Office of the State Coroner

Annual Report

2002/2003

State Coroner Western Australia

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20th November, 2003

The Honourable Jim McGinty
BA Bjuris(Hons) LLB JP MLA
Attorney General

Dear Minister

In accordance with Section 27 of the Coroners Act 1996 I hereby submit for your information and presentation to each House of Parliament the report of the Office of the State Coroner for the year ending 30 June, 2003.

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

Yours sincerely

Alastair Hope
STATE CORONER

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State Coroner's Overview

The bombings which occurred on Saturday 12 October, 2002 in Bali, commonly known as the Bali Tragedy, had a considerable impact on the state's coronial system.

Immediately following the bombing bodies and body parts were retrieved by Indonesian volunteers and authorities and taken to Denpasar's Sanglah hospital mortuary. At the mortuary in the absence of airconditioning and because of limited facilities the bodies were laid out and ice was used to keep them cold.

It was clear from an early stage that the coronial system would have an involvement and on Tuesday 15 October, 2002, an Australian Disaster Victim Identification (DVI) team arrived in Bali. With the team was Dr C T Cooke, Chief Forensic Pathologist, PathCentre Perth.

Dr Clive Cooke,
MBBS, BmedSci, FRCPA
Chief Forensic Pathologist

Following liaison with the Indonesian DVI Commander, Brigadier Commander Dr Eddy Saparwoko, Australian DVI teams examined the bodies. Unfortunately at that stage 16 bodies had already been released.

Families of the deceased were clearly extremely distressed and there was great pressure applied to all involved to have identification of the bodies completed as quickly as possible.

In order to identify bodies ante-mortem information had to be obtained in relation to all missing persons. Unfortunately in Australia there was delay involved with the Department of Foreign Affairs and Trade providing a missing persons list for the obtaining of ante-mortem data. A list was released on 17 October, 2002.

In Western Australia ante-mortem data to assist with identification was obtained by WA police officers trained in DVI procedures who were accompanied on visits to families with counselors.

The Coronial Counsellors, Simon Walker and Kristine McCulloch, played a pivotal role liaising with families about the obtaining of the ante-mortem data and were assisted by counsellors from the Victim Support Service and a private provider, Occupational Services Australia.

In Bali each of the bodies was examined, in a large number of cases by Dr Cooke. Also involved in the DVI process were forensic odontologists and anthropologists as well as DNA scientists. Western Australians involved were Dr Stephen Knott, forensic odontologist, and Dr Alanah Buck, anthropologist.

(L-R) *Dr Sindhy Malingkas, Dr Stephen Knott, Dr Musaddeq Ishaq & Dr Peter Sahelangi part of the odontologist team*

Odontologists played a major part in the identification of deceased persons as dental identification played an

extremely important part in the identification process. Anthropologists were involved because of the extent of burning of some of the bodies and body parts.

Following review of the bodies and ante-mortem information a reconciliation board commenced to complete the process of identification of bodies and body parts, the first meeting of the board was on Friday 25 October, 2002.

Identification was effectively complete by Friday 15 February, 2003. At that stage it was determined that there had been 202 fatalities. Deceased persons came from 21 different countries and 199 positive identifications had been achieved.

All 88 Australian fatalities were identified including 16 Western Australian victims. In each case following the identification arrangements had been put in place for release of the bodies and communicating with families. The Office Manager, Mr Glenn Spivey, played an important role in liaising with different organizations including QANTAS, which transported the bodies, and the Government Contractor and the Grief Counsellors had an ongoing role in liaison with families.

The role of the Coroner's Court in assisting with the DVI process and liaison with family members was recognized by the presentation of a certificate of appreciation from the Premier of Western Australia.

The Bali tragedy has bought to Australia an appreciation of the ramifications which can be associated with terrorist acts.

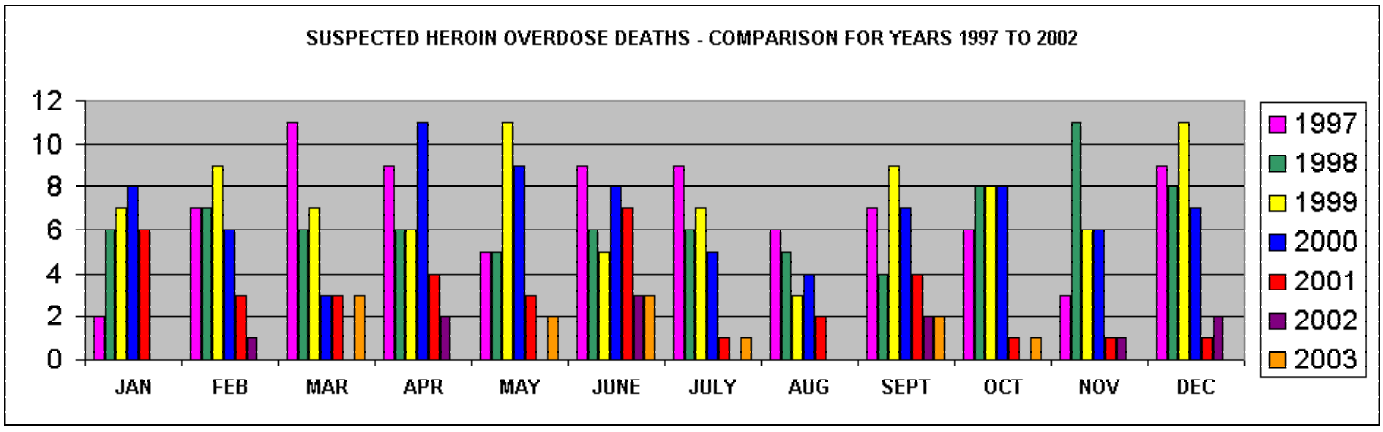
Following the tragedy there has been close interaction between all Australian State Coroners and their equivalents with a view to improving our collective capability to deal with disasters of significant magnitude. In this case particular

problems were encountered because of the need for interaction between Federal Government instrumentalities, such as the Department of Foreign Affairs and Trade, with the State Coronial Systems, each of which is slightly different. It was important for the families of the deceased persons to be treated reasonably consistently throughout Australia, but it was also important to ensure that procedures which have worked well in each State continued to be applied even in a case which crossed State boundaries.

Western Australian does have an active DVI Committee which had addressed a number of the issues which arose in Bali prior to the tragedy occurring. The Committee is currently in the process of reviewing the response to the Bali tragedy and assessing the suitability of the various protocols which had been put in place.

On a different note, our review of deaths in Western Australia continues to identify a dramatic reduction in the number of heroin associated deaths since the year 2000.

The following chart demonstrates the dramatic reduction in heroin related deaths which has occurred in the last 2 years compared with previous high levels.



For the first six months of 2003 there were 8 suspected drug overdose deaths. In 2002 there were 11 suspected drug overdose deaths. In 1997, 1998, 1999 and 2000 there were 83, 78, 89 and 82 suspected drug overdose deaths respectively.

This is a matter which merits continual monitoring as it would be most disappointing if the number of accidental deaths associated with heroin overdoses returned to earlier levels.

In conclusion I would like to thank all staff at the Coroner's Court who have worked together as a team to deal with extremely difficult situations. Over the course of the year there have been a large number of distressing, difficult and often complex issues to be addressed and all staff members have played an important part in the process.

Involvement of Relatives

The *Coroners Act 1996* involves relatives of deceased persons in the coronial process to a far greater extent than previously was the case.

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

In practice the information is contained in a brochure which is provided by a police officer who is also required to explain the brochure. A police officer is further required to record details about the provision of the information on a mortuary admission form which is viewed by the Coroner or a delegate prior to any decision being made about whether or not a post mortem should be conducted.

During the year 1 July 2002 - 30 June 2003 a total of 1,897 deaths were referred to the Coroners Court. In 293 cases a death certificate was issued at an early stage and the body was not taken to the mortuary. Of the remaining 1,604 cases, a total of 140 objections were made to the conducting of a post mortem examination.

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

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

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

It is a rare case in which there are no external factors which would give some insight into a likely cause of death.

The following charts detail statistics relating to objections to post mortem examinations for the year. The cases where a death certificate was issued by a doctor and the body did not reach the mortuary have not been included.

Deaths Referred to the Coroners Court from 1 July 2002 - 31 December, 2003

	Jul	Aug	Sept	Oct	Nov	Dec	*Total*
Death Certificate issued although the body was admitted to the Mortuary	18	18	20	21	15	13	105
Immediate post mortem ordered (usually these are homicide cases)	2	1	5	3	0	1	12
No objection to post mortem	116	103	96	90	107	100	612
Objection received by the Coroners Court	11	12	17	10	13	10	73
No PM conducted (e.g. missing persons, Death Certificate originally issued etc)	1	0	1	5	7	3	17
TOTAL NUMBER OF DEATHS	148	134	139	129	142	127	819

Developments in Cases where an Objection was initially received

	Jul	Aug	Sept	Oct	Nov	Dec	*Total*
Objection withdrawn prior to a ruling being given by a Coroner	6	3	6	3	5	3	26
Objection accepted by a Coroner and no post mortem ordered	5	7	11	7	8	7	45
Objection over-ruled by a Coroner*	0	2	0	0	0	0	2
TOTAL	11	12	17	10	13	10	73

Deaths Referred to the Coroners Court from 1 January 2003 - 30 June 2003

	Jan	Feb	Mar	Apr	May	Jun	*Total*
Death Certificate issued although the body was admitted to the Mortuary	19	18	14	18	16	22	107
Immediate post mortem ordered (usually these are homicide cases)	5	1	4	1	0	0	11
No objection to post mortem	100	100	114	97	90	95	596
Objection received by the Coroners Court	13	6	15	11	13	9	67
No PM conducted (e.g. missing persons, Death Certificate originally issued etc)	3	0	0	0	0	1	4
TOTAL NUMBER OF DEATHS	140	125	147	127	119	127	785

Developments in Cases where an Objection was initially received

	Jan	Feb	Mar	Apr	May	Jun	*Total*
Objection withdrawn prior to a ruling being given by a Coroner	3	1	7	2	1	1	15
Objection accepted by a Coroner and no post mortem ordered	9	5	6	8	11	8	47
Objection over-ruled by a Coroner	1	0	2	0	1	0	4
TOTAL	13	6	15	10	13	9	66

It can be seen from the above charts that of the total number of deaths referred to the Coroners Court there were relatively few objections to the conducting of post mortem examinations.

In the majority of cases where an objection was received the decision which was ultimately made was in accordance with the wishes of the family. There were a total of 140 objections of which 41 were withdrawn prior to a ruling being given by a Coroner and 92 were accepted by a Coroner and no post mortem examinations were ordered. In the remaining cases the objection was over-ruled after which the objection was withdrawn.

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

REFERRALS - CORONIAL COUNSELLING SERVICE

1 July, 2002 – 30 June, 2003

TOTAL NEW CONTACTS

(letters to Next of Kin or referral from clients, other agencies or police)

4,191

Information			
Objection	**Coronial Procedure**	**Retention**	**File Viewing**
312	**2,026**	**152**	**168**

Counselling		
Phone	**Office**	**Home**
992	**177**	**218**

Support	
Scene Mortuary	**Court**
71	**75**

Coronial Ethics Committee

The Coronial Ethics Committee has undergone no changes in composition since the previous financial year, apart from the addition of two laymen members in the new financial year to bring it in line with the suggested composition of Ethics Committees as detailed in the National Health and Medical Research Councils (NHMRC) Guidelines.

Felicity Zempilas returned to the Office to replace Sarah Linton as Counsel Assisting the State's Coroners and consequently as Secretary for the Committee in May 2003. To perform this function, Mrs Zempilas is now assisted by Ms Kayt Deverill, who provides secretarial support. The Secretary is responsible for ensuring that committee members are equipped with necessary documents for meetings and for ensuring that a projects register is maintained and monitored. This register is retained at the Coroner's Office.

The Coronial Ethics Committee welcomed two new members to the Committee during the year.

Mr Clive Deverall AM., HON. D. LITT.(CURTIN) retired in December 1999 after 22 years as the Director of the Cancer Foundation of Western Australian and as a member of the Board of the Cancer Council of Australia.

Mr Jim Fitzgerald has a Bachelor of Applied Science in Mechanical Engineering.

Both men since being appointed have been active members and continue to play an important role to ensure the successful functions of the Coronial Ethics Committee.

The members of the Committee are as follows:

The Committee attempts to strike a balance between family concerns (including privacy, confidentiality and consent issues), and the possible benefits of research to the community at large. The Committee then makes recommendations to the State Coroner to assist him to decide whether to approve a project or to allow access to coronial records.

The Application Form, drafted by the Committee in 1999, for use by persons seeking access to coronial information or to tissue, has proved to be a very fair and efficient means of assessing possible research projects and has allowed the Committee to consider a number of such projects more quickly.

The Committee has addressed the following projects during the last financial year as indicated in the table below.

Number of Projects Considered	Number of projects approved	Number of projects not approved
16	10	3

The considerable efforts of the Ethics Committee during the year are very much appreciated by the Coroners Court, particularly when it is considered that the Committee works on a voluntary basis and all members fit Committee work into otherwise very busy schedules.

Counsel to Assist Coroners

In May, 2003 Mrs Felicity Zempilas replaced Ms Sarah Linton as counsel assisting pursuant to a secondment arrangement with the Office of the Director of Public Prosecution.

Mrs Zempilas will continue to be seconded to the Coroner's Court until the beginning of May 2004.

In addition the Police Service continues to provide assistance to the Coroner's Court in the form of two police officers who act as officers assisting, namely Sergeant Peter Harbison and Sergeant Geoff Sorrell, who replaces Sergeant Dominic Licastro. These officers bring a wealth of experience and relevant knowledge to the task.

In a number of more complex cases Mr Dominic Mulligan was retained as counsel assisting. Mr Mulligan was the first counsel assisting appointed at the Coroner's Court in 1997-1998 and he now practices as a Barrister and Solicitor in private practice.

Ms Linton, Mrs Zempilas and Mr Mulligan have provided the Court with a very high level of processional assistance which is necessary for the conducting of complex and important Inquest hearings and their assistance is clearly necessary in cases where issues arise relating to police involvement.

Inquests

During the year Inquests were heard by the State Coroner, Mr Alastair Hope and the Deputy State Coroner, Ms Evelyn Vicker.

A total of 36 Inquests were commenced during the year and have now been completed with a total number of 101 sitting days. In addition there were uncompleted inquests such as the inquest into the four deaths which occurred on HMAS Westralia in 1998. That case alone required a substantial number of sitting days and a considerable amount of preparation but is not included in these statistics.

Of the inquests commenced during the year the State Coroner heard 17 Inquests with a total of 52 sitting days. The Deputy State Coroner heard 19 Inquests with a total of 49 sittings

days. As indicated above these statistics are incomplete as they do not include part heard cases.

Because of the overlap of uncompleted inquests and the variable preparation time it has not been considered helpful to attempt to calculate the total number of sitting days for the year as these do not provide an accurate indicator of the work performed by the court and are not easily accessible at this time. In future years it is intended to identify all completed cases which will provide a better indication of court sitting days.

In part because the Court has been required to change location twice in 2003 some files are not readily accessible and for this year comprehensive compilation of inquest statistics would involve considerable effort which was not considered to be an efficient use of resources.

There were 8 Inquests heard which involved prison deaths in custody and 6 deaths which had police involvement.

The State Coroner and Deputy State Coroner conducted a total of 7 Inquests in country regions.

A chart follows detailing the inquests commenced during the year.

It should be noted that in the case of over 1,500 cases each year which are not Inquested, each of these cases is investigated and in every case Findings are made by a Coroner and a Record of Investigation into Death document is completed detailing the results of the investigations which have been conducted.

In Perth the majority of these cases are determined by the Deputy State Coroner while in the country regions they are determined by the Regional Coroner.

Brief observations in relation to a number of inquests which were conducted during the year are set out following the chart of inquests commenced.

INQUESTS COMMENCED DURING THE YEAR 1 JULY, 2002 - 30 JUNE, 2003

NAME	REGISTRY NUMBER	DATE OF DEATH	DATE OF INQUEST	NUMBER OF SITTING DAYS	CORONER	COURT SITTING	FINDING COMMENTS OR RECOMMEND	DATE OF FINDING
SUMARYO Basuki Iman Subroto	23/02	18/8/00	2-4/7/02	3	STATE	Karratha	Misadventure	4/7/02
STUDD Elizabeth Ann	24/02	28/8/99	8-9/7/02	2	DEPUTY	Perth	Suicide	18/7/02
CHESTERFIELD-EVANS Guy	25/02	14/4/01	23-25/7/02	3	STATE	Perth	Accident	31/7/02
AUSTIN Alan Edward	26/02	25/12/00	6-7/8/02	2	STATE	Perth	Natural Causes	16/10/02
SALEH Mohammed Yousef	27/02	23/6/01	27 & 29/8/02	2	STATE	Port Hedland and Perth	Misadventure	5/10/02
BECKETT Richard John	28/02	21/5/00	4/9/02	1	DEPUTY	Perth	Suicide	27/9/02
HUSSEINI Nurjan HUSSEINI Fatimeh	29/02	8/11/01	4-8/11/02	5	STATE	Fremantle	Open Finding	16/12/02
YAPPO Mervyn Richard	30/02	4/4/01	10/9/02	1	DEPUTY	Perth	Natural Causes	27/9/02
MOODY Eric Clarence	31/02	6/12/99	17-18/9/02	2	DEPUTY	Perth	Natural Causes	4/10/02
SMYTH Clayton Peter	32/02	5/2/01	8-9/10/02	2	DEPUTY	Perth	Open Finding	5/12/02
MILNE Stuart Davey	33/02	17/8/00	29/10/02	1	STATE	Perth	Open Finding	29/10/02

INQUESTS COMMENCED DURING THE YEAR 1 JULY, 2002 - 30 JUNE, 2003

NAME	REGISTRY NUMBER	DATE OF DEATH	DATE OF INQUEST	NUMBER OF SITTING DAYS	CORONER	COURT SITTING	FINDING COMMENTS OR RECOMMEND	DATE OF FINDING
MILLER Reginald Henry MILLER Eileen Mary UGLE Derek Ferguson	34/02	3/5/01	29/10/02	1	STATE	Perth	Open Finding	29/10/02
HUGHES George Albert	35/02	27/7/01	30-31/10/02 - 1/11/02	3	STATE	Collie	Accident Comment	1/11/02
BROWN Corey Anthony	36/02	23/2/00	30/10/02	1	DEPUTY	Perth	Misadventure	15/11/02
PORRO Dean Lawrence	37/02	20/3/01	19-20/11/02	2	DEPUTY	Perth	Accident	20/12/02
EVERETT Donald Richard DEWAR David Adrian RULAND Phillip Gavin CAPES Gavin Ashley	38/02	26/1/01	18-29/11/02 16-17/12/02	12	STATE	Fremantle Perth	Accident	17/12/02
PALMER Yola Wanita	39/02	29/12/01	25-26/11/02	2	DEPUTY	Perth	Suicide	20/12/02
GRAHAM Delamina Tracey	40/02	21-23/5/01	18-20/12/02	3	STATE	Kalgoorlie	Open Finding	24/12/02

INQUESTS COMMENCED DURING THE YEAR 1 JULY, 2002 - 30 JUNE, 2003

NAME	REGISTRY NUMBER	DATE OF DEATH	DATE OF INQUEST	NUMBER OF SITTING DAYS	CORONER	COURT SITTING	FINDING COMMENTS OR RECOMMEND	DATE OF FINDING
KITCHING Lauren Jay	41/02	5/7/00	2, 10-11/12/02	3	DEPUTY	Perth	Accident	20/12/02
MARTIN Marjorie	42/02	23/7/01	3-5/12/02 & 24-26/3/03	6	DEPUTY	Perth	Accident Recommendations	11/4/02
SOUTH Ashley Charles	1/03	8/9/00	14-15/1/03	2	STATE	Perth	Accident	15/1/03
WALSHAM Phillip John	2/03	28/2/98	20-24/1/03 & 31/1/03	5	STATE	CLC	Unlawful Homicide	17/4/03
TANAI Pangky	3/03	9/10/01	5-6/2/03	2	STATE	Albany	Natural Causes	7/2/03
LOOHUYS Mark Kristian Ewout	4/03	18/2/00	11-14/2/03	4	DEPUTY	Perth	Accident	7/3/03
TENBOKKEL Ryan David	5/03	10/8/01	18-20/2/03	3	STATE	Perth	Open Finding	28/3/03
CASSIDY Michael Patrick	6/03	18/3/02	28/2/03	1	STATE	Perth	Natural Causes	28/3/02
BOYLE James Hugh	7/03	2/12/01	28/2/03	1	STATE	Perth	Natural Causes	28/3/02
SLATER Evan Charles	8/03	12/3/01	18-20/2/03	3	DEPUTY	Fremantle	Suicide	7/3/03
STEEL	9/03	17/5/01	11-13/03/03	3	DEPUTY	Perth	Accident	6/6/03
UGLE	10/03	9/12/00	1-3/4/03	3	DEPUTY	Fremantle	Natural Causes	29/4/03
MITTON	11/03	29/3/02	22-24/4/03	3	STATE	Broome	Accident	24/4/03
BRAID	12/03	28/5/00	6-8/5/03	3	DEPUTY	Perth	Unlawful Homicide	23/5/03

INQUESTS COMMENCED DURING THE YEAR 1 JULY, 2002 - 30 JUNE, 2003

NAME	REGISTRY NUMBER	DATE OF DEATH	DATE OF INQUEST	NUMBER OF SITTING DAYS	CORONER	COURT SITTING	FINDING COMMENTS OR RECOMMEND	DATE OF FINDING
BRENTNALL	13/03	25/1/02	19-21/5/03	3	DEPUTY	Perth	Accident	6/6/03
HONEY	14/03	16/11/01	27-30/5/03	4	DEPUTY	Bunbury	Accident	30/5/03
HOLCROFT	15/03	19/9/01	10-11/6/03	2	DEPUTY	Fremantle	Natural Causes	20/6/03
BURNSIDE	16/03	7/11/01	26-27/6/03	2	DEPUTY	Perth	Natural Causes	18/7/03

Mr Hope 17 Inquests 52 sitting days
Ms Vicker heard 19 Inquests 49 sitting days

Total Inquests heard 36

Number of Sitting Days 101

8 Prison Deaths In Custody Heard
7 Country deaths commenced by Metropolitan Coroners

Brett Hewett; Frederick Ellis Fineberg, Shaun Brian Mackay, Justin Leigh Woods, Barry Leslie Woods, Roger Allen Clarkson, Matthew John Luberda and Kenneth Hugh Mosedale (Beech Craft Super King Air 200 VH-SKC)

The State Coroner assisted by Dominic Mulligan, counsel assisting, held an inquest into the circumstances of the deaths of Brett Hewett, Frederick Ellis Fineberg, Shaun Brian Mackay, Justin Leigh Woods, Barry Leslie Woods, Roger Allen Clarkson, Matthew John Luberda and Kenneth Hugh Mosedale. All deaths occurred on 4 or 5 September, 2000 at an unknown location between Perth, Western Australia and "Wernadinga" Station approximately 65 kilometres south east of Burketown, Queensland as a result of unknown causes, possibly either Hypobaric Hypoxia, Toxic Fume inhalation or Multiple Injuries.

On the 4 September, 2000 a Beech Super King Air 200, VH-SKC, took off from Perth at approximately 6:08pm.

According to the ATSB, who carried out an investigation into the subsequent events, the plane was properly maintained and the pilot was correctly licensed and was qualified to be in command of this type of aircraft.

At about 6:32pm the pilot appeared to suffer difficulties and became unresponsive. All of the other occupants of the aircraft appeared to have become incapacitated at about the same time as the pilot.

The plane continued to climb steadily and all attempts to raise the pilot were unsuccessful. The aircraft subsequently crashed into a farm property near Burketown in Queensland.

The State Coroner found that it is possible that the occupants of the aircraft died as a result of hypobaric hypoxia, the State Coroner could not exclude the possibility that some unknown and unidentified toxic fumes caused their incapacity and death or the possibility that some or all of the occupants, although incapacitated, survived the flight and died at the time when the aircraft struck the ground as a result of multiple injuries.

The State Coroner found that there were no suspicious circumstances surrounding all deaths and that the deaths arose by way of Accident.

The State Coroner made a number of Comments on matters connected with the deaths including comments on safety issues together with a number of recommendations.

These recommendations and relevant subsequent responses include –

- That an audible warning system be fitted to pressurized aircraft to be triggered by a separate barometric switch from visual alert systems – CASA is seeking comments as to a possible new rule;
- That aircraft manufacturers should develop and publish methods for testing passenger oxygen systems – CASA has issued an Airworthiness Bulletin addressing this issue;
- That CASA should ensure the adequacy of maintenance requirements for barometric pressure switches, particularly those used to deploy passenger oxygen masks in pressurized aircraft – CASA has issued an Airworthiness bulletin in relation to this issue;
- That CASA examine the benefits to be obtained by mandating installation of aircraft recorders in general aviation aircraft used in air transport operations – CASA has not adopted this recommendation but is giving the matter further consideration following a request from the ATSB;
- That CASA consider increasing the operations classification required for operators of aircraft charter operations – CASA has advised that a revised "Classification of Operations" policy is currently being finalized;
- That the ATSB review its procedures to ensure that there can be early liaison between ATSB investigators and pathologists – There has been ongoing communication between the ATSB and Australian coroners in relation to this issue.

Basuki Iman Subroto SUMARYO

The State Coroner assisted by Sergeant Dominic Licastro held an inquest at the Karratha Court on 2-4 July, 2002 into the circumstances of the death of Basuki Iman Subroto Sumaryo (the deceased).

The deceased was a 39 year old male who died at Nickol Bay Hospital, Karratha on Friday 18 August, 2000 having been admitted on 15 August, 2000.

The inquest was held in order to examine the circumstances that led to the death, particularly in the context where the condition of the deceased was never accurately diagnosed.

A post mortem examination was conducted on 22 August, 2000 by Dr C T Cooke, Chief Forensic Pathologist. Dr Cooke determined that the medical cause of death was Staphylococcal Laryngo-tracheo-bronchitis and Pneumonia.

The deceased suffered from what was essentially a bacterial infection which was not diagnosed. The wife of the deceased had repeatedly raised the issue of bacterial infection with medical staff at the hospital.

In the light of the failure to diagnose the condition of the deceased and the fact that he died in hospital after a considerable period during which time his condition deteriorated dramatically the State Coroner found the death arose by way of Misadventure.

The State Coroner made a number of Comments on Public Health Issues in his Record of Investigation.

On the 7 August, 2002 the Acting Minister for Health advised the State Coroner that a copy of the finding had been forwarded to Dr Brian Lloyd, the Department's Deputy Director General (Health Care), for review and consideration of the State Coroner's Comments on Public Health Issues.

A response from Dr Lloyd has not been received by the State Coroner.

Guy CHESTERFIELD-EVANS

The State Coroner assisted by Sergeant Peter Harbison held an inquest at the Perth Coroners Court on 23-25 July, 2002 into the circumstances surrounding the death of Guy Chesterfield-Evans (the deceased).

On 14 April, 2001 the deceased was on a yacht with his parents and brother when the mast of the yacht came into contact with overhead power lines which carried 22,000 volts ac.

At the time the mast made contact with the power lines, the deceased was standing on the bow of the yacht holding the main forestay with his right hand and with his leg against the starboard bow rail.

The deceased received a high voltage shock which threw him from the yacht into the water and caused his death.

At the conclusion of the post mortem examination the medical cause of death was given as electrocution.

The State Coroner found that the death arose by way of Accident and made a number of recommendations and comments on safety issues.

In brief these recommendations were as follows –

1. Western Power should liaise with the Energy Safety Directorate and the Department of Planning and Infrastructure so as to ensure that all existing power line crossings over waterways which are potentially navigable to masted craft be either placed underground, or if this is not feasible in the short term, protected by suitably

marked guide wires and clear, well placed warning signs to be regularly checked and maintained;

2. It was the view of the State Coroner that signage was a safety issue in this case, and various organisations and instrumentalities involved including supply authorities, state and local government should co-operate with a view to ensure that adequate signage be put in place in and near the waterways in question;
3. The State Coroner supported proposed changes to the drafting of charts and boating guides. He further recommended that the Department for Planning and Infrastructure be appraised of significant changes in relation to power line river crossings so that those changes could be adequately and accurately reflected in charts and, where appropriate, also in brochures and pamphlets provided to the public;
4. The State Coroner recommended that Western power take steps to immediately survey all of its power lines over navigable waters. Any lines which are considered to be dangerously low should be immediately raised and there should be a program put in place to ensure that all lines are of minimum clearance over full supply level;
5. The State Coroner recommended that consideration be given to enacting legislation which would require supply authorities to either place lines underground or, where that was not practicable, to ensure that the lines are –
   - Of an adequate clearance over waterways;
   - Protected by clearly marked and regularly maintained guard wires; and
   - Identified by appropriately located warning signs.
6. That Western Power continually review procedures in place so that preventable incidents and accidents can be identified and if possible avoid in the future.

On the 31 July, 2002 copies of the State Coroner's Findings were sent to the Minister for Consumer and Employment Protection and the Minister for Planning and Infrastructure.

The Minister for Consumer and Employment Protection advised the State Coroner that it was the Government's intention to promptly progress the improvements suggested in a practical manner. The Minister further advised that the remedial work could take up to 2 years to complete but, in any event, the measures to bring about the remedial work would be progressed as quickly as possible.

The Chief of Staff for the Office of the Minister for Planning and Infrastructure advised the State Coroner that the Department had already initiated the following –

- The Department was liaising with both Western power and the Office of Energy in respect of the arrangements of power distribution lines over inland navigable waterways;
- The Department is reviewing its current policies for the provision and maintenance of safety signage within departmental areas to ensure that such signage is adequate, appropriate and remains fit for the intended purpose. This review will include a consideration of introducing warning signs on buoys or channel markers as required;
- The cartography section of the Department had commenced a review of local charts and once clearance heights are available from Western Power, would ensure adequate warnings and safety information are provided on future local charts and boating brochures/pamphlets as appropriate.

Mohammed Yousef SALEH

The State Coroner assisted by Mrs Sarah Linton held an inquest into the circumstances of the death of Mohammed Yousef Saleh (the deceased) at the Port Hedland Court House on 27 August, 2002 and Perth Coroners Court on 29 August, 2002. The State Coroner found that death occurred on 23 June, 2001 at Hollywood Private Hospital, Monash Avenue, Nedlands as a result of Gastro-intestinal Haemorrhage due to penetration of Aorta by Mediastinal Abscess.

The deceased was a 41 year old Palestinian man who had arrived in Australia on an Indonesian vessel illegally. He was initially detained at the Port Hedland Detention Centre until 5 April, 2001 when he had been admitted at the Hollywood Private Hospital. At the time of his death the deceased was detained under the *Migration Act 1958* (Cth) as an unlawful non-citizen as defined in section 14(1) of that Act.

The State Coroner found that while at the Port Hedland Detention Centre the deceased received regular treatment from nursing and medical professionals until he was transferred to the Hollywood Hospital in Perth for expert psychiatric treatment of his condition.

As a result of tests which had been conducted at the Port Hedland Detention Centre it was discovered that he had a gastro-intestinal stromal tumour.

The State Coroner found that the deceased received medical treatment of the highest quality. Although the State Coroner was satisfied that the medical procedures were carried out in a professional and competent manner it was as a consequence of those procedures that the death resulted and in those circumstances found that the death arose by way of Misadventure.

A number of comments on matters connected with the death were made by the State Coroner

The State Coroner observed that documentation provided by the Department of Immigration and Multicultural and Indigenous Affairs (DIMIA) was deficient and the Department was not able to provide any information as to whether or not the deceased had been placed in confinement while at the detention center.

On 17 October, 2002 the Assistant Secretary, DIMIA, forwarded a file to the Coroner's Court, said to be a file described as missing at the time of the inquest.

That file did not contain relevant information about the deceased's detention and did not indicate whether or not he had been placed in confinement. Further documentation was also provided relating to detention of detainees placed in confinement but those documents did not identify detainees involved. The record keeping of the department relating to detainees and in particular to the deceased appears to have been very poor.

Lauren Jay KITCHING

The Deputy State Coroner assisted by Mrs Sarah Linton held an inquest at the Perth Coroners Court on 2 and 10-11 December, 2002 into the circumstances surrounding the death of Lauren Jay Kitching (the deceased).

On 4 July, 2000 the deceased, who was aged 5 years, and her sister were taken by their mother to participate in the Shire of East Pilbara's Holiday Program. The mother of the deceased understood the children were to roller skate and did not put her mind to the other activites for that day.

After roller skating the children participated in go kart (called Fun Kart) activity conducted at the nearby netball courts. The groups were separated to ensure appropriate supervision but this also prevented later groups from observing the previous groups.

The deceased was asked if she was confident to drive by herself and she stated she was. The Deputy State Coroner, however, found that due to her young age and inexperience she was unable to control the Fun Kart and, as a result, collided with the back of a utility motor vehicle. She received head and neck injuries which were sustained as a result of colliding with the lowered tail gate and the tow ball of the vehicle. Despite urgent medical attention the injuries sustained were fatal.

The Deputy State Coroner found that the death arose by way of Accident.

On the 23 December, 2002 recommendations made by the Deputy State Coroner were provided to the Minister for police and Emergency Services and the Minister for Education and Training.

On 5 March, 2003 the Minister for Police and Emergency Services responded advising that a suitable no risk replacement program has been identified and commenced.

Nurjan HUSSEINI and Fatimeh HUSSEINI

The State Coroner assisted by Mr Dominic Mulligan held an inquest into the circumstances of the deaths of Nurjan Husseini and Fatimeh Husseini at the Fremantle Court House on 4-8 November, 2002 and found that both women died as a result of Immersion 24 nautical miles from any portion of Australian Territory on 8 November, 2001.

Both women came from Afghanistan and had not learned to swim. They were forced into the water as a result of the vessel on which they were traveling to Australia, the Sumber Lestari, having caught fire. The State Coroner found that while it would appear that the fire on the vessel may have been deliberately lit, neither woman had any part in lighting the fire and both were innocent victims.

Indonesian crew members on the Sumber Lestari had provided both women with deficient life jackets, there were no life rafts on the boat and the crew did nothing to assist after the fire started.

On 8 November, 2001 Australian Customs Service Vessel ACV Arnhem Bay, intercepted the Sumber Lestari on its voyage to Australia and the Commander used a loud hailer to request it to heave to so a warning notice could be issued. There was no change in the vessel's course or speed so the commander of the ACV Arnhem Bay directed that a boarding party go by tender to the Sumber Lestari.

A warning notice was handed to a person on board the Sumber Lestari advising that it was an offence to bring persons illegally into Australia and that the vessel should turn back.

Shortly afterwards the ACV Arnhem Bay was joined by the HMAS Woollongong.

A boarding party was then sent to the Sumber Lestari from the HMAS Woollongong but when they reached the vessel an explosion took place and it burst into flames.

Occupants of the Sumber Lestari jumped in the ocean and both the Arnhem Bay and the Woollongong launched tenders to uplift the survivors. Within a period of approximately 30 minutes all 164 persons who had been on board the Sumber Lestari were recovered.

The State Coroner found that the bodies of the two deceased persons were recovered relatively shortly after their deaths and every effort was made to resuscitate them by Naval and Customs Officers.

Evidence was given by the family members who were clearly mislead as to the condition of the vessel on which they were to travel to Australia. In fact the boat was leaking from the outset, there was not enough food and no bedding. Family members told the Court that they would never have attempted the terrifying and disastrous voyage in question had they been accurately informed as to the likelihood that they would be detained and sent back to Afghanistan if intercepted.

While there was a body of evidence which suggested that the fire was deliberately lit, whether or not the fire was intended to ignite diesel stored on the vessel (which happened) was another question which could not be determined on the available evidence.

At the conclusion of the evidence the State Coroner found that in all the circumstances it was possible that the deaths arose by way

of unlawful homicide or by way of accident and made an Open Finding as to how the deaths arose.

The State Coroner made a number of safety recommendations directed to both the Australian Customs Services and the Australian Navy, most of which have already been acted upon.

Phillip John WALSHAM

The State Coroner assisted by Mrs Sarah Linton held an inquest at the Central Law Courts on 20-24 January, 2003 and 31 January, 2003 into the circumstances surrounding the death of Phillip John Walsham (the deceased) whose death occurred on 28 February, 1998 at the Mitchell Freeway, Stirling Railway Station, Stirling as a result of Multiple Injuries.

The State Coroner held the inquest in order to determine the circumstances of the unnecessary death of the deceased. In the intervening period from 1998 a number of police investigations had been conducted and police held suspicions of the involvement of four males who were present at an earlier assault on the deceased. Evidence was heard to determine whether they were involved in his subsequent death.

The State Coroner found that a very ugly incident took place in the vicinity of the Stirling Bridge on the evening of 28 February, 1998 involving the four suspects.

Metal tyre levers had been secreted in the boot of the motor vehicle occupied by the four young men and subsequently two of these were removed from the boot to be used in the pursuit of two persons attempting to escape the four persons.

Two of those persons then kicked the deceased in the face as he sat minding his own business on a seat.

The State Coroner found that the deceased was later seen falling from the Stirling Bridge and some minutes later an ambulance

was called. The time between the two assaults on the deceased appears to have been less than 15 minutes.

Having examined the evidence the State Coroner considered it likely that the deceased was assaulted with a tyre lever or similar instrument prior to his falling from the bridge.

The State Coroner was satisfied that all four suspects had made numerous false statements to the police and the court.

The State Coroner determined that the only reasonable conclusion which was open to him was that those four persons were responsible for striking the deceased with a tyre lever and for pushing or throwing the deceased from the footbridge and causing his death although it was not possible on the evidence available to him to determine individual responsibility for particular acts.

Ryan David TENBOKKEL

The State Coroner assisted by Mrs Sarah Linton held an inquest at the Perth Coroners Court on 18-20 February, 2003 into the circumstances surrounding the death of Ryan David Tenbokkel (the deceased) who died on 10 August, 2001 at Dawson Avenue, Forrestfield as a result of Multiple Injuries.

The deceased was a 19 year old male who was a passenger in a 8 cylinder HJ Holden Sedan being driven by its owner Michael Roy Jefferson. They had been at the High Wycombe Hotel and were following a Toyota Utility being driven by a friend.

Evidence at the crash scene clearly indicated that the vehicle in which the deceased was travelling had travelled onto its incorrect side of the road and struck a Holden VK Commodore traveling in the opposite direction with such force that the Commodore was pushed backwards in the opposite direction to its direction of travel, the HJ Holden Sedan continued across the road, went over the kerb and collided with a tree a short distance from the roadway.

The deceased died at the scene of the crash.

The State Coroner found that the loss of control of the vehicle which lead to the crash was caused by excessive speed.

The State Coroner found in the circumstances it would not be appropriate to determine whether the death arose by way of Unlawful Homicide and accordingly made an Open Finding as to how the death arose and referred the matter to the Director of Public Prosecution and the Commissioner of Police.

The State Coroner expressed the view that the quality of the police investigation in this case was poor in that –

- Photographs of the crash scene were inadequate;
- Photographs of the vehicles involved in the crash were inadequate;
- No sample of the driver's blood was taken for analysis.

The State Coroner recommended that –

- The Major Crash Investigation Section review procedures to ensure that basic steps are always taken; and
- Consideration should be given to legislative amendment to permit police to obtain a sample of blood for testing from each driver involved in a fatal crash.

At this time these recommendations have not been adopted by the Police Service.

Amanda Helen BRAID

The Deputy State Coroner assisted by Sergeant Peter Harbison held an inquest at the Perth Coroners Court on 6-8 May, 2003 into the circumstances surrounding the death of Amanda Helen Braid (the deceased) whose death occurred on 28 May, 2000 at Royal Perth Hospital as a result of Head Injury.

The deceased was 29 years old and on the morning of 21 May, 2000 was a passenger in the front seat of her motor vehicle which was being driven by another person.

The vehicle was a Toyota Corolla Sedan traveling on the Goomalling Road towards Toodyay on its return to Perth. The vehicle was being driven at speed on a sweeping down hill left-hand bend when the passenger-side wheels of the vehicle veered onto the gravel verge causing a loss of control which caused the vehicle to slide slideways across the road where it collided with a tree and rolled over.

The driver of the motor vehicle was convicted of dangerous driving causing death in respect of the death in the Perth District Court on 15 May, 2002.

The Deputy State Coroner found that the death arose by way of Unlawful Homicide.

At the inquest concerns were raised as to the ability of the public health system to treat the injuries of the deceased in the circumstances and in particular as to the ability of the Northam Regional Hospital to provide adequate trauma treatment resources.

The following recommendations were made that the Health Department of WA ensure –

(i) Adequate resourcing of the proposed helicopter retrieval system;
(ii) A system be developed along the NRTAC template for the workable care of trauma patients in the state including –
Protocols for transfer by different modes of transport covering appropriate documentation for advice, personnel, communication, care and priorities.
(iii) The system to be developed by appropriate funding to an independent committee comprised of trauma care specialists without specific hospital affiliation.

On the 16 June, 2003 a response from the Minister for Health advised that a copy of the finding had been forwarded to Dr Brian Lloyd, the Department's Deputy Director General (Health Care), for review and consideration.

Donald Richard Everett, David Adrian Dewar, Phillip Gavin Ruland and Gavin Ashley Capes (Cessna C310R)

The State Coroner assisted by Mr Dominic Mulligan, counsel assisting, held an inquest at the Fremantle Court House on 18-29 November, 2002 and Perth Coroners Court on 23-25 July, 2002 into the circumstances surrounding the deaths of all those on board a Cessna C310R and whose deaths occurred on 26 January, 2001, 12.6 kilometres south east of Newman Airport, Newman as a result of Multiple Injuries.

The Cessna C310R aircraft which had been in the process of landing at Newman Airport in WA crashed into the ground causing the death of the pilot and three passengers on board. All four persons were members of the WA Police Service and were on duty.

An Australian Transport Safety Bureau (ATSB) investigation determined that both of the aircraft's engines had failed due to fuel starvation prior to impact with the ground. This was in spite of the fact that the investigation calculated that the aircraft probably had about 165 litres of useable fuel on board at impact. It appeared that the ancillary tanks of the aircraft were full, but that the main tanks had been emptied.

The State Coroner acknowledged the thorough and comprehensive investigation conducted by Inspector A P Flack of the Internal Investigations Unit of the WA Police Service and the reports published by the ATSB which the State Coroner considered of assistance.

At the conclusion of the evidence the State Coroner found that the primary cause of the crash related to pilot error in that the pilot

failed to switch from the main engines to the ancilliary engines after approximately 90 minutes of flight when the aircraft was cruising. This resulted in the engines failing.

The State Coroner, however, found a number of antecedent factors contributed to the crash, some of which related to the performance of the Western Australian Police Service in operating the Air Support Unit.

He found that it was particularly unsatisfactory that there should have been only one pilot operating in the country area of Western Australia, the largest police district in the world, and that pilot appears to have been chosen for reasons which did not adequately take into account safety factors.

The State Coroner found that it was not appropriate to post a Trainee Line Pilot without a Command Instrument Rating to be on his own in Karratha when he was likely to be called out to perform potentially hazardous duties.

He also found it of particular concern that issues relating to financial constraints impacted on the Air Support Unit's operations and there was inadequate regard to safety implications when this occurred.

The State Coroner found that all deaths arose by way of Accident.

The State Coroner made a number of detailed comments on safety issues relating to the Air Support Unit of the WA Police Service.

Mark Kristian Ewout LOOHUYS

The Deputy State Coroner assisted by Mrs Sarah Linton held an inquest at the Perth Coroners Court on 11-14 February, 2003 into the circumstances surrounding the death of Mark Kristian Ewout Loohuys whose death occurred on 18 February, 2000 at an area on Great Eastern Highway, Glen Forrest as a result of Head Injury.

The deceased was 22 years old and a serving member of the WA Police Service at the time of his death. Immediately prior to his death the deceased was on duty and was a passenger in a police vehicle being a Holden Commodore V8 sedan, driven by Constable Guy Grant. The vehicle was traveling under Priority 1 conditions.

Following an investigation of the crash involving the deceased, Constable Grant was charged with dangerous driving causing death pursuant to s.59(1) of the *Road Traffic Act 1974*.

Constable Grant elected to have the matter dealt with summarily. On 23 May, 2001 following a five day hearing, the charge was dismissed on the grounds that it had not been proved beyond a reasonable doubt.

The Deputy State Coroner made a number of recommendations and the Minister for Police and Emergency Services advised on 3 June, 2003 that essentially all of the recommendations were being addressed.

Donald Anthony Glynn Gard and Errol Frederick Glass

The Deputy State Coroner assisted by Sergeant Peter Harbison held an inquest at the Perth Coroners Court on 25-26 February, 2003 into the circumstances surrounding the deaths of Anthony Glynn Gard and Errol Frederick Glass on 18 January, 2001 approximately 2 kilometres north-east of the Bencubbin Townsite.

Post mortem examinations were conducted on the two men by a forensic pathologist on 22 January, 2001 and the medical causes of death were given that Anthony Glynn Gard died as a result of multiple injuries with incineration and Errol Frederick Glass died as a result of incineration.

Anthony Glynn Gard was 48 years of age and an experienced pilot with over 8,000 hours helicopter flying. He was the pilot of the helicopter which crashed.

Errol Frederick Glass was 46 years of age and was an experienced linesman with Western Power Corporation for which he had worked for approximately 18 years. He was experienced in power line inspections by use of a helicopter.

The Deputy State Coroner was satisfied that on the afternoon of 17 January, 2001 arrangements were implemented for a power line inspection of 3 phase lines in the Bencubbin area. Preston Helicopter Services were to provide a helicopter and pilot to enable Western Power Corporation inspectors to examine the lines for faults.

The inspection took place on 18 January, 2001 and the pilot, Anthony Gard, flew from Jandakot to Northam and collected two Western Power Corporation employees.

The front left passenger seat was occupied by the Work Co-ordinator for the district, Errol Glass. The rear left passenger seat was occupied by a Mr Smith who was following the course of the power line on a Western Power Corporation map.

After lunch the inspection proceeded north out of Bencubbin and the pilot flew the helicopter over the power line so it was flying in a southerly direction to the west of the power line. The inspectors observed the suspect insulator further and decided there was no problem and asked the pilot to resume the inspection flight in a northerly direction. He did this in a low south-westerly sweep intending to bank either left or right back over the power line and resume a northerly flight path on the eastern side of the power line.

In executing the low sweep the existence of a spur line running west was entirely overlooked. It was not visible against the stubble of the paddock once the helicopter was on a south-westerly bearing prior to the turn. The left skid of the helicopter became entangled in the spur line which restricted the further forward movement of the helicopter causing it to flip over and impact with the ground. The helicopter effectively exploded on

impact and at least one of the transported jerry cans appears to have contributed to the resulting fire.

Both deceased persons died at the scene of the crash. Mr Smith managed to drag himself way and attract the attention of a passer by.

The Deputy State Coroner found that the deaths arose by way of Accident.

The Deputy State Coroner made recommendation's that –

- Electricity suppliers and distributors should provide markers on wires for spur lines which would stand out;
- Helicopters required to fly at low levels should be fitted with approved Wire Strike Protection (WPS) kits; and
- There should be continued relevant training in relation to hazard identification and minimization.

The Deputy Premier responded on 13 June, 2003 advising that –

The Electricity Supply Association of Australia (ESAA) is developing a guide to address aerial inspection and patrol of overhead lines for helicopter and fixed wing aircraft. This is being done in consultation with the Civil Aviation Safety Authority (CASA) and the Australian Transport Safety Bureau (ATSB);
WPS is considered to provide limited protection for helicopters and the decision of whether to fit WPS equipment should be left to commercial users of the aerial patrol service;
The Direct of Energy Safety has been requested to prepare an appropriate Code of Practice to be a benchmark for industry practice and a basis for assessment of whether procedures and practices are unsafe.

Deaths In Custody

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

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

Inquests – Persons Under Care of a Member of the Police Service

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

In this context there were three relevant Inquests, the following is a summary of the Inquest Findings.

Stuart Davey MILNE

The State Coroner assisted by Mrs Sarah Linton held an inquest at the Perth Coroners Court on 29 October, 2002 into the circumstances surrounding the death of Stuart Davey Milne (the deceased) on 17 August, 200 at Geraldton Regional Hospital, Geraldton as a result of Methylamphetamine Toxicity.

The deceased had been arrested shortly before his death as a result of his behaving in a very strange manner and attempting to cut his genitals off, then telling police who had been called that he had a gun.

A post mortem examination was conducted on the deceased by the Chief Forensic Pathologist who in his findings noted that the toxicology analysis showed a very high level of methyalmpthetamine in the blood and liver. Analysis also detected a level of methylampthetamine and amphetamine in a plastic bag which the deceased had been holding and from which he had been drinking.

Injuries were noted around the right wrist of the deceased including two distinct, tram track line abrasions. These would have been consistent with the use of handcuffs.

Two jagged incised wounds on the left side of the penis and areas of purple coloured bruising were also noted.

The State Coroner found that the deceased was deeply disturbed, probably as a result of being sexually molested when he was a young child.

The deceased was seen behaving strangely in a private suburban property and police had been called. When police officers arrived they did not immediately apprehend the deceased as he had indicated that he had a gun.

The deceased was eventually rushed by police after which was conveyed by ambulance to the Geraldton Regional Hospital where he went into cardiac arrest and subsequently died.

The State Coroner found that there were no suspicious circumstances surrounding the death and that it was unclear as whether the deceased had intended to take his own life or whether he had taken a large quantity of methylamphetamine in order to release his inhibitions. The drugs had been consumed before his arrest.

The State Coroner made an Open Finding as to how the death arose.

The State Coroner found that the police involvement in the matter was not connected with the death and indeed had it not been for the intervention of police the deceased would not have been in hospital at the time of his cardiac arrest.

George Albert HUGHES

The State Coroner assisted by Mr Dominic Mulligan held an inquest at the Collie Court House on 30-31 October and 1 November, 2002 into the circumstances surrounding the death of George Albert Hughes on 27 July, 2001 at Throssell Street, Collie as a result of Multiple Injuries.

On 27 July, 2001 the deceased was traveling in a Holden Torana vehicle with defective lights when he was observed by police officers. He then drove at great speed into the Collie townsite in an effort to avoid apprehension. At the time the deceased was a disqualified driver driving an unsafe vehicle.

The deceased drove the motor vehicle in an unsafe manner and at great speed. The deceased was aware of the dangerous manner of his driving and he told his girlfriend to "curl up in a ball" in the rear of the vehicle.

At the time the deceased was seriously affected by alcohol and drugs and the road was wet.

All independent witnesses described the vehicle as traveling at considerable speed through Collie. As a result of the speed of the vehicle, the condition of the deceased and the state of the wet roads, the deceased lost control of the vehicle and it crashed into a tree causing his death.

The State Coroner found that although the deceased was being followed by police vehicles, none of the vehicles were in sight at the time of the crash.

The State Coroner found that the death arose by way of Accident.

The State Coroner noted that a number of breaches of the Police Urgent Duty Driving Operating Procedures had been identified during the inquest and made recommendations designed to assist control of pursuits by country police stations.

The State Coroner also noted that there had been no audio record of the radio transmissions, such a record would have assisted in resolving disputed issues in relation to the pursuit and would have helped in the timing of various events and determinations of the speed of vehicles involved and in that context recommended that the Police Service review the situation in relation to the capability of country stations to tape record radio transmissions.

Reginald Henry MILLER, Eileen Mary MILLER and Derek Ferguson UGLE

The State Coroner assisted by Sergeant Dominic Licastro held an inquest at the Perth Coroners Court on 29 October, 2002 into the circumstances surrounding the deaths of Reginald Henry Miller, Eileen Mary Miller and Derek Ferguson Ugle on 3 May, 2001 at Tonkin Highway, Martin as a result of Multiple Injuries.

On 3 May, 2001 Reginald and Eileen Miller were traveling in a southerly direction on Tonkin Highway on the correct side of the carriageway. The lights of their vehicle were illuminated and the vehicle was not exceeding the speed limit. At that stage the vehicle in which their were driving was struck by a Jeep Jerokee vehicle which was traveling in a northerly direction in the southbound lane. It was apparent that Mr Miller had no real opportunity to take evasive action taking into account the speed of the Jeep and its location on the incorrect side of the road.

The Jeep Jerokee vehicle was being driven by Derek Ugle and there were three other occupants in the vehicle. At the time of the crash Derek Ugle was attempting to evade police.

As a result of the crash Mr and Mrs Miller and Mr Ugle were all killed.

The State Coroner at the conclusion of the evidence found that the collision in this case was due to the speed and manner of driving of the deceased, Derek Ugle.

The State Coroner made an Open Finding as to how the three deaths arose.

The State Coroner was satisfied that the police had acted properly and that the driver of the police vehicle exhibited sound risk management on his own initiative in aborting the pursuit and that police actions played no part in the subsequent tragic events.

Yola Wanita PALMER

The Deputy State Coroner assisted by Mrs Sarah Linton held an inquest at the Perth Coroners Court on 25-26 November, 2002 into the circumstances surrounding the death of Yola Wanita Palmer whose death occurred on 29 December, 2001 at 7 Kennett Street, Maddington as a result of a Penetrating Wound to the Heart.

Yola Wanita Palmer (the deceased) was 45 years of age and was born in Yugoslavia. The deceased had a long history of mental illness, including previous admissions to hospital as a psychiatric patient. During a period of several days prior to her death the deceased was observed by neighbours to be behaving in an erratic manner.

On 29 December, 2001 a call was received by the Psychiatric Emergency Team (PET) from the deceased. The deceased agreed

the PET staff could arrange contact with by a local community mental health clinic staff member from the Armadale Clinic.

Subsequently two nurses from Armadale Clinic spent some time with the deceased and assessed that she needed to be transported to hospital. Police were called to assist with the transfer on a number of occasions, but a lengthy delay occurred and it was decided that as the deceased appeared to have calmed down and as it was not known when police should arrive the nurses would leave.

Some time after the two nurses left a neighbour and her partner saw the deceased standing on her front lawn and heard her shouting. Police from the Victoria Park Police Station were on patrol in the Bentley area when they received a call to attend at the Maddington address. When they arrived at the deceased's house they saw her standing on her front lawn holding a small animal. When the deceased saw the police van she ran back inside her house.

After being advised that mental health nurses would take approximately 15 minutes to arrive at the Maddington address, the police moved the van away in order to avoid agitating the deceased further.

As the police and mental health nurses approached the deceased's house they could hear the deceased screaming and shouting. The deceased was observed to be holding a large knife to her chest.

The deceased had locked herself into her house and when entry was finally achieved by police breaking open the front door, the deceased was seen to push the knife into her chest.

The Deputy State Coroner found that the on 29 December, 2001 the deceased was in a disordered mental state, possibly induced by non-compliance with her medication and cannabis intoxication. In her disordered state, the deceased was unpredictable and required treatment. As a result, the attending

police officers and the two community mental health nurses attempted to apprehend the deceased to take her to hospital for assessment and treatment. Despite their endeavours the deceased gained access to a knife and, before she could be disarmed, stabbed the knife into her heart, resulting in a fatal injury.

The Deputy State Coroner found that the death arose by way of Suicide.

The Deputy State Coroner observed that the delay in police attending to escort the deceased resulted in the situation becoming elevated, with the deceased moving to an environment where she had access to weapons and cannabis. If she had been apprehended earlier the situation would not have developed as it did. The Deputy State Coroner recommended that the police priority ranking for a Form 3 (*Mental Health Act 1996*) apprehension should be raised unless police are advised that the apprehension is not urgent.

On 5 March, 2003 the Minister for Police and Emergency Services wrote to advise that tasking priorities for police have been changed in accordance with the recommendations of the Deputy State Coroner.

Marjorie Christine MARTIN

The Deputy State Coroner assisted by Mrs Sarah Linton held an inquest at the Perth Coroners Court on 3-5 December, 2002 and 24-26 March, 2003 into the circumstances surrounding the death of Marjorie Christine Martin on 23 July, 2001 at Williams as a result of Severe Compound Head Injury.

Marjorie Christine Martin (the deceased) was 14 years of age. On the evening prior to her death the deceased spent the night at the home of a friend, together with two other friends. The next day the four girls were seen traveling to Victoria Park by train.

Later that day they attended the office of a Real Estate Agent in Victoria Park where it was discovered that a set of car keys belonging to the company owned vehicle were missing. Staff members gave chase and attempted to stop the girls from driving the vehicle away, but were unsuccessful.

At the conclusion of the evidence the Deputy State Coroner found that the deceased and three girls were driving a stolen motor vehicle on Albany Highway heading towards Narrogin. After being alerted to the presence of police the driver of the stolen vehicle pulled over and all four girls fled the scene.

When the police pursued two of the deceased's friends, the deceased and her cousin returned to the stolen vehicle. The deceased got into the driver's seat and her cousin in the front passenger seat. They evaded an attempt by a police officer to stop them and the deceased drove the stolen vehicle in a southerly direction along the Albany Highway.

Having sighted another police vehicle further down the road, it appears the deceased believed she would be pursued by police. As a result she drove the vehicle at high speeds and in an erratic manner in an attempt to escape apprehension. The young age and lack of driving experience of the deceased, in the context of the speed at which the vehicle was driven, resulted in her losing control of the vehicle. Near the town of Williams, the stolen vehicle slid from the road and became airborne, before coming to rest on its roof. As a result of head injuries sustained in the crash the deceased died at the scene.

The Deputy State Coroner found that the death arose by way of Accident.

The Deputy State Coroner recommended that the Police Service give consideration to wider distribution of stinger devices and appropriately trained operators to police stations such as the Williams Police Station where traffic duties are the predominant workload of the station.

Mark Anselo UGLE

The Deputy State Coroner assisted by Mrs Sarah Linton held an inquest at the Fremantle Court House on 1-3 April, 2003 into the circumstances surrounding the death of Mark Anselo Ugle on 9 December, 2000 at the East Perth Lockup as a result of an Acute on Chronic Myocardial Infarction.

Mark Anselo Ugle (the deceased) was 36 years of age. The deceased had a prior history of cardiac problems for which he had received treatment at both Royal Perth Hospital and Fremantle Hospitals in the years preceding his death.

The deceased was estranged from his defacto partner and had a violence restraining order against him.

At the conclusion of the evidence the Deputy State Coroner found that on Friday 9 December, 2000 the deceased was lawfully taken into police custody and could not be released on bail by any person other than a Magistrate. He was transferred from the Kwinana Lockup to Fremantle and then to East Perth Lockup where a Magistrate would be presiding on the Saturday morning.

The Deputy State Coroner observed the available lockup facilities' video footage and the deceased appeared calm and co-operative at all times. This was in accordance with the various police and fellow prisoner's assessments. He did not appear to be experiencing medical difficulties, but the Deputy State Coroner noted he was not in the habit of expressing any problem until it was at crisis point. He did exhibit an inclination to be processed and sent through to the cells at East Perth Lockup as quickly as possible, at one stage attempting to follow his escort through to the cells before he had been assessed.

The Deputy State Coroner accepted that the deceased was not held in observation for the standard period of 2 hours prior to being placed in Cell 66. The deceased was placed in Cell 66 with

two other prisoners and appears to have fallen asleep without concern.

The Deputy State Coroner found that at some stage during the early morning the deceased suffered a 'fit' of some description, and also found that the deceased appeared to those sharing a cell with him to have recovered to an extent. Neither person believed it necessary to try and alert the police guard.

At some time in proximity to the 5.30am check the deceased suffered an acute myocardial infarction which caused him to become unconscious. The deceased could not be revived and died prior to ambulance officers arriving.

The Deputy State Coroner found that the death arose by way of Natural Causes.

Inquests – Deaths In Care – Ministry of Justice

During the year 17 Inquests were conducted into the deaths of persons who died while in the custody of the Department of Justice.

It is not proposed to detail the Findings in relation to each of these Inquests in this report and in each case the Record of Investigation into the Death is publicly available, but a brief summary is as follows.

Alan Edward AUSTIN

The State Coroner assisted by Sergeant Peter Harbison held an inquest at the Perth Coroners Court on 6-7 August, 2002 into the circumstances surrounding the death of Alan Edward Austin on 25 December, 2000 at the Casuarina Prison Infirmary as a result of Pneumonia in association with Arteriosclerotic cardio-vascular disease.

Alan Edward Austin (the deceased) was a 91 year old male who was a prisoner at Casuarina Prison. As a result of his age and ill health the deceased was housed in the Prison Infirmary. The deceased's general health deteriorated and on 14 December, 2000 he was diagnosed as terminally ill.

The State Coroner found that there were no suspicious circumstances in relation the death and found that the death arose by way of Natural Causes.

Richard John BECKETT

The Deputy State Coroner assisted by Sergeant Peter Harbison held an inquest at the Perth Coroners Court on 14 September, 2002 into the circumstances surrounding the death of Richard John Beckett who died on 21 May, 2001 in bushland near the

perimeter of Karnet Prison Farm as a result of Ligature Compression of the Neck (Hanging).

Richard John Beckett (the deceased) was a 39 year old male and at the time of his death was a sentenced prisoner for offences of aggravated stalking. He was a diagnosed paranoid schizophrenic and some of his delusional belief systems were responsible for the offences for which he was imprisoned.

On 7 February 2001 after sentencing the deceased was placed in a Crisis Care Unit at Casuarina Prison. On 8 February, 2001 he was assessed by the Prisoner at Risk Assessment Group and at that stage maintained in the Crisis Care Unit with constant observations and referral to the Forensic Case Management Team. On 9 February, 2001 he presented as being a "low risk" of self-harm. The deceased wished to be placed in mainstream and sent to Karnet Prison Farm.

The deceasee exhibited no management problems while at Casuarina Prison and was recommended for transfer to Karnet Prison Farm on 19 March, 2001. On receipt at the Karnet Prison Farm he was immediately assessed for his medical status and appropriate management.

The Deputy State Coroner found that nothing of significance appeared to happen to the deceased in the time leading up to his disappearance and subsequent death other than the receipt of a telephone call on 20 May, 2001.

The last muster of the day failed to locate the deceased and escape procedures were put into place. The deceased was located on 21 May, 2001.

The Deputy State Coroner found that the deceased at some stage during the evening of 20 May, 2001 or early the next day, had determined he would hang himself with the intention of taking his life. He fashioned a ligature and obtained what appears to be a collapsed trolley from a scrap heap to assist him in this course of action.

The Deputy State Coroner found that death arose by way of Suicide.

In comments on the quality of the supervision, treatment and care of the deceased the Deputy State Coroner commented on the tension between the health system and the prison system as to the appropriate placement of sentenced prisoners with established mental illness.

The Deputy State Coroner concluded, however, that in the case of the deceased there did not appear to have been any prior indication communicated to anyone in authority he needed to be taken into a safe environment, whether in Casuarina Prison or Graylands Hospital.

Mervyn Richard YAPPO

The Deputy State Coroner assisted by Sergeant Peter Harbison held an inquest at the Perth Coroners Court on 10 September, 2002 into the circumstances surrounding the death of Mervyn Richard Yappo who died on 4 april, 2001 in the Intensive Care Unit at Fremantle Hospital, Fremantle and whose death was consistent with Multiple Organ Failure following Progressive Advanced Liver Disease.

Mervyn Richard Yappo (the deceased) was 34 years of age. At the time of his death he was both on remand and serving a sentence after having his parole breached. At the time of his death the deceased was housed at Hakea Prison before being transferred to Fremantle Hospital.

The deceased was identified as testing positive to the hepatitis B surface antigens as early as 1988. In 1999 he was known to be hepatitis B core and antibody and antigen positive and had chronic Hepatitis from that time. He was also know to abuse alcohol.

During his time in custody he was regularly reviewed in relation to his liver function. He was medicated as suggested by various consultants.

His progress and deterioration were as expected for the progress of his liver disease and the manner of his death was in accordance with diagnoses which had been made.

The Deputy State Coroner found that death arose by way of Natural Causes.

Pangky TANADI

The State Coroner assisted by Sergeant Dominic Licastro held an inquest at the Albany Court House on 15-6 February, 2003 into the circumstances surrounding the death of Pangky Tanadi who died on 9 October, 2001 at Pardelup Prison Farm as a result of Ischaemic Heart Disease.

Pangky Tanadi (the deceased) was a 54 year old male and was a sentenced prisoner serving his term at the Pardelup Prison Farm. The deceased was a citizen of Indonesia who arrived in Australia in 1998 and was arrested on that day in relation to offences of drug importation. The deceased was sentenced to a period of 10 years imprisonment.

At the time of his death the deceased had served approximately 3 years and was rated as a minimum security prisoner. He was working as a cleaner in the Pardelup Prison Farm. His cleaning duties were classified as very light work.

At the conclusion of the evidence the State Coroner found that the deceased throughout his period of imprisonment was known to have suffered from significant heart disease and while the timing of his collapse and death was unexpected, the eventual outcome was of no surprise.

The deceased was appropriately referred for assessment and received continual medical treatment and review.

The State Coroner found the quality of supervision, treatment and care provided to the deceased was of a high quality and there was nothing about his imprisonment which contributed to his death.

The State Coroner found that the death arose by way of Natural Causes.

The State Coroner commented that after the deceased's collapse it took almost 30 minutes for ambulance officers to arrive with a defibrillator and recommended that the Department of Justice give consideration to providing defibrillators to all prisons with fairly high muster levels.

The State Coroner also recommended that the Department of Justice ensure that prisons which do not have health professionals always available, at least have available a prison officer trained to use an oxy viva device and that consideration be given to training prison officers in the use of defibrillators so that there would always be someone on duty capable of using one in an emergency situation.

The Department of Justice has since advised –

- The Department supports the provision of defibrillators to all public prisons and is currently in the process of identifying the appropriate model to purchase;
- The Department will address provision of support training in 2003 and proposes to use oxy ports with air viva devices which regulate the amount of oxygen administered and which are simple to use.

James Hugh BOYLE

The State Coroner assisted by Sergeant Dominic Licastro held an inquest at the Perth Coroners Court on 28 February, 2003 into

the circumstances surrounding the death of James Hugh Boyle who died on 2 December, 2001 at Royal Perth Hospital as a result of Mengingitis and Penumonia in a man with surgically treated Laryngeal Carcinoma.

James Hugh Boyle (the deceased) was a 64 year old male sentenced prisoner.

On 2 August, 2000 the deceased presented with a sore throat and cough. Various treatments were attempted without success and a test on 23 January, 2001 revealed a Squamous Cell Carcinoma (throat cancer). He underwent throat surgery at Royal Perth Hospital on 13 March, 2001. Following surgery the deceased was given a course of radiotherapty to the throat. He suffered some side affects from this treatment and further complications lead to his admittance to Royal Perth Hospital on three occasions.

The deceased developed pneumonia in August, 2001 and was treated at Fremantle Hospital. In addition he experienced further complications as a result of not complying with medical instructions.

On 29 October, 2001 the deceased developed a severe chest infection and was admitted to Royal Perth Hospital. He collapsed on 14 November, 2001. The condition of the deceased continued to deteriorate and on 2 December, 2001 he died.

The State Coroner found that death arose by way of Natural Causes.

Evan Charles SLATER

The Deputy State Coroner assisted by Sergeant Peter Harbison held an inquest at the Fremantle Court House on 18-20 February, 2003 into the circumstances surrounding the death of Evan Charles Slater whose death occurred on 12 March, 2001 at Hakea Prison as a result of Ligature Compression of the Neck (Hanging).

Evan Charles Slater (the deceased) was a 28 years of age and at the time of his death was a remand prisoner at Hakea Prison facing charges of breaching a restraining order and assault.

On receipt into Hakea Remand Prison on 29 January, 2001 the deceased was assessed as normal. As a result of his presentation and past history of self-harm he was admitted into the At Risk Management System to be reviewed by the Prisoner at Risk Assessment Group. He was placed in a safe cell in the Crisis Care Unit for fears as to his potential for self-harm.

The Deputy State Coroner concluded that on the whole of the evidence the deceased was generally in an agitated state of mind during the days immediately prior to his death. A review of a telephone conversation with his defacto and evidence about his behaviour generally while in Unit 6 and on transfer to Unit 10 seemed to indicate he was in a very aroused state of mind about his personal life.

The Deputy State Coroner was satisfied that shortly after lockdown the deceased, on impulse, became so dissatisfied with his levels of frustration and his fears for a long period of incarceration that he deliberately fashioned a ligature from his bed sheets and suspended himself from the metal bars across his window.

The Deputy State Coroner was also satisfied that he did so with the intention of taking his life. As an experienced prisoner he would have known there would be a period of time before the night muster check.

I these circumstances the Deputy State Coroner found the death occurred by way of Suicide.

The Deputy State Coroner commented about the Forensic Case Management Team generally and a lack of follow up reviews in this case.

The Deputy State Coroner also expresses surprise about obvious hanging points in the cell in what was a relatively new cell and recommended that the ongoing review of window treatments in prison cells be expedited.

The Department of Justice has subsequently responded to the recommendations advising that procedures have been put in place to ensure that in future follow up reviews take place when recommended by a Forensic Case Management Team professional.

The Department's response to the Deputy State Coroner's concern about hanging points indicated that the first phase of a project to audit standard cell accommodation is in progress and that two other phases are planned which will ultimately lead to a prioritized list of required modifications with an assessment of the costs of those modifications.

This response from the Department of Justice is disappointing almost 12 years after the Royal Commission into Aboriginal Death in Custody recommendations were delivered highlighting this issue and after other states, such as Victoria, have addressed the relevant recommendations in detail.

Gary John HOLCROFT (aka Williams)

The Deputy State Coroner assisted by Sergeant Peter Harbison held an inquest at the Fremantle Court House on 10-11 June, 2003 into the circumstances surrounding the death of Gary John Holcroft who died on 19 September, 2001 at Casuarina Prison Complext as a result of Hypertrophic Cardiomyopathy.

Gary John Holcroft (the deceased) was 30 years of age and at the time of his death was a sentenced prisoner in the Casuarina Prison Complex.

The deceased is recorded throughout his prison medical files as having had a heart murmur since he was a child. It was not medicated nor did it appear to cause the deceased any particular

problems. When in the community he did appear to suffer serious substance abuse which was dealt with on his returns to custody.

A post mortem examination was performed on 21 September, 2001 by a forensic pathologist at the PathCentre who noted that the deceased had a markedly enlarged heart with an aortic valvular stenosis. This indicated the supply of blood to the rest of his body was restricted. The pathologist also noted epicardial petechial haemorrhages which could have been caused by vigorous resuscitation and there was also evidence of atheromatous change in the pulmonary arterial system. His lungs were heavy, congested and there was possible aspiration.

After further investigation the cause of death given by the forensic pathologist was Hypertrophic Cardiomyopathy.

The Deputy State Coroner was satisfied that the deceased had made no complaint of any health difficulties. He had attended work in the vegetable preparation area and returned to the unit. The deceased then retired to his room to watch television and subsequently became unconscious. Upon being found resuscitation attempts were immediately undertaken by hospital officers who were trained nurses and were present in the unit.

The Deputy State Coroner found that death arose by way of Natural Causes.

The following chart details cases of deaths in care where the deceased was either in prison custody or there was police involvement from 1 July, 2002 to 30 June, 2003

Date of Death	Name of Deceased	Police/ Prison Custody	Place of Death	Medical Cause of Death
11/7/02	GREEN Dylan Robert	Prison	Hakea Prison	Ligature Compression of the Neck (Hanging)
23/8/02	TAYLOR Louis Bernard	Police	Inglewood	Stabbed himself in police presence
3/9/02	WILLIAMS Thane Anthony	Police	Kalgoorlie	Conveyed home by police after scuffle in pub
12/9/02	JUMBURRA Lionel Paul	Police	Broome	Ligature Compression of the Neck (Hanging) after police conveyed him for loitering
24/11/02	WARE Marileen	Home Detention	Perth	Natural Causes
24/11/02	WEBSTER William Hoani	Police	Port Beach North Fremantle	Chest Injury
12/12/02	FLOWERS Larence Brian	RPH	Prison	Cardiac Arrest
21/12/02	DODD Austin Edward	Prison	Casuarina Prison Infirmary	Natural Causes
22/12/02	YAMERA Wesley Russell	Police	Fitzroy Crossing	Head Injury
31/1/03	GROOTHEDE Jan Hendrik	Prison	Hakea Prison	Ligature Compression of the Neck (Hanging)
1/3/03	KEEN Donald Leonard	Prison	Hakea Prison	Ligature Compression of the Neck (Hanging)
5/4/03	GARLETT Damien George	Prison	Hakea Prison	Ligature Compression of the Neck (Hanging)
6/4/03	WINGO Veronica	Police Lockup	Geraldton Police Station	
6/5/03	GAMBLE Charles Raymond	AIMS	Rear of Van	Ligature Compression of the Neck (Hanging)
17/5/03	HERRICK Michael John	Prison	Acacia Prison/Sir Charles Gairdner	Severe Liver Failure

Deaths Referred to the Coroners Court
1 July 2002 – 30 June 2003

A total of 1,897 deaths were referred to the coronial system during the year.

Of these deaths, in 505 cases death certificates were ultimately issued by doctors. In many cases there were initial problems experienced in locating a treating doctor or a treating doctor had initial reservations about signing a certificate which were ultimately resolved.

In the Perth area there were 993 Coroner's cases and in the country regions there were 399 Coroner's cases.

Coroner's cases are 'reportable deaths' as defined in section 3 of the *Coroners Act 1996*. In every Coroner's case the body is in the possession of the Coroner until released for burial or cremation. In all Coroner's cases an investigation takes place and either on the basis of that investigation or following an Inquest subsequent to the investigation, a Coroner completes Findings as to the identity of the deceased, how the death occurred and the cause of death.

Statistics relating to the manner and cause of deaths referred to the Coroner for investigation are detailed below. In a number of cases a Finding by a Coroner had not been made at the time of compilation of the statistics, but an apparent manner and cause of death has been provisionally determined from the circumstances in which the body was found and from other information available.

Deaths referred to a Coroner for investigation for the Metropolitan area

1 July, 2002 - 30 June, 2003

Natural		500
Suicides		190
Accidents		136
Traffic		91
Homicide		39
Open		7
Misadventure		2
Inconclusive		19
No Post Mortem Examination		7
Subsequent referral to Coroner		2
	TOTAL	**993**

Deaths referred to a Coroner for investigation for the Country area

1 July, 2002 - 30 June, 2003

Natural		166
Suicides		80
Accidents		51
Traffic		70
Homicide		13
Open		2
Inconclusive		17
Misadventure		0
	TOTAL	**399**