28/2/2023	Open Finding	9/3/2023
ALBERT Frank	8/1/2021	21/2/2023	Natural Causes	13/3/2023
WARD Hugh	5/10/2021	14/3/2023	Natural Causes	30/3/2023
CUTLER Julie Leanne	20/6/1988	3-4/11/2022	Open Finding	6/4/2023
AFRICH Edward Ivan	18/2/2019	1/3/2023	Natural Causes	17/4/2023
BARTLETT-TORR Errol Warren	20/6/2021	31/1/2023	Natural Causes	22/5/2023
*TAULELEI Jacob George Isaac	8/2/2020	28-30/3/2023	Suicide	26/5/2023
MITCHELL Iveta	3/5/2010	22-24/11/2022	Homicide	16/6/2023
*MILCHERDY Lee	28/2/2019	13-14/4/2023	Misadventure	23/6/2023
CRIPPS Nicholas Arthur	31/5/2021	7/6/2023	Accident	28/6/2023
*Child R	5/1/2017	5-7/7/2022	Open Finding	29/6/2023

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

The Tables appearing after Table A (Tables B, C, and D) are subsets of the information contained in Table A, and the following Tables all relate to mandated inquests.

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

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

Table B below shows the number of inquests (**4**) finalised in 2022/23 year into deaths that appeared to be caused, or contributed to, by any action of a member of the Police Force.

TABLE B

Name of Deceased	Date of Death	Inquest Date	Finding	Date of Finding
NARRIER Roderick Malcolm	27/10/2019	30/5/2022 to 2/6/2022	Misadventure [Police Restraint]	22/8/2022
MATTHEWS Warren Keith	21/10/2020	2/2/2022	Accident [Police Pursuit]	14/9/2022
Ms L Name subject to suppression order	4/3/2021	29-30/11/2022	Suicide [Police Presence]	23/12/2022
BRADY Paul James	15/5/2020	21-22/6/2022	Suicide [Police Presence]	28/2/2023

In each of the 4 instances, the Coroner found that the police did not cause or contribute to the death.

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

SUSPECTED DEATHS – MISSING PERSONS

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

Table C below shows the number of inquests (**8**) finalised in 2022/23 year into suspected deaths.

TABLE C

Name of Deceased	Date of Death	Inquest Date	Finding	Date of Finding
PALKOVICS Roland	On or about 22/7/2020	2/8/2022	Open Finding	21/9/2022
PAVLIDIS Nicholas	Unknown	22/7/2022	Open Finding	18/8/2022
FULTON Sharon Elizabeth	18/3/1986	3-5/5/2022	Homicide	10/1/2023
NIXON Roly	28/1/2018	1/2/2023	Open Finding	3/2/2023
WHEILDON Ronald Leslie FLOCKTON Douglas Ronald	27/5/1976	28/2/2023	Open Finding	9/3/2023
CUTLER Julie Leanne	20/6/1988	3-4/11/2022	Open Finding	6/4/2023
MITCHELL Iveta	3/5/2010	22-24/11/2022	Homicide	16/6/2023

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

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

PERSONS HELD IN CARE

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

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

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

or

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

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

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

(c) a person

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

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

Table D below shows the number of inquests (**24**) finalised in 2022/23 year into deaths of persons held in care.

TABLE D

Name of Deceased	Date of Death	Inquest Date	Finding	Date of Finding
KEATING Paul Stephen	12/5/2020	28/6/2022	Natural Causes	6/7/2020
YEEDA Seth Gregory Victor	3/5/2018	31/8/2021 to 2/9/2021	Natural Causes	20/7/2022
MITCHELL Callum	21/4/2019	13-14/6/2022	Suicide	22/7/2022
BUCKLAND Ronald Joseph	9/7/2020	28/7/2022	Natural Causes	1/8/2022
ALLEN Henry	14/6/2020	8/6/2022	Natural Causes	2/8/2022
HARDIE Michael James	7/2/2020	14/7/2022	Accident	5/7/2022
TRAN Quoc Xuan	7/2/2020	17/8/2022	Open Finding	5/8/2022
SHORTTE Leslie	3/3/2020	6/9/2022	Natural Causes	15/9/2022
RICE David Arthur	23/1/2021	28/9/2022	Natural Causes	5/10/2022
ROONEY Jeffery William	1/7/2021	1/11/2022	Natural Causes	3/11/2022
LARDER Wayne Thomas	22/2/2021	18-20/11/2022	Suicide	28/11/2022

INQUESTS
(continued)

Name of Deceased	Date of Death	Inquest Date	Finding	Date of Finding
CHILD B	27/10/2019	30/5/2022 to 2/6/2022	Natural Causes	22/8/2022
WESTON Lewis Henry	3/11/2020	4/10/2022	Suicide	12/12/2022
ANDERSON William Frederick	24/12/2020	20/9/2022	Natural Causes	13/12/2022
Child F	19/6/2013	12/12/2022	Natural Causes	9/1/2023
WINTER Colin Albert	19/12/2019	7/12/2022	Natural Causes	11/1/2023
Child C	27/11/2020	13/12/2022	Unlawful Homicide	24/1/2023
GRAHAM Cally	26/2/2017	13/12/2022	Accident	31/1/2023
SULLEY Philip	27/4/2020	16-18/1/2023	Natural Causes	13/2/2023
ALBERTFrank	8/1/2021	21/2/2023	Natural Causes	13/3/2023
WARD Hugh	5/10/2021	14/3/2023	Natural Causes	30/3/2023
AFRICH Edward Ivan	18/2/2019	1/3/2023	Natural Causes	17/4/2023
BARTLETT-TORR Errol Warren	20/6/2021	31/1/2023	Natural Causes	22/5/2023
CRIPPS Nicholas Arthur	31/5/2021	7/6/2023	Accident	28/6/2023

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

The individual cases summaries follow.

Paul Stephen KEATING
Inquest held in Perth 28 June 2022, investigation finalised 6 July 2022

Mr Paul Stephen Keating (Mr Keating) died on 12 May 2020 at Fiona Stanley Hospital. The cause of death was atherosclerotic heart disease. The Coroner found the manner of death was natural causes. He was 60 years old.

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

Mr Keating was incarcerated in Western Australia for over 42 years of his life. Upon Mr Keating's initial admission to prison he had no underlying health issues. Prison records show that he was seen regularly by prison medical staff, and he received regular health reviews and nursing care. In 2011 he was diagnosed with high cholesterol. An angiogram showed significant atheroma with an occluded right coronary artery and partially occluded other arteries. There was aortic stenosis and some heart muscle weakness. Mr Keating was placed on a medical management plan with tablets; however, he would often decline this medication.

In June 2014, Mr Keating was reviewed by a cardiologist and his test results showed worsening valvular heart disease. He refused to take any cholesterol-lowering medications, continued to smoke despite advice to the contrary and in the last years before his death, he refused to engage in routine health reviews.On 11 May 2020, Mr Keating was in his cell when he used the cell call system to advise prison staff he was having difficulty breathing and had chest pain. Prison staff, which included prison nursing staff, responded to Mr Keating's medical emergency. After several minutes, Mr Keating stopped using the oxygen mask, saying he could breathe better without it. Despite the aid he was receiving, Mr Keating's condition deteriorated, and he became sweaty before losing consciousness. An ambulance had been arranged and paramedics attended and noted CPR was being conducted by prison officers. Paramedics continued CPR as the ambulance transferred Mr Keating to Fiona Stanley Hospital. However, Mr Keating could not be revived.

The Coroner was satisfied that Mr Keating's various medical conditions, including his heart disease, were appropriately managed and the standard of supervision, treatment and care he received whilst he was in custody was appropriate.

The Coroner did not make any recommendations.

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

Seth Gregory Victor YEEDA

Inquest held in Perth 31 August 2021 to 2 September 2021, investigation finalised 20 July 2022

Mr Seth Gregory Victor Yeeda (Mr Yeeda) died on 3 May 2018 at the West Kimberley Regional Prison. The cause of death was rheumatic heart disease (severe aortic valve regurgitation). The State Coroner found the manner of death was natural causes. He was 19 years old.

Immediately before death Mr Yeeda was a "person held in care" under section 3 of the *Coroners Act 1996* because he was a sentenced prisoner, and pursuant to the *Prisons Act 1981* he was in the custody of the Chief Executive Officer of the Department of Justice. He was serving his sentence at West Kimberley Regional Prison.

As a young child, Mr Yeeda had been diagnosed with rheumatic fever. This illness led to him suffering persisting heart damage, known as rheumatic heart disease. It was a serious cardiac disease that required regular medication and monitoring over Mr Yeeda's lifetime. When he was ten years old, Mr Yeeda underwent surgery for an aortic valve repair. This surgery was successful, but did not cure his rheumatic heart disease, and he was required to have ongoing monitoring and treatment.

To prevent ongoing damage to the heart valves through recurrent bouts of rheumatic fever, throughout his life, Mr Yeeda was supposed to have regular monthly intramuscular benzathine penicillin G injections. These were offered to him as required, but on occasion he was resistant and refused to have them, despite the best endeavours used to explain their importance to him and/or his carer.

On 5 May 2017, Mr Yeeda was taken into custody, and he died in custody approximately one year later. At the time of his death, he had a severe aortic valve regurgitation and left ventricular dilatation, as a result of the progression of his rheumatic heart disease. Mr Yeeda was due to see a cardiologist, but the referral from the Prison Medical Officer made on 5 December 2017 was not progressed to the stage of having an appointment made for him. If Mr Yeeda had been seen by the Visiting Cardiologist it is likely that he would have been advised that he needed urgent surgery for an aortic valve replacement. For reasons outlined in the finding, related to the transition of the Visiting Cardiology Service, the appointment was not made as contemplated by the referral and Mr Yeeda died approximately five months later. If Mr Yeeda had undergone aortic valve replacement surgery, it is likely that his death would have been prevented.

The State Coroner was satisfied that the WA Country Health Service bore the ultimate responsibility for the referral not being actioned, that the Department of Justice missed an opportunity in this regard by not having in place a computer-based tracking system with an adequate recall system for managing prisoners who had urgent referrals, and that WA Cardiology missed a number of opportunities to assist in the adequate transition of the Visiting Cardiology Service.

The State Coroner was satisfied Mr Yeeda received a high level of treatment and care in respect to his administration of penicillin injections whilst in custody. However, the State Coroner noted the standard was not of sufficient quality in the treatment and care with respect to Mr Yeeda's rheumatic heart disease and the need for him to be urgently reviewed by the Visiting Cardiologist.

The State Coroner made three recommendations in support for the progression of the Referral Tracking System which is aimed at avoiding prisoners falling through the gaps and missing out on vital medical care and treatment.

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

Callum MITCHELL
Inquest held in Perth 13-14 June 2022, investigation finalised 22 July 2022

Mr Callum Mitchell (Callum) died on 21 April 2019 at Hakea Prison. At the request of his family, the deceased was referred to as Callum at the inquest. The Coroner found the cause of death was ligature compression of the neck and the manner of death was suicide. He was 26 years old.

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

Callum was diagnosed with attention deficit disorder and had a history of seizures and polysubstance use. His periods of imprisonment were characterised by repeated incidents of self-harm. Between January and April 2019, he was the subject of 55 self-harm and/or behavioural incidents. Although Callum was seen by nurses and psychologists at various times, he did not meet the criteria for specialist psychiatric care because he had not been diagnosed with a major mental illness. Instead he was managed on the At Risk Management System and placed in a safe cell at various times.

On 21 April 2019 Callum went to the medical centre at Hakea Prison to receive prescribed medication. Instead of returning directly to his cell, he went to a restricted area where he spoke to a prisoner from another unit. When he was eventually discovered he was escorted to his cell and subjected to a strip-search. He appeared to be in good spirits and was locked in his cell for the remainder of the afternoon. At about 4.20 pm, a prison officer unlocked the cell to serve Callum his dinner and found Callum slumped up against the cell wall. He was unresponsive and had white strips of material around his neck that were tied to a tap in the cell's sink. Despite resuscitation efforts Callum could not be revived.

The Coroner concluded that the supervision, treatment and care provided to Callum during his incarceration was of a lower standard than it might have been, because in the period leading up to his death, custodial staff were unable to access specialised psychological support to help him to manage his extremely challenging and confronting self-harming behaviours.

The Coroner made four recommendations directed towards improvements in the management of prisoners with complex behavioural needs and minimisation of risk.

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

Ronald Joseph BUCKLAND
Inquest held in Perth 28 July 2022, investigation finalised 3 August 2022

Mr Ronald Joseph Buckland (Mr Buckland) died on 9 July 2020 at Fiona Stanley Hospital (FSH). The cause of death was bronchopneumonia in a man with intra-abdominal carcinoma and multiple co-morbidities, with terminal palliative care. The Coroner found the manner of death was natural causes. He was 70 years old.

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

Mr Buckland's medical history included depression, high blood pressure, high cholesterol, cirrhosis of the liver, atrial defibrillation, chronic obstructive pulmonary disease, gastroesophageal reflux disease, heart failure, left ventricular hypertrophy and mild valvular disease. Mr Buckland had coronary artery bypass grafts in March 2018 and a coronary angiogram in June 2018. He was regularly reviewed at the prison medical centre, and he routinely declined recommended diagnostic tests and/or referrals to specialist medical practitioners.

On 25 March 2020, Mr Buckland was reviewed by a prison medical officer and found to have a large circular mass in his abdomen. He initially declined to have the mass investigated, but on 30 March 2020 he experienced severe pain and was transferred to FSH. A CT scan confirmed he had an abdominal mass involving his stomach, colon and liver.

On 8 July 2020 Mr Buckland's condition declined and he was taken to FSH by ambulance. Following a discussion with his treating team, Mr Buckland indicated he did not wish to be resuscitated in the event of an arrest. His condition continued to decline and he was declared deceased on 9 July 2020.

Following Mr Buckland's death, a review of his medical care concluded that opportunities to diagnose his abdominal cancer at an earlier stage were thwarted by Mr Buckland's repeated refusals (throughout 2019) to undergo colonoscopies and/or gastroscopies to investigate his persistent anaemia.

The Coroner was satisfied Mr Buckland was appropriately managed whilst he was incarcerated, and that his supervision was of a good standard. The Coroner also found that the medical care and treatment that Mr Buckland received whilst he was in custody was of a very good standard and exceeded general community standards.

The Coroner did not make any recommendations.

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

Henry ALLEN
Inquest held in Perth 8 June 2022, investigation finalised 2 August 2022

Mr Henry Allen (Mr Allen) died on 14 June 2020 at Fiona Stanley Hospital. The cause of death was sepsis and aspiration pneumonia in a man with oral squamous cell carcinoma and multiple comorbidities with terminal palliation. The Deputy State Coroner found the manner of death was natural causes. He was 60 years old.

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

Mr Allen had a complex medical history and well-established chronic disease. He had been diagnosed with multiple underlying diseases, including diabetes, hypertension, hypercholesterolemia, gastro-oesophageal reflux disease and ischaemic heart disease. He was also a heavy smoker and had a history of alcohol abuse. He was unwilling to make lifestyle changes to improve his health.

In early 2017, Mr Allen was diagnosed with squamous cell carcinoma of the right tonsil and lung cancer. After receiving chemotherapy, radiotherapy and surgery, his cancers were determined to be in remission. In March 2020 Mr Allen's oral cancer was found to have returned. His treating team determined that Mr Allen was a poor candidate for further intervention, and he was referred for palliative care.

The Deputy State Coroner concluded that the supervision, treatment and care provided to Mr Allen during his incarceration was of an appropriate standard. The Deputy State Coroner did observe that the Department had failed to initiate the Royal Prerogative of Mercy (RPOM) procedures, as per policy, but it was unlikely that Mr Allen would have been recommended for release in the circumstances. The Deputy State Coroner was satisfied that the Department has now rectified the problem that led to a significant number of prisoners not being considered for RPOM in the recent past.

The Deputy State Coroner made one recommendation directed towards review of terminally ill prisoners who are subject to a continuing detention order.

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

Michael James HARDIE
Inquest held in Perth 14 July 2022, investigation finalised 5 August 2022

Mr Michael James Hardie (Mr Hardie) died on 7 February 2020 at Fiona Stanley Hospital (FSH). The cause of death was from haemothorax due to ruptured thoracic aortic aneurysm in a man with Marfan syndrome and methylamphetamine effect. The Coroner found the manner of death was accident. He was 41-years of age.

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

Mr Hardie was born with Marfan syndrome, a genetic disorder affecting the body's connective tissues that can cause issues with the heart, eyes, blood vessels, and skeleton. Although Mr Hardie underwent various surgical procedures for his thoracoabdominal aortic aneurysm there were limited treatment options because of the size of his aneurysm. Mr Hardie's condition was managed conservatively, and there remained a very high risk that his aneurysm would eventually rupture resulting in his chances of survival being minimal.

On 7 February 2020 Mr Hardie was chatting to his cell mate as he cleaned their cell when he suddenly collapsed to the floor. Prison staff were alerted and CPR was immediately commenced but Mr Hardie could not be revived.

The Coroner concluded that the treatment and care provided to Mr Hardie whilst he was in prison was appropriate and commensurate with community standards. However, the Coroner found the fact that Mr Hardie was able to obtain methamphetamine whilst in he was in custody, in circumstances where he was not subject to random or targeted cell searches or drug tests, meant that the supervision Mr Hardie received whilst incarcerated was substandard.

The Coroner made three recommendations directed towards minimising access to illicit substances while in custody and encouraging end of life planning for prisoners.

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

Quoc Xuan TRAN
Inquest held in Perth 9 August 2022, investigation finalised 17 August 2022

Mr Quoc Xuan Tran (Mr Tran) died on or about 10 April 2019 in the waters of the Swan River near Heirisson Island. The cause of death was from immersion (drowning). The Coroner made an open finding as to the manner of death. He was 36 years old.

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

Mr Tran's first recorded contact with mental health services was in Victoria in 2002, when he was diagnosed with paranoid schizophrenia. He was subsequently diagnosed with comorbid anxiety disorder in 2004, and his habitual and impulsive gambling was noted. At the time of his death Mr Tran's diagnoses were schizoaffective disorder and autism spectrum disorder. He regularly reported auditory hallucinations and at times, he exhibited aggressive and/or agitated behaviour.

Mr Tran was managed in the community on a succession of CTOs from 2015. On several occasions when his mental health deteriorated, he was admitted to psychiatric facilities. He received regular depot injections of an antipsychotic medication at a clinic. A CTO was required because Mr Tran lacked insight into his mental health conditions and was unable to make treatment decisions about his mental health.

In the last 30-months of his life, Mr Tran was evicted from his accommodation on five occasions and his mental state deteriorated each time this occurred. It was observed that his mental illnesses were hampered by the lack of appropriate accommodation options.

On 9 April 2019 Mr Tran attended the Clinic for his depot injection. He exhibited no psychotic symptoms and did not disclose any self-harm or suicidal ideation. Mr Tran discussed his living arrangements and Clinic notes show that attempts were being made to secure new accommodation. Calls to Mr Tran on 10 April 2019 were unanswered and he did not reply to a voice message. Mr Tran's body was found on the same day in the Swan River by a member of the public.

The Coroner was satisfied that the decision to place Mr Tran on successive CTOs was justified and that the supervision, treatment and care that Mr Tran received whilst he was an involuntary patient in hospital and whilst he was the subject of successive CTOs, was appropriate and of a good standard.

The Coroner made one recommendation directed towards availability of supported accommodation for mental health consumers.

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

Leslie SHORTTE
Inquest held in Perth 6 September 2022, investigation finalised 15 September 2022

Mr Leslie Shortte (Mr Shortte) died on 3 March 2020 at Bethesda Health Care. The cause of death was complications of metastatic squamous cell carcinoma (terminal palliation). The Coroner found the manner of death was natural causes. He was 71 years old.

Immediately before death Mr Shortte was a "person held in care" under section 3 of the *Coroners Act 1996* because he was a sentenced prisoner. Pursuant to the *Prisons Act 1981* he was in the custody of the Chief Executive Officer of the Department of Justice. He was serving his sentence at Casuarina Prison.

Mr Shortte was a life-long heavy smoker of cigarettes and in the community he was a heavy drinker who consumed alcohol on a daily basis. However, on his admission to prison, Mr Shortte had no recorded medical conditions. Mr Shortte was regularly seen in the prison medical centre and departmental records show he routinely declined recommended diagnostic tests and/or referrals to specialist medical practitioners.

On 21 March 2019 Mr Shortte saw a prison medical officer about a lesion on his shoulder, which was diagnosed as a basal cell carcinoma and the lesion was surgically removed on 2 April 2019. A biopsy determined that the lesion removed from Mr Shortte's shoulder was a squamous cell carcinoma, a lesion with a known high risk of spreading. Mr Shortte failed to hand the slip of paper given to him to the prison medical centre which would have enabled the prison medical centre to book an appointment for any follow up.

In any case an appointment was booked for 10 September 2019, but Mr Shortte failed to attend and no follow up action was taken. Mr Shortte next presented to the prison medical centre on 20 November 2019 with a large solid mass at the right hand base of his neck. Although an ultrasound was requested by the prison medical officer, it was not immediately conducted. Mr Shortte was admitted to hospital on 2 January 2020 and diagnosed with an invasive squamous cell carcinoma of the neck with secondary tumours. He commenced radiotherapy but this was discontinued when he became unwell. Mr Shortte's condition deteriorated and he was transferred to Bethesda Health Care and treated palliatively until his death.

The Coroner was satisfied Mr Shortte was appropriately managed whilst incarcerated and that his supervision was of a good standard. However, the Coroner identified a number of deficiencies in Mr Shortte's treatment, including a failure to follow up key appointments that Mr Shortte did not attend. The Coroner found that these errors lead to the inevitable conclusion that, when considered holistically, Mr Shortte's treatment whilst he was in prison was suboptimal. However, the Coroner found there was no evidence that Mr Shortte's clinical journey would necessarily have been any different, had these errors not been made.

The Coroner made no recommendations.

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

David Arthur RICE
Inquest held in Perth 28 September 2022, investigation finalised 5 October 2022

Mr David Arthur Rice (Mr Rice) died on 21 January 2021 at Fiona Stanley Hospital. The cause of death was complications of acute bronchopneumonia in a man with comorbidities. The Coroner found the manner of death was natural causes. He was 75 years old.

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

Mr Rice had been a heavy smoker and drinker, and his complex medical history included serious heart issues and chronic obstructive pulmonary disease. Although he was regularly seen in the prison medical centre, Mr Rice often declined recommended diagnostic tests and/or specialist referrals, and was often non-compliant with prescribed medication. In 2020 Mr Rice was admitted to hospital on several occasions and diagnosed with heart failure and exacerbation of his chronic COPD. He was also treated for a blocked artery in his leg.

On 3 January 2021 Mr Rice was at Osborne Park Hospital undergoing rehabilitation, when he experienced severe abdominal pain, fever, vomiting and faecal incontinence. He was diagnosed with urosepsis, bowel obstruction and gout. While surgery was considered for his bowel obstruction, because of the very high risk of complications it was decided to manage Mr Rice conservatively. His observations remained stable, and he was returned to the infirmary at Casuarina Prison on 22 January 2021.

On 23 January 2021 a Code Red medical emergency was called after was found semi-conscious under his bed. Mr Rice was taken to Fiona Stanley Hospital and a chest X-ray showed consolidation within his right lung, possibly due to aspiration. He was diagnosed with right sided pneumonia and septic shock. He was transferred to the intensive care unit where he went into cardiac arrest. Despite resuscitation efforts Mr Rice could not be revived.

The Coroner was satisfied that Mr Rice was appropriately managed and supervised whilst he was incarcerated and further, that the treatment and care Mr Rice received in prison was reasonable, and may have exceeded the standards of care he would have received had he been in the general community.

The Coroner made no recommendations.

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

Jeffery William ROONEY
Inquest held in Perth 1 November 2022, investigation finalised 4 November 2022

Mr Jeffery William Rooney (Mr Rooney) died on 1 July 2021 at Sir Charles Gairdner Hospital. The cause of death was subarachnoid haemorrhage due to rupture of a berry aneurysm. The Coroner found the manner of death was natural causes. He was 41 years old.

Immediately before death Mr Rooney was a "person held in care" under section 3 of the *Coroners Act 1996* because he was a sentenced prisoner, and pursuant to the *Prisons Act 1981* he was in the custody of the Chief Executive Officer of the Department of Justice. He was serving his sentence at the Wooroloo Prison Farm.

Mr Rooney's medical history included long standing migraines and headaches, chronic low back pain, hepatitis C and high blood pressure. He sustained head and facial injuries on several occasions following various incidents, and he had a history of polysubstance use including methamphetamine, cannabis and alcohol. In 2008 he was diagnosed with antisocial personality disorder and he experienced episodes of drug induced psychosis, and anxiety. He reportedly attempted to take his own life using a firearm in 1998. In 2014, he sustained stab wounds, which were through to be self-inflicted. He had an extensive criminal history.

On 2 June 2021 Mr Rooney presented at the prison medical centre complaining of right facial pain centred on his cheek. He also reported a blocked nose and sniffles over the previous few days and it was noted he had a loose right upper tooth. Mr Rooney was diagnosed with sinusitis and treated with oral antibiotics. When he was reviewed by a prison medical officer on 22 June 2021, Mr Rooney reported only a slight improvement in his symptoms and although a head CT was ordered, it was not performed before Mr Rooney's death.

On 30 June 2020 Mr Rooney collapsed in his cell and a Code Red medical emergency was initiated. Mr Rooney was taken to hospital where scans showed he had experienced extensive bleeding around the brain due to the rupture of a berry like weakness in an artery in his brain.

The Coroner was satisfied that the supervision, treatment and care Mr Rooney received in prison was reasonable and appropriate.

The Coroner made no recommendations.

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

Wayne Thomas LARDER
Inquest held in Perth 18-20 October 2022, investigation finalised 28 November 2022

Mr Wayne Thomas Larder (Mr Larder) died on 22 February 2021 at Hakea Prison. The cause of death was ligature compression of the neck. The Coroner found the manner of death was suicide. He was 42 years old.

Immediately before death Mr Larder was a "person held in care" under section 3 of the *Coroners Act 1996* because he was a remand prisoner, and pursuant to the *Prisons Act 1981* he was in the custody of the Chief Executive Officer of the Department of Justice. He was serving his sentence at Hakea Prison.

Mr Larder had been diagnosed with depression and in 2016, he was seriously injured when a hay bale fell onto him. He also had a history of polysubstance use, including methylamphetamine. Mr Larder was managed in prison on the At Risk Management System and placed in a safe cell on several occasions. On 19 February 2021 after his court appearance via video-link he repeatedly ran at the walls of his holding cell and told a mental health nurse that if he was not released on bail he would kill himself.

On 20 February 2021 Mr Larder was placed in a safe cell after consuming medication he had found in his cell. He was removed from the safe cell on 21 February 2021 and placed in a three-point ligature minimised cell. Mr Larder made a further court appearance by video-link on 22 February 2021. During the appearance his lawyer told the court that there were significant concerns for Mr Larder's safety and that everyone *"was scared he will commit suicide and he should be on 24-hour watch"*. These comments were not conveyed to custodial staff at Hakea Prison, nor were comments Mr Larder reportedly made to another prisoner, namely that if no-one went surety for him in court that day he would kill himself.

Mr Larder appeared at the lunchtime muster and was seen standing by his cell door. A short time later as officers moved through the wings to lock prisoners in their cell Mr Larder was discovered lying face down on the cell floor apparently hanging. Prison staff removed the ligature from around Mr Larder's neck and started CPR. Ambulance officers arrived and took over resuscitation efforts but Mr Larder could not be revived.

The Coroner found that the management of Mr Larder's physical health was commensurate with community standards. However, the Coroner found that the management of Mr Larder's mental health was demonstrably suboptimal, and further that his risk of suicide and/or self-harm was not properly appreciated.

The Coroner made six recommendations directed towards improved management of At Risk prisoners and ligature minimisation of cells.

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

Child B *(Name Subject to Suppression Order)*
Inquest held in Perth 16 November 2022, investigation finalised 8 December 2022

Child B died on 8 December 2020 at Perth Children's Hospital. The cause of death was hypoxic ischaemic encephalopathy complicating hypoglycaemia with shock and status epilepticus in a child with a recent febrile illness and a history of septo-optic dysplasia and panhypopituitarism, medically palliated. The Coroner found the manner of death was natural causes. Child B was 3 years old.

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

Child B had a complex medical history including significant endocrine issues, cardiac defects, blindness, and developmental delay. As a result Child B suffered from a congenital condition, adrenocorticotrophic hormone deficiency. Child B's parents were unable to provide adequate care, and a provisional care and protection was made on 2 January 2018. The Children's Court of Western Australia made a care and protection order until age 18 years in relation to Child B on 11 November 2019.

On 29 November 2020 Child B was given a bath and a bottle of baby formula. Other than a slightly elevated temperature Child B seemed fine. At about 6.20 am on 30 November 2020, Child B's foster carer checked on him and found he was unresponsive. Emergency services were called and Child B was taken to hospital by ambulance, but his condition deteriorated, and he was declared brain dead on 8 December 2020.

The Coroner was satisfied that the supervision, treatment and care Child B received while in care was of a very good standard.

The Coroner made one recommendation directed towards annual training for carers.

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

Lewis Henry Mark WESTON
Inquest held in Perth 4 October 2022, investigation finalised 12 December 2022

Mr Lewis Henry Mark Weston (Mr Weston) died on 3 November 2020 at Higgins Park in East Victoria Park. The cause of death was ligature compression of the neck. The Coroner found the manner of death was suicide. He was 22 years old.

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

In 2014, Mr Weston was diagnosed with Attention Deficit Hyperactivity Disorder. He was prescribed dexamphetamine and his ADHD responded well to that treatment. Mr Weston was also using cannabis and was advised to monitor his cannabis use carefully. By mid-2017, Mr Weston's self-care had deteriorated and he was not sleeping due to being stressed about his university exams. He had increased his cannabis use and ADHD medication, and began having psychotic episodes which resulted in hospital admissions.

On 4 January 2019, his treating psychiatrist saw Mr Weston who presented as speaking rapidly, being elevated in mood and having grandiose beliefs that he had a special purpose. Mr Weston lacked insight into his illness and maintained he was not unwell. As he refused to take his antipsychotic medication, the psychiatrist placed Mr Weston on a CTO. Mr Weston would eventually be placed on three CTOs before his death.

Mr Weston continued to object to taking his antipsychotic medication and his ongoing psychotic experiences led him to believe that he was destined for a better, more fulfilling afterlife. In the early hours of 3 November 2020, he left home and attended a park where he hanged himself.

The Coroner found the supervision, treatment and care provided to Mr Weston by his treating mental health service providers during all three CTO's was appropriate.

The Coroner made one recommendation directed towards the reciprocal sharing of clinical information in the area of mental health, with appropriate safeguards.

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

William Frederick ANDERSON
Inquest held in Perth 20 September 2022, investigation finalised 13 December 2022

Mr William Frederick Anderson (Mr Anderson) died on 24 December 2020 at Kalgoorlie Regional Hospital. The cause of death was intracerebral haemorrhage. The Deputy State Coroner found the manner of death was natural causes. He was 42 years old.

Immediately before death Mr Anderson was a "person held in care" under section 3 of the *Coroners Act 1996* because he was a sentenced prisoner, and pursuant to the *Prisons Act 1981* he was in the custody of the Chief Executive Officer of the Department of Justice. He was serving his sentence at the Eastern Goldfields Regional Prison.

On admission to prison on 24 November 2020, Mr Anderson advised that he suffered from anxiety, high blood pressure and diabetes and took regular medications for these conditions. Steps were taken by prison medical staff to commence Mr Anderson on his usual medications, pending a medical review by a prison doctor at the end of December 2020. Mr Anderson was seen by nurses who regularly checked his blood pressure and also commenced him on a diabetes care plan and treated him for some other minor health issues, including ongoing pain in his knee due to gout.

On 23 December 2020 Mr Anderson was in his cell with a relative. He seemed in good spirits before they went to bed. Mr Anderson got up to take some pain medication for his knee and then went to the toilet. He was standing up for the toilet when he collapsed and was caught by his cell mate before hitting the ground. The cell mate pressed the cell call button to ask prison officers for assistance. Prison officers attended and a medical emergency was activated. An ambulance was requested and Mr Anderson was conveyed to hospital. At the hospital Mr Anderson was assessed and it was established that he had suffered an unsurvivable intracranial haemorrhage. Family members who lived nearby were able to visit Mr Anderson before he died.

The Deputy State Coroner was satisfied that the medical care provided to Mr Anderson on his admission to prison and until his collapse was appropriate and of a high standard. However, a number of issues arose in relation to the care and treatment provided to Mr Anderson after his sudden collapse, in particular a delay in entering Mr Anderson's cell and a delay in the ambulance leaving the scene as they were waiting for paperwork. The delay was not appropriate in the circumstances, but did not affect the outcome in this case given the extent of Mr Anderson's intracranial haemorrhage.

The Coroner made three recommendations directed towards improved communications and training for prison officers including in the area of First Aid Qualification.

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

Child F *(Name Subject to Suppression Order)*
Inquest held in Perth 12 December 2022, investigation finalised 9 January 2023

Child F died on 19 June 2013 at South Hedland. The cause of death was respiratory failure in association with pneumonia in a child with metachromatic leukodystrophy. The Deputy State Coroner found the manner of death was by way of natural causes. Child F was 3 years old.

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

Child F was known to the Department of Communities from an early stage. The Department had received reports of domestic violence. There were concerns raised about Child F's mother's ability to care for Child F. There was ongoing contact between Communities and Child F's relatives, which eventually lead to an informal arrangement in August 2010 for Child F and another sibling to live with a relative in Karratha. Child F's mother indicated she wished to have her children back and they were returned into her care in November 2010. On 17 December 2010, the Mawarnkarra Health Service wrote to the Communities regarding Child F's presentation to the service two days prior. Child F was assessed and found to have multiple bruises on the body, including one on the upper left ear, one to the left cheek and another on the sacrum. On 26 December 2010 the Communities substantiated physical harm of Child F and a provisional protection and care order was made. On 27 December 2010 Child F was transferred to Princess Margaret Hospital where it was established Child F had been subjected to multiple injuries and abuse.

Child F was discharged from hospital and placed into permanent foster care on 1 April 2011. Child F lived from that time with his carer together with an older sister. Child F was provided with a loving and caring home and made improvements in his health, but then began to regress. After various investigations, Child F was eventually diagnosed with metachromatic leukodystrophy, which is a genetic disorder that is inherited. The prognosis was poor and Child F was not expected to live beyond five years. The Deputy State Coroner noted that all efforts were made to provide Child F with the best care possible, , and there was a good relationship between Communities staff, doctors and his carer. Child F was eventually treated palliatively and died in the arms of the carer and in the presence of Child F's father.

The Deputy State Coroner was satisfied that the treatment, supervision and care provided to Child F prior to death was of a high standard.

The Coroner made no recommendations.

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

Colin Albert WINTER
Inquest held in Perth 7 December 2022, investigation finalised 11 January 2023

Mr Colin Albert Winter (Mr Winter) died on 19 December 2019 at Bethesda Hospital, Claremont. The cause of death was end-stage chronic obstructive pulmonary disease and atherosclerotic heart disease in an elderly man on a background of progressive deconditioning chronic malnutrition and recent pneumonia. The Coroner found the manner of death was natural causes. He was 71 years old.

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

During his time in custody, which commenced in 1986, Mr Winter developed multiple and significant medical conditions, which included chronic obstructive pulmonary disease, ischaemic heart disease, valvular heart disease, atrial fibrillation and an abdominal aortic aneurysm. Mr Winter's smoking habit was a major component in the development of a number of his medical conditions. He ignored repeated advice from his prison health service providers to stop smoking and improve his eating habits. The health care provided to Mr Winter during his final years of imprisonment extended to a number of significant surgical procedures and he was treated by specialists in areas of cardiology, haematology, respiratory, vascular, ENT, spinal and scoliosis.

On 15 November 2019, Mr Winter was admitted to Fiona Stanley Hospital for treatment of an exacerbation of his COPD which was regarded as severe. He was discharged 10 days later but readmitted back on the same day due to limited health care resources at the infirmary in Casuarina Prison. On 2 December 2019, Mr Winter was discharged, however prison medical staff determined he was too unwell to remain in prison and was again returned to FSH. That evening, he was discharged again and returned to prison. Arrangements were then made for Mr Winter to be admitted to Bethesda Hospital for palliative care due to his end-stage COPD and significant ischaemic heart disease.

The Coroner was satisfied that Mr Winter's various medical conditions, including his COPD, were appropriately managed and that the standard of supervision, treatment and care he received whilst he was in custody was not only appropriate but was most likely better than he would have accessed in the community.

The Coroner made no recommendations.

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

Child C *(Name Subject to Suppression Order)*
Inquest held in Perth 13 December 2022, investigation finalised 24 January 2023

Child C died on 27 November 2020 at Royal Perth Hospital. The cause of death was a head injury. The Coroner found the manner of death was by unlawful homicide. Child C was 15 years old.

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

Child C's family first came to the attention of the Department in September 2008. On 15 August 2014, the Department made an application in the Children's Court for Child C to be placed into the provisional protection and care of its CEO. This application was granted.

On 20 October 2016, a further application was made and granted for a period of two years for Child C to remain the responsibility of the Department's CEO and to continue to live with foster carers. On 9 May 2019, the Children's Court granted the Department's application for Child C to remain in its care until the age of 18 years. At the time, Child C was happy to consent to the application. Shortly after this application was granted, Child C became disruptive and non-compliant both at school and home. On 10 July 2019, Child C self-selected to return to the care of her mother.

In the early hours of 27 November 2019, Child C was in a group of five young people that was in a car driven by a 17-year-old girl who held a provisional driver's licence. The group was behaving in a reckless manner as the car was being driven. At one stage, Child C moved from the boot of the car where she was sitting and stood on the tow bar. She fell and struck her head on the road. Despite a nearby resident administering CPR and attending ambulance officers continuing resuscitation efforts, Child C died later that day in hospital. The driver pleaded guilty to the manslaughter of Child C and was sentenced.

The Coroner was satisfied that the Department's overall standard of treatment, supervision and care to Child C prior to her death was appropriate, though noting that Child C's self-selection to return to the care of her mother remained as an unendorsed placement.

The Coroner made no recommendations.

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

Cally GRAHAM
Inquest held in Perth 4-8 April 2022, investigation finalised 31 January 2023

Ms Cally Graham died on 26 February 2017 at Fiona Stanley Hospital. The State Coroner found the cause of death was hypoxic ischaemic encephalopathy, bronchopneumonia and myocardial ischemia complicating a cardiorespiratory arrest in association with probable Takotsubo cardiomyopathy and methylamphetamine effect. The State Coroner found the manner of death was accident. She was 31 years old.

Cally Graham was referred to as Cally at the inquest at the request of her family.

Immediately before death Cally was a "person held in care" under section 3 of the *Coroners Act 1996* because she was imprisoned under warrants of commitment for non-payment of fines, and pursuant to the *Prisons Act 1981* she was in the custody of the Chief Executive Officer of the Department of Justice. She was serving her term at Melaleuca Remand and Reintegration Facility (Melaleuca Prison).

Cally was taken into custody at Melaleuca Prison on 20 February 2017. Just under 12 hours after her arrival she collapsed in her cell and was conveyed by ambulance to Fiona Stanley Hospital, where she later died without regaining consciousness.

Cally had taken some methylamphetamine before she was taken into custody. The State Coroner was satisfied that the methylamphetamine contributed to Cally's death, most likely by precipitating a tachyarrhythmia that gave rise to the cascade of events leading to her death. The State Coroner found that Cally's death was by way of accident.

At the time of Cally's admission, Melaleuca Prison had only recently been opened. Some practices and procedures were still being developed and some staffing issues were still being worked out. When the night nurse and custodial staff arrived to resuscitate Cally, there was no functioning oxygen tank to attach to the Oxy Via resuscitation kit brought by the nurse, (as the tank was found to be empty). Cally was ventilated by means of rescue breaths from her cellmate.

The State Coroner found that while Cally's prospects of survival, after her cardiac arrest, were very slim, they were not wholly absent. Were it not for the cellmate's rescue breaths, the State Coroner would have concluded that the CPR given at Melaleuca Prison was not of an appropriate standard. However, in light of the cellmate's rescue breaths (together with other first aid that included compressions), the State Coroner was satisfied that Cally was afforded an appropriate opportunity for lifesaving CPR.

In the circumstances the State Coroner found that Melaleuca Prison's standards of care fell below what should ordinarily be expected in delivering CPR to Cally, by reason of not having a functioning oxygen tank when the staff entered Cally's cell, as a consequence of which it took another eight minutes to make one available.

The State Coroner referred to improvements since Cally's death, including in the area of the availability of, and the checking of, resuscitation equipment.

The Coroner made one recommendation directed towards a post-incident care policy for prisoners.

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

Philip SULLEY
Inquest held in Perth 16-18 January 2023, investigation finalised 13 February 2023

Mr Philip Sulley (Mr Sulley) died on 27 April 2020 at Bentley Mental Health Unit. The cause of death was from coronary artery arteriosclerosis. The Coroner found the manner of death was natural causes. He was 58 years old.

Immediately before death, Mr Sulley was a "person held in care" under the *Coroners Act 1996* as he was subject to an Inpatient Treatment Order made under the *Mental Health Act 2014*. He was therefore an "involuntary patient".

From 2004 to 2013, Mr Sulley had a number of hospital admissions relating to his mental health. The principal diagnoses were drug-induced psychosis and paranoid schizophrenia.

On 19 April 2020, and again on 22 April 2020, Mr Sulley was taken to Royal Perth Hospital for mental health assessments after he was found behaving in an irrational manner. On the 22 April 2020 occasion, he remained in the emergency department overnight before he was taken to Bentley Mental Health Unit (BMHU) for a psychiatric review the next day. At BMHU he was agitated and refused to have a physical assessment. Two attempts to conduct a psychiatric review were terminated due to Mr Sulley's threatening behaviour.

On 24 April 2022, Mr Sulley became an involuntary patient. He was prescribed antipsychotic medication and pain relief medication when he complained of body pain. During his admission to BMHU, Mr Sulley refused a physical assessment on four separate occasions. At no time did he complain of symptoms suggesting a heart-related condition.

On 27 April 2020, Mr Sulley was in the communal dining room preparing a drink when he staggered backwards and fell to the floor. Medical staff immediately went to his assistance and saw that he had no respiratory rate and was not breathing. Despite CPR and doses of adrenaline, Mr Sulley remained unresponsive. A short time later a doctor certified he had died.

The Coroner found the supervision, treatment and care that Mr Sulley received was appropriate to his needs, and the need for his detention as an involuntary patient under the *Mental Health Act 2014* was necessary for his own safety.

The Coroner made no recommendations.

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

Frank ALBERT
Inquest held in Perth 21 February 2023, investigation finalised 13 March 2023

Mr Frank Albert (Mr Albert) died on 8 January 2021 at Derby Regional Hospital. The cause of death was atherosclerotic heart disease. The Coroner found death occurred by way of natural causes. He was 46 years old.

Immediately before death Mr Albert was a "person held in care" under section 3 of the *Coroners Act 1996* because he was a sentenced prisoner, and pursuant to the *Prisons Act 1981* he was in the custody of the Chief Executive Officer of the Department of Justice. He was serving his sentence at West Kimberley Regional Prison (WKRP).

While he was in custody at WKRP Mr Albert was regularly seen by nursing staff and although he was encouraged to take his diabetes medication, he was adamant that he did not wish to do so. He also refused to undergo a cardiac stress test to check his heart function. Mr Albert said he preferred to manage his diabetes by exercise and diet, and he was given information about healthy eating. After Mr Albert was seen by a physician on 25 September 2020, he agreed to start taking his diabetes medication, but his blood sugar levels remained high and he was prescribed additional medication.

On 8 January 2021 prison officers were alerted to the fact that Mr Albert was in his cell clutching his chest, apparently having a heart attack. Nurses attended and gave Mr Albert aspirin and glyceryl trinitrate spray, before he was taken to the Derby Regional Hospital by ambulance. As Mr Albert was being prepared for a transfer to Perth for further management, his condition suddenly deteriorated and he went into cardiac arrest. Despite resuscitation efforts he could not be revived.

One of the issues explored at the inquest was the availability of culturally appropriate diet options for Aboriginal prisoners with diabetes. Another issue concerned the likely improvement to his health if an Aboriginal Health Worker had been employed by WKRP.

The Coroner was satisfied that the supervision, treatment and care provided to Mr Albert while he was in custody was of an appropriate standard.

The Coroner made five recommendations directed towards improvements when contacting emergency services, improvements to medication parades, efforts to recruit Aboriginal Health Workers, and the development of culturally appropriate dietary options for Aboriginal prisoners with diabetes.

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

Hugh WARD
Inquest held in Perth 14 March 2023, investigation finalised 30 March 2023

Mr Hugh Ward (Mr Ward) died on 5 October 2021 at Sir Charles Gairdner Hospital (SCGH). The cause of death was from complications of cerebrovascular accident (stroke). The Coroner found death occurred by way of natural causes. He was 89 years old.

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

Mr Ward's medical history included high blood pressure, atrial fibrillation, heart disease, type-2 diabetes, sleep disorder, unsteadiness on his feet, and hearing loss. Mr Ward had undergone surgery to treat colon cancer, and was taking warfarin to prevent blood clots as a result of his atrial fibrillation. He had also been diagnosed with severe depression, dementia, cognitive impairment and memory loss. Mr Ward was accommodated in the infirmary at Casuarina Prison because of his frailty and medical issues and he was taken to hospital on several occasions for treatment of issues including: bleeding gastric ulcers, embolic strokes, and falls.

On 4 October 2021, Mr Ward was found slumped over in his wheelchair in the infirmary. The right side of his face was drooping and he had right-sided weakness and no grip strength. He was taken to SCGH by ambulance, where CT scans showed blockages in multiple blood vessels in his brain. Mr Ward underwent an uneventful procedure to treat the blocked blood vessels, but a follow-up CT scan showed a subarachnoid haemorrhage and associated swelling of the brain. Mr Ward's prognosis was assessed as poor and after discussions between his family and his treating team, it was decided to treat him palliatively. He was kept comfortable until his death.

The Coroner was satisfied that the supervision, treatment and care provided to Mr Ward while he was incarcerated was of a good standard.

The Coroner three recommendations directed towards consent procedures for improved communications with next of kin about medical management.

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

Edward Ivan AFRICH
Inquest held in Perth 1 March 2023, investigation finalised 17 April 2023

Mr Edward Ivan Africh (Mr Africh) died on 18 February 2019 at Fiona Stanley Hospital. The cause of death was from bronchopneumonia and sepsis with chronic obstructive pulmonary disease in a man with underlying advanced chronic myelomonocytic leukaemia and heart failure, medically palliated. The Coroner found the manner of death was natural causes. He was 64 years old.

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

Mr Africh had a number of significant pre-existing illnesses which included atrial fibrillation, alcohol-related liver disease, interstitial lung disease and emphysema. While he was in custody, he was further diagnosed with chronic myelomonocytic leukaemia, right side heart failure and worsening emphysema.

On 15 February 2019 Mr Africh complained of feeling unwell. His oxygen saturation levels were very low and he had difficulty breathing. A prison doctor assessed that he may be having heart failure and arrangements were made to transfer him from the infirmary at Casuarina Prison to Fiona Stanley Hospital (FSH). Following hospital admission, Mr Africh was diagnosed with pulmonary oedema secondary to decompensated heart failure and possible chest sepsis. He also had an acute kidney injury and fluid around the lungs. He did not respond to treatment and as he remained extremely unwell, the treating team determined that his care should become palliative only. Mr Africh subsequently died on 18 February 2019.

The Coroner noted the complexity of Mr Africh's various medical conditions, which would have been made challenging to manage even outside a prison setting. With one notable exception regarding the inappropriate and unnecessary restraining of Mr Africh when he was in FSH, the Coroner was satisfied that the supervision, treatment and care provided to Mr Africh while he was in custody was of an appropriate standard.

The Coroner made no recommendations.

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

Errol Warren BARTLETT-TORR
Inquest held in Perth 31 January 2023, investigation finalised 22 May 2023

Mr Errol Warren Bartlett-Torr (Mr Bartlett-Torr) died on 20 June 2021 at Bethesda Hospital, Claremont. The cause of death was metastatic carcinoma of the prostate with complications (end of life palliative care). The Coroner found the manner of death was natural causes. He was 86 years old.

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

Mr Bartlett-Torr was already an elderly man when he commenced his prison term in March 2020. His previous medical history included a pacemaker insertion, atrial fibrillation, gastro-oesophageal reflux, hypertension, osteoarthritis, and blood clotting management. He reported long-standing poor urinary flow. He was medically assessed in prison and noted to very frail and unsteady on his feet. Due to his age, frailty and cardiac disease he was placed on the terminally ill register.

On 21 May 2021, Mr Bartlett-Torr was admitted to St John of God Midland Hospital for a diagnosis of abdominal pain and a cardiac assessment. He was diagnosed with advanced prostate cancer and later developed a coagulopathy.

Given his worsening condition, on 11 June 2021, Mr Bartlett-Torr expressed a desire to die due to his poor quality of life. The following day, he stated a wish for palliative care only and he was discharged and transferred to the infirmary at Casuarina Prison. On 17 June 2021, Mr Bartlett-Torr was admitted to Bethesda Hospital for palliative care and he died three days later.

The Coroner was satisfied that the medical supervision, treatment and care provided to Mr Bartlett-Torr while he was incarcerated was of an appropriate standard. However, the use of restraints upon Mr Bartlett-Torr during his transfer to, and subsequent admission at, Bethesda Hospital for several days was entirely inappropriate and failed to comply with the Department of Justice's own policies and procedures.

The Coroner made one recommendation directed towards prisoner restraints within the context of palliative care.

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

Nicholas Arthur CRIPPS
Inquest held in Perth 7 June 2023, investigation finalised 28 June 2023

Mr Nicholas Arthur Cripps (Mr Cripps) died on or about 24 May 2021 at his home in Doubleview. The cause of death was combined acute effects of multiple drugs in an obese man with an enlarged heart and arterial hypertension. The Coroner found the manner of death was accident. He was 47 years old.

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

Mr Cripps had an extensive mental health history and was diagnosed with treatment resistant schizophrenia and anti-social personality disorder. The management of Mr Cripps' mental health issues was complicated by his non-compliance with prescription medication, and by his persistent polysubstance use, including methylamphetamine, alcohol and cannabis.

For about 10-years, Mr Cripps had been successfully treated with clozapine, an antipsychotic medication regarded as "the gold standard" for treatment resistant schizophrenia. Patients using this medication must submit to monthly blood tests to monitor side-effects and Mr Cripps stopped taking clozapine in March 2003 because he refused to have the required blood tests.

Mr Cripps was placed on a CTO because he was non-compliant with his medication, lacked insight into his mental health conditions and lacked the capacity to make treatment decisions about his mental health.

Mr Cripps complex needs were managed by means of a fortnightly depot injection of antipsychotic medication which Mr Cripps often declined. As he was on a CTO Mr Cripps was obliged to receive treatment, and when he refused his depot injection he was taken to Graylands Hospital by police. Once at the hospital Mr Cripps invariably accepted the depot injection and was discharged a few days later.

Mr Cripps was found deceased at his home on 31 May 2021 after a number of unsuccessful attempts to contact him following his failure to attend for his scheduled depot injection.

The Coroner was satisfied that the decision to place Mr Cripps on a CTO was justified and that the treatment Mr Cripps received whilst he was the subject of the CTO was reasonable when considered in the context of the resources available to his treating team.

The Coroner did not make any recommendations.

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

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