Office of the State Coroner

Annual Report

2003 – 2004

State Coroner Western Australia

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30th June, 2004

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, 2004.

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

Yours sincerely

Alastair Hope
STATE CORONER

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State Coroner's Overview

During the year 2003-2004 there were a number of external events which had considerable impact on the State's coronial system.

Of particular significance was the move from the Gain Pool Building to the May Holman Centre by way of the Hyatt Centre.

On 29 September, 2003 as a result of the finalisation of the lease agreement which the Department of Justice had previously held in respect to floors 9 and 10 of the Grain Pool Building, the Coroner's Court was required to leave that building. Accommodation at the Grain Pool Building had included a Courtroom together with offices for coroners and staff, registry facilities, exhibit storage, viewing rooms and waiting areas for family members wishing to view files etc. The Coroner's Court was temporarily housed at the Hyatt Centre, in premises previously occupied by the Guardianship Board, until on 19 January, 2004 the Coroner's Court moved to the May Holman Centre. At the May Holman Centre the Coroner's Court was provided with a reception area, office facilities, registry facilities etc on the 13th floor of the building and a dedicated courtroom on the 10th floor of the building.

Prior to the moves considerable planning was necessary, particularly in respect to the permanent move to the May Holman Centre where significant changes and upgrading of the accommodation was required, especially in respect of the structure of the new courtroom.

I wish to express my thanks to all staff of the Coroner's Court and the Department of Justice who worked extremely hard to effect the transfers with a minimum of disruption. Clearly two moves within one year, involving movement of all active files, and ultimately movement or replacement of office furniture etc involved a great amount of work.

At the time of writing it is also important to recognise that Mr Glenn Spivey, the former Manager of the Coroner's Court, retired from the Public Service on 12 August, 2004. Mr Spivey worked with the Department of Justice since 1961 and has been a great contributor to the Coroner's Court over the years.

Particularly at the time when the *Coroner's Act 1996* was to be implemented, Mr Spivey's considerable experience and wisdom was invaluable.

During the year a review was conducted of the Coronial Counselling Service by Mr John Merrick, himself a senior coronial counsellor, at that time working for the New South Wales State Coroner.

In a report which was finalized in July, 2004 Mr Merrick made a number of recommendations in respect of the Counselling Service. Those recommendations have been referred to Mr Joe Calleja, Director Court Support Services, who is working to assist the Coroner's Court in reviewing those recommendations and implementation of those which are supported.

At the Australasian Coroner's Society Inc Annual Conference which was held in Darwin on 20-23 September, 2004, I was appointed as President of the Society. That appointment was made in recognition of the fact that a decision had been made that the next conference of the Australasian Coroner's Society is to be held in Perth on 16-18 November, 2005. Arrangements are already being put in place for hosting the conference, the proposed site of the conference is the Duxton Hotel Perth.

While topics for consideration at the conference are still subject to review, a main topic for the conference will be indigenous health. It is also likely that in the light of the recent Tsunami tragedy, coronial issues relating to body identification etc will form part of the agenda for the conference.

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 2003 - 30 June 2004 a total of 2,092 deaths were referred to the Coroners Court. In 484 cases a death certificate was issued at an early stage and the body was not taken to the mortuary. Of the remaining 1,608 cases, a total of 152 objections were made to the conducting of a post mortem examination. In 4 cases there was a first referral to the Coroner after burial.

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 2003 - 31 December, 2003

	Jul	Aug	Sept	Oct	Nov	Dec	*Total*
Death Certificate issued although the body was admitted to the Mortuary	**16**	**20**	**20**	**16**	**16**	**21**	**109**
Immediate post mortem ordered (usually these are homicide cases)	**1**	**2**	**3**	**1**	**0**	**5**	**12**
No objection to post mortem	**84**	**118**	**111**	**112**	**116**	**104**	**645**
Objection received by the Coroners Court	**11**	**16**	**18**	**14**	**14**	**13**	**86**
No PM conducted (Missing person or subsequent request for investigation)	**3**	**0**	**1**	**2**	**0**	**0**	**6**
TOTAL NUMBER OF DEATHS	**115**	**156**	**153**	**145**	**146**	**143**	**858**

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	**3**	**3**	**2**	**3**	**2**	**4**	**17**
Objection accepted by a Coroner and no post mortem ordered	**7**	**13**	**16**	**9**	**8**	**7**	**60**
Objection over-ruled by a Coroner*	**1**	**0**	**0**	**2**	**4**	**2**	**9**
Application to Supreme Court	**0**	**0**	**0**	**0**	**0**	**0**	**0**
TOTAL	**11**	**16**	**18**	**16**	**14**	**13**	**86**

In each case the ruling of the coroner was accepted and the objection was subsequently withdrawn

Deaths Referred to the Coroners Court from 1 January 2004 - 30 June 2004

	Jan	Feb	Mar	Apr	May	Jun	*Total*
Death Certificate issued although the body was admitted to the Mortuary	**12**	**14**	**19**	**22**	**21**	**16**	**104**
Immediate post mortem ordered (usually these are homicide cases)	**4**	**2**	**3**	**1**	**5**	**2**	**17**
No objection to post mortem	**112**	**80**	**93**	**94**	**85**	**91**	**555**
Objection received by the Coroners Court	**11**	**10**	**9**	**9**	**16**	**11**	**66**
No PM conducted (Missing person or subsequent request for investigation)	**1**	**1**	**0**	**2**	**2**	**2**	**8**
TOTAL NUMBER OF DEATHS	**140**	**107**	**124**	**128**	**129**	**122**	**750**

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	**5**	**3**	**2**	**2**	**6**	**3**	**21**
Objection accepted by a Coroner and no post mortem ordered	**3**	**6**	**7**	**6**	**8**	**8**	**38**
Objection over-ruled by a Coroner	**3**	**1**	**0**	**1**	**2**	**0**	**7**
TOTAL	**11**	**10**	**9**	**9**	**16**	**11**	**66**

Of the 7 cases when a coroner overruled an objection there were 2 appeals to the Supreme Court and in the other 5 cases the coroner's ruling was accepted and the objection was subsequently withdrawn.

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 (approximately 7.3%).

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 161 objections of which 61 were withdrawn prior to a ruling being given by a Coroner and 99 were accepted by a Coroner and no post mortem examinations were ordered. In only 1 case did a Coroner order that a post mortem examination should be conducted.

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, 2003 – 30 June, 2004

TOTAL NEW CONTACTS

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

2,698

Information			
Objection	**Coronial Procedure**	**Retention**	**File Viewing**
278	**1,762**	**153**	**108**

Counselling		
Phone	**Office**	**Home**
864	**176**	**138**

Support	
Scene Mortuary	**Court**
21	**36**

Coronial Ethics Committee

The Coronial Ethics Committee welcomed one new member to the Committee during the year.

Dr Adrian Charles currently holds the position as a consultant in the Department of Pathology, Princess Margaret and King Edwards Memorial Hospitals Perth.

The members of the Committee are as follows:

Associate Professor Jennet Harvey	*Chairperson* Department of Pathology, UWA
Reverend Michaela Tiller	*Deputy Chairperson* Executive Officer of Uniting Care, Uniting Church
Mrs Felicity Zempilas	*Secretary* Lawyer, Coroner's Office
Ms Evelyn Vicker S.M.	Deputy State Coroner
Dr Gerard Cadden	Forensic Pathologist, PathCentre
Dr Adrian Charles	Paediatric Pathologist, Princess Margaret Hospital
Ms Jan Battley	Executive Director, Holyoake
Ms Pam McKenna	Director, Palmerston
Ms Martine Pitt	Executive Director, Communicare
Mr Clive Deverall	Layman Member
Mr Jim Fitzgerald	Layman member

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
11	9	2

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 Mrs Sarah Linton as counsel assisting. Mrs Zempilas is now attached to the Coroner's Court on an ongoing basis and at present works 3 days per week.

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. 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.

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 43 Inquests were heard during the year with a total number of 132 sitting days.

The State Coroner heard 17 Inquests with a total of 71 sitting days. The Deputy State Coroner heard 22 Inquests with a total of 45 sittings days. The Carnarvon Regional Coroner heard 2 Inquests with a total of 10 sitting days. Mr Cockram SM also heard 2 matters and sat a total of 6 sitting days.

There were 11 Inquests heard which involved prison deaths In Custody and 3 deaths which had potential police involvement (only in 1 of those cases was it found that there was relevant police involvement).

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

A chart follows detailing the Inquests conducted during the year.

It should be noted that in the case of the 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 complete 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.

INQUESTS FOR THE YEAR 1 JULY, 2003 - 30 JUNE, 2004

Name	Date of Death	Date of Inquest	Court	Coroner	Finding
SADLER	25/5/02	30/6/03 1-2/7/03 23/7/03 31/7/03	Broome Kununurra Perth	State	Natural Causes Delivered 6/8/03
RICHARDSON	12/6/01	1-2/7/03	Perth	Deputy	Suicide Delivered 23/7/03
HASEEB	11/9/01	15-16/7/03	Perth	State	Natural Causes Delivered 23/7/03
CAUST	4/3/02	22/7/03	Perth	State	Suicide Delivered 24/7/03
VAUGHAN	17/2/03	22-24/7/03	Fremantle Perth	Deputy	Natural Causes Delivered 1/8/03
VASILKOV	16/3/02	29/7/03	Perth	State	Accident Delivered 29/7/03
ALTIMIRA	14/4-28/5/79	30/7/03	Perth	State	Open Finding Delivered 30/7/03
JANKOWSKI	20/2/01	8-9/7/03 16/7/03	Perth	Deputy	Misadventure Delivered 1/8/03
WAYMAN	9/5/02	6-7/8/03	Perth	Deputy	Suicide Delivered 15/8/03
WANG HAN YAN ZHAO JI LI KONG MENG (NEGO KIM)	18/11/01 18/11/01 18/11/01 18-19/11/01 4/12/01 18/11/01 18/11/01 18/11/01	19/8/03	Perth	State	Accident Delivered 27/8/03
HARTREE	22/4/02	27-28/8/03 14/10/03	Perth	State	Open Finding Delivered 15/10/03

Name	Date of Death	Date of Inquest	Court	Coroner	Finding
ACKERMANS CHAMPION	On or about 9/11/02	1-2/9/03 16-17/10/03	Esperance	State	Open Finding Delivered 17/10/03
TAYLOR	12/8/02	9/9/03	Perth	State	Adj sine die
MONSON McGEE	13/9/01 7/2/02	16-19/9/03	Perth	State	Accident Delivered 31/10/03
WARWICKER	20/3/02	21/10/03	CLC	State	Accident
SPRATT	20/9/01	21-23/10/03 11/12/03 23/3/04	Fremantle CLC	Deputy	Accident Delivered 2/4/04
RILEY	18/6/02	28-30/10/03	Bunbury	State	Suicide Delivered 7/11/03
FENTON	18/8/02	6/11/03	Perth	State	Accident Delivered 7/11/03
YAMERA	22/12/02	10-13/11/03	Broome	State	Accident Delivered 21/11/03
HATCHER	8/3/02	2-3/12/03	Fremantle	Deputy	Suicide Delivered 19/12/03
CROFT x 2	29/7/01	16/1/04	Perth	State	Unlawful Homicide Delivered 16/1/04
SHAW	16/6/99	27-29/1/04	Perth	Deputy	Natural Causes Delivered 13/2/94
GREEN	11/7/03	3-4/2/04	Perth	Deputy	Accident Delivered 27/2/04
RAMSEY	12/4/02	17-18/2/04	Perth	State	Suicide Delivered 18/2/04
NELSON	On or about 28/12/02	4/9/03	Perth	State	Suicide Delivered 2/3/04
QUARTERMAINE	28/12/02	24-26/2/0	Fremantle	State	Suicide Delivered 2/3/04
JACK	28/4/00	3/3/04	Geraldton	Deputy	Accident Delivered 11/3/04
DODD	21/12/02	16-17/3/04	Perth	State	Natural Causes Delivered 19/3/04
KEEN	1/3/03	19/3/04	Perth	Deputy	Suicide Delivered 19/3/04

Name	Date of Death	Date of Inquest	Court	Coroner	Finding
HOWARTH	15/12/02	30/3/04	Perth	Deputy	Accident Delivered 15/4/04
COOMERANG	28/2/02	1/4/04	Kununurra	State	Accident Delivered 14/4/04
JUMBURRA	12/9/02	5/4/04	Derby	State	Suicide Delivered 5/4/04
GIMME & MILNER	7/11/02 9/03	6-8/4/04	Balgo Broome	State	Suicide Delivered
LUKARIS	16/1/03	14/4/04	Perth	Deputy	Accident Delivered 3 May, 2004
DANN	22/1//02	16/4/04	Perth	State	Accident Delivered 20/4/04
CHROMIAK		20-21/4/04	Bunbury	Deputy	Suicide Delivered 30 April, 2004
EDMISTON	14/2/03	20-30/4/04	Perth	State	Misadventure Delivered 17/6/04
FLOWERS	13/12/03	4-5/5/04	Perth	Deputy	Natural Causes Delivered 21/5/04
HARRIS		3-5/5/04	Kalgoorlie	State	Accidend Delivered 5/8/04
MUCKERSIE	31/7/01	10-14/5/04	Perth	State	Adj sine die
SANDY	26/1/03	18-21/5/04	Perth	State	Accident Delivered 21/5/04
LONG	4/11/02	25-27/5/04	Perth	State	Open Finding Delivered June 2004
STALLARD x 4	20/4/03	3/6/04	Perth	State	Accident Delivered 9 June 2004
NEUMANN	1/2/03	9/6/04	Perth	State	Suicide Delivered 4 June 2004
JONES	5/6/01	15/6/04	Perth	State	Natural Causes Delivered 21 June, 2004
McNAIR x 2	27/1/03	29/6/04	Perth	State	Accident Delivered 30 June, 2004

The following is a brief summary of a number of inquest findings.

Rupert SADLER

The State Coroner assisted by Mrs Felicity Zempilas, counsel assisting, held an inquest into the circumstances of the death of Rupert Sadler (the deceased). The death occurred on 25 May, 2002 at the Intensive Care Unit, Royal Perth Hospital, Wellington Street, Perth as a result of Pneumonia complicating a Head Injury.

The deceased was a 39 year old male Aboriginal person who resided at Mirrima Reserve in Kununurra. The deceased presented to the Kununurra District Hospital on 23 May, 2002 with confusion, headaches and tiredness. A decision had been made that an urgent CT scan was required. As there were no CT scan facilities in the Kimberley region and Royal Darwin Hospital indicated that it could not accept the patient, the deceased was eventually evacuated to Perth for CT scan.

The time which elapsed from the decision that the CT scan was required until the deceased's arrival in Perth was over 14 hours. On the arrival of the deceased at Royal Perth Hospital neurosurgical opinion was that it was too late for surgical treatment and the deceased was certified life extinct at 10:00am on 25 May, 2002.

It is possible that the deceased would have survived if CT facilities had been available in the Kimberley, if he could have been admitted to Royal Darwin Hospital or if he could have been transported quickly to Perth for treatment.

The Royal Flying Doctor Service (RFDS) had been contacted but was unfortunately not able to have an aircraft immediately available in the Kimberley Region and it was not until 2:45am on 24 May, 2002 that the RFDS personnel arrived at the hospital. The aircraft left with the deceased at 4:35am but was required to refuel at Telfer. The aircraft, a Beechcraft B200 King Air Turbo Prop Aircraft, arrived at Perth at 11:16am. Flight time from Kununurra to Perth was 5 hours 58 minutes.

A flight to Darwin would have taken less than 1 hour from Kununurra.

The Medical Director of the RFDS Western Operations gave evidence in relation to the RFDS services in the Kimberley and advised that provision of a jet aircraft would improve the handling of long distance transfers and would dramatically reduce flying times (by approximately 1/3$^{rd)}$ improving response times and preventing frequent overnight stays of crews in Perth.

The State Coroner found that this case highlighted the need for a CT service in the Kimberley region.

The State Coroner made a number of Comments and recommendations on matters connected with the death.

These recommendations included –

- That the representatives of State and Federal governments and RFDS devise and implement a plan for the purchase and integration into RFDS services of a jet aircraft to be based in the north-west of Western Australia for use by the RFDS in appropriate patient transfers;
- That the Department of Health for Western Australia install a CT service at Broome District Hospital as soon as possible; and
- That formal contractual arrangements be developed and put in place between the Department of Health for WA on behalf of hospitals in the north west of Western Australia and Royal Darwin Hospital to facilitate the regular inter-hospital transfer of patients between those hospitals where required for the provision of appropriate medical treatment.

Brian RICHARDSON

The Deputy State Coroner assisted by Sergeant Peter Harbison held an inquest into the circumstances of the death of Brian Richardson (the deceased). The death occurred on 12 June, 2001 in bushland on the northern side of Welshpool Road, Carmel and was consistent with Acute Carbon Monoxide Toxicity.

The deceased was a 25 years of age male person. The deceased was diagnosed as suffering from Becker's Muscular Dystrophy when he was 15 years of age. The deceased experienced the sudden and tragic loss of his brother at the age of 16 years and his first recorded attempt at self-harm occurred when he was 19 years of age in October 1995. The deceased was diagnosed at this time suffering from an Adjustment Disorder and Poly Substance Abuse.

The next major event with respect to symptoms of the deceased's psychological status occurred on 26 July, 1996 when he was 20 years of age. In October 1996 a psychiatric registrar identified the issues for the deceased at that time as his relationship with his mother; anger about his Muscular Dystrophy and ongoing involvement with police because of his alcohol abuse.

In November 1999 the deceased married and acted as a stepfather to his wife's son. The marriage produced a child. By April 2001 the deceased's condition

had deteriorated dramatically and his wife asked him to the leave the family home until he had obtained help with his anger management issues.

The deceased admitted himself voluntarily to the Bentley Hospital on the 26 April, 2001. The deceased was discharged on 3 May, 2001 and his discharge papers were referred to the Armadale Clinic. No contact was received by the clinic from the deceased in response to a request for contact until 16 May, 2001. The deceased was re-admitted to the Bentley Hospital on 19 May, 2001 after an attempt to hang himself. On 23 May, 2001 the deceased was prescribed a different antidepressant and was provided with a referral to the Armadale Clinic for follow-up.

The Deputy State Coroner was satisfied that some time in the early morning of 12 June, 2001 the deceased decided his only course of action was to take his life. The Deputy State Coroner also concluded that the deceased made his decision after returning from the Mills Street center.

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

Alexander Nikolaevich VASILKOV

The State Coroner assisted by Sergeant Geoff Sorrell, police officer assisting, held an inquest into the circumstances of the death of Alexander Nikolaevich Vasilkov. Alexander Nikolaevich Vasilkov (the deceased) was 44 year old male who was born in Kaliningrad, Russia on 11 August, 1957. He died on 16 March, 2002 as a result of Methanol Ingestion.

At the time of his death the deceased was the Captain/Master of the merchant fishing vessel Volga which together with the MV Lena had been seized by officers of the Royal Australian Navy and the Australian Fisheries Management Authority for allegedly fishing unlawfully for Patagonian-tooth-fish in a designated Australian Fishing Zone.

The vessels had been bought to Victoria Quay in Fremantle where investigations were being conducted. The crew were considered to be "unlawful non-citizens" and were detained by the Department of Immigration, Multicultural and Indigenous Affairs under the provisions of the *Fisheries Management Act 1991 (Cth).*

As the deceased was a person who was detained at the time of his death it was considered appropriate for a public inquest to be held into the circumstances of the death although technically the deceased was not a ***"person held in care"***

for the purposes of the *Coroners Act 1996*, being detained by Commonwealth rather than State authorities.

The vessels, MV Lena and MV Volga, docked at Victoria Quay on the morning of 19 February, 2002. There were 85 persons on board the 2 vessels all of whom were detained.

Australian Correctional Management Pty Ltd (ACM) were contracted by the Department of Immigration, Multicultural and Indigenous Affairs (DIMIA) to deploy a team of detention staff to provide escort and detention services for those detained.

The day shift supervisor employed by ACM gave evidence that the morning headcount of Monday 25 February, 2002 was correct and normal routine continued until about 2:00pm when he was advised that the Captain of the MV Volga, the deceased, was unwell.

The day shift supervisor immediately went to the deceased's cabin where the deceased appeared to be in some discomfort.

The deceased was then transferred to the nearby Fremantle Hospital.

During his stay in the hospital the deceased remained unresponsive and his prognosis was extremely poor.

At 8:23pm on 16 March, 2002 the deceased suffered respiratory arrest and attempts to resuscitate him were unsuccessful.

A search conducted after the deceased had become ill revealed 12 bottles labelled "ALKOHOL 70%" on the vessel.

A post mortem examination was conducted on the deceased on 19 March, 2002 by forensic pathologist Dr K A Margolius.

Following receipt of toxicology analysis and ongoing investigations Dr Margolius formed the opinion that the cause of the death was Sequelae of Acute Methanol Ingestion.

In a brief explanation of her findings Dr Margolius noted that the ingestion of methanol causes severe brain damage and that it is a toxic substance requiring dialysis and metabolite blocking. .

Toxicology analysis conducted on 16 July, 2002 of the contents of one of the bottles labelled "ALKOHOL 70%" revealed that the contents included 11% by volume of alcohol and 39% by volume of methanol.

An earlier toxicology analysis conducted on a different bottle at Fremantle Hospital on 26 February, 2002 revealed contents of one of the methanol 68% and alcohol 14% by volume.

It is possible that the different concentrations of methanol in the bottles resulted in part from evaporation, but it is likely that the bottles did not contain consistent concentrations of the substances concerned.

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

The State Coroner made comments on matters connected with the death and they are as follows ·

1. Having reviewed the evidence relating to the detention of the deceased I am satisfied that ACM provided adequate supervision for those on board the two vessels including the deceased.

While the vessel, the MV Volga, remained at Fremantle, it was reasonable for the ACM staff to allow the occupants of the vessel a reasonable amount of privacy. It could not have been anticipated that the deceased would consume the contents of the bottle in question.

Adequate medical care was provided to those detained by Mr Fyfe who provided regular clinics for those seeking care and had made appropriate arrangements with Fremantle Hospital in the event of a clinical emergency.

2. This case has highlighted the fact that methanol is a toxic agent which is extremely dangerous if ingested.

3. In this case the labelling on the bottles in question was grossly inadequate and provided no warning of their toxic contents.

This case has highlighted the fact that great care should be taken when consuming substances packaged and purchased overseas which are not subject to packaging and labelling requirements which exist in Australia.

Richard Christopher JANKOWSKI

The Deputy State Coroner assisted by Sergeant Peter Harbison, held an inquest into the circumstances of the death of Richard Christopher Jankowski (the deceased). The death occurred on 20 February, 2001 at Royal Perth Hospital as a result of Hypoxic Brain Injury due to Respiratory Obstruction following Surgery for a Dental Abscess with Cellulitis.

The deceased was a 39 year old man who at the time of his death was married with two children. He was employed and appears to have been a happy, health, family man who rarely visited his doctor other than for minor medical ailments.

The deceased initially experienced a sore throat which progressed to a state of swelling which caused him considerable pain as a result of which he attended both his doctor and a dentist.

In the early hours of the 17 February, 2001 the deceased contacted an ambulance to take him to hospital. He was taken from Swan District Hospital to Royal Perth Hospital for emergency treatment and consented to prompt attention as a public patient.

Surgery for the draining of a dental abscess commenced at approximately 8:15am.

The process of draining the abscess passed uneventfully and he was given a standard dose of antibiotics. Shortly before noon the recovery nurse detected some difficulty with the deceased although she was unable to articulate precisely her concern. Dr Thornton, the senior anaesthetic registrar, examined the deceased and being satisfied as to his condition returned to another patient. Later Dr Thornton was recalled from surgery and realized the situation was then critical and proceeded to anaesthetize the deceased for intubation. A significant time lapsed in terms of adequate ventilation before the lack of appropriate intubation was established. An emergency was called while Dr Thronton attempted to continue intubation efforts, including her failed attempts at needle cricothyroidotomy, which did not reach any appropriate professional support and it was by chance that Dr Gross followed by Dr Edibam, appeared in recovery shortly thereafter.

A laryngeal mask airway was then used and an emergency cricothyroidotomy performed.

Despite the return of the deceased to adequate ventilation his significant hypoxia could not be reversed and he ultimately died three days later as a result of the oxygen deprivation experienced during the airway obstruction.

The Deputy State Coroner found that the death resulted from a lack of adequate immediate systems response to a recognized risk of airway compromise in a patient recovering from the type of surgery it was necessary to undertake.

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

The Deputy State Coroner made a number of detailed comments on the administration of public health and the following recommendations –

Patients who have had infection and surgery in the vicinity of their airways be –

- Monitored as to their O_2 saturation levels at all times.
- Positioned in proximity to an expired CO_2 monitor which is functioning and user friendly at all times.
- Placed in a unit with immediate access to surgical intervention if it becomes necessary

until such time as it is clinically likely the infection is under control.

On the 8 August, 2003 a copy of the finding was forwarded to the Minister for Health. On the 5 September, 2003 the Minister for Health advised that a copy of the Coroner's finding had been forwarded to Dr Brian Lloyd, the Department's Deputy Director General (Health Care), for review and consideration of the Deputy State Coroner's Recommendations.

The State Coroner has not received any response from the Department of Health with respect to the implementation of the recommendations made by the Deputy State Coroner.

Nego Kim

The State Coroner assisted by Mrs Felicity Zempilas, counsel assisting, held an inquest into the circumstances of the deaths of Xin Zeng Wang; Dee Qiang Han, Zhen Yan, Jun Ji and Dan Zhao and the suspected deaths of Yi Li, Jun Kong and Fan Jun Meng.

On the afternoon of Sunday 18 November, 2001 an explosion took place on board the Hong Kong registered bulk carrier Nego Kim which was at anchor,

approximately 15 nautical miles north of the Dampier Townsite in Western Australia.

As a result of the explosion five persons were known to have died. Also as a result of the blast a number of persons who were blown overboard had not been sighted again. Extensive searches were conducted for the missing persons as a result of which it was suspected that they had all died.

The Nego Kim was a Hong Kong flag and port of registry vessel which was built in 1985. It was a geared bulk carrier owned by Saratoga Shipping Limited.

On Saturday 17 November, 2001 the Nego Kim anchored at A4C buoy, approximately 15 nautical miles north of Dampier, to await permission to berth at the Material Offloading Facility Wharf in Dampier to load scrap iron. Over the previous period of some months the ship's crew had been engaged in progressively painting the top side ballast tanks using two different types of paint.

On the morning of Sunday 18 November, 2001 eight members of the crew commenced painting the forward port side of the tank. The crew were using marine paint and thinners in an airless spraying unit inside the tank. The tank was ventilated by means of an open ended, 19mm, compressed air hose led through a man hole from the supply at the forecastle space and a 300mm diameter electric fan set to blow air into the tank.

At about 4:30pm an explosion occurred in or within the vicinity of the forward port side tank. The Master activated the emergency alarm and called the Port Authority on the emergency channel 16 requesting assistance. It would appear that the Master was unaware that the Dampier Port Authority was closed.

The State Coroner found that all eight persons died as a direct result of the explosion and that their deaths arose by way of Accident.

The State Coroner made a number of comments in relation to safety issues and recommendations.

The State Coroner expressed concern about the decision of the Dampier Port Authority to limit the operation of the Port Control Tower Services and direct monitoring of the emergency channel.

The State Coroner also observed that the search for the missing bodies could have been more effective if datum buoys had been readily available to Dampier Police and these had been involved in the search.

Two recommendations made by the State Coroner were –

- *I recommend that immediate steps be taken to provide the Officer in Charge of Dampier Police Station with access to the location where the datum buoys are stored.*
- *I recommend that AUSSAR give consideration to the provision of 2 datum buoys to be stored in Dampier, preferably on the Volunteer Sea Search and Rescue vessel if that is practicable, for use in the event of an emergency in the region of the Dampier Port.*

On the 26 November, 2003 the State Coroner received a letter from the Minister for Police and Emergency Services who advised that datum buoys are part of a search and rescue kit owned and controlled by AUSSAR and that they are to be located at the airport and be readily available to be dropped by aircraft involved in search and rescue operations. Both the Dampier and Karratha Police Station now had ready access to the location where the datum buoys were stored.

The letter further advised that additional search and rescue kits could be made available to the Dampier Sea Search and Rescue by AUSSAR at a cost of $550.00 per kit. This would be further investigated.

Stephen Andrew HARTREE

The State Coroner assisted by Mrs Felicity Zempilas, counsel assisting, held an inquest into the circumstances of the death of Stephen Andrew Hartree (the deceased) whose death occurred on 22 April, 2002 at 227 Vincent Street, West Perth as a result of Multiple Injuries.

The deceased was a 33 year old man who suffered from mental illness for the last 16 years of his life. The deceased's mental health problems commenced when he was just over 17 years of age when he had a psychotic episode, apparently induced by his having taken marijuana, amphetamines and alcohol. The deceased received treatment for depression and severe anxiety through the WA Public Mental Health System and private psychiatric and clinic psychology services for most of his adult life.

The deceased was admitted to Royal Perth Hospital between 17-22 March, 2002. At that stage it appeared that the deceased had stopped taking his medications for some weeks and subsequently become unwell with chaotic thinking, panic attacks and several days of incoherence and apparent paranoia. The deceased walked out of Royal Perth Hospital as he felt threatened by another male patient and would not go back.

After his discharge from Royal Perth Hospital on 22 March, 2002 he was referred to the Inner City Mental Health Services, which was the appropriate service for his address in North Perth.

The State Coroner concluded that prior to the deceased's death there were a number of factors which appeared to have increased his anxiety. These factors included visits from a psychiatric support worker and the pending visit of his 8 year old daughter and her mother. In addition it appears that the deceased may have felt threatened as a result of the behaviour of a woman who had pestered him on a number of occasions shortly before his death.

Shortly before 3:00am on 22 April, 2002 the deceased fell a considerable distance at units where he was staying, but the location from which he fell was not close to his own unit.

Evidence from the occupants of other units indicated that there did not appear to have been an altercation or loud argument immediately prior to his falling. There was no eye witness evidence available as to the fall and particularly as to whether or not the deceased was alone when he fell.

The State Coroner concluded that while the deceased may have taken his own life deliberately, in part as a consequence of his depression and anxiety, other possibilities remained open. In these circumstances an Open Finding was made as to how the death arose.

The State Coroner made a number of comments:

1. *This case is one of a number of cases where family members of a person suffering from mental health problems have considered that they were inadequately informed as to his treatment and progress in circumstances where the family had an important ongoing role to play. While confidentiality issues are important in this context, it is important for family members to be involved and included in treatment plans when the patient is to be treated in the community;*

2. *This case has highlighted the importance of police officers called to a sudden death scene approaching the case as a potentially suspicious case until there is clear evidence to the contrary.*

   Unfortunately this approach was not taken in this case which appears to have limited the usefulness of the scene investigation to a significant extent.

The State Coroner received a letter from the Minister for Police and Emergency Services on 6 April, 2004 who advised that the recommendations had been adopted and were contained within the COPS Manual.

Herbertus Jacobus Franciscus ACKERMANS and Jeffrey Ross CHAMPION

The State Coroner assisted by Sergeant Geoff Sorrell held an inquest into the circumstances of the suspected deaths of Herbertus Jacobus Franciscus Ackermans and Jeffrey Ross Champion at the Esperance Courthouse on 1-2 September, 2003 and 16-17 October, 2003.

The two men departed from the Brandy Creek Boat Harbour, Esperance at approximately 5:30am on Friday 8 November, 2002 on the vessel LFBE46 Adriatic Star (Adriatic Star). The destination was a fishing camp at Wanteen, via Mundrabilla in Western Australia. The last known contact with either of the two men took place on 9 November, 2002 at approximately 8:15pm. There had been no known sighting of either of the two men since that date and portions of the vessel were sighted floating on the sea some days later. An extensive search was conducted for the two men without success.

The weather which the vessel would have experienced on 9 November, 2002 appeared to have been fairly rough with onshore wind speed variations from 30-46kph. In these circumstances the vessel may have experienced difficulties due to the prevailing sea scape.

The State Coroner concluded that the evidence available to him did not allow him to determine the cause of the sinking of the vessel with any confidence although it appeared likely that the incident which led to the sinking was relatively sudden and unexpected and that the deceased men did not have time to take emergency action such as activating the EPIRB .

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

The State Coroner recommended that the Department of Planning and Infrastructure should give consideration to mandating the use of 406 mHz EPIRBs with hydrostatic release functions on all commercial vessels operating in Western Australian waters well before 2009.

The Minister for Planning and Infrastructure advised the State Coroner by letter dated 6 January, 2004 that the Minister had been advised that the Australian Maritime Group (AMG), whose membership comprises senior executive officers of each of the marine safety jurisdictions, is reviewing the current arrangements for marine distress and safety radio communications. This is being done as

part of the national reform process, so as to achieve a nationally uniform system for marine radio communications by mid 2005. The issue of float-free 406 mHz PIRBs had also been brought to the attention of the AMG for consideration during that process.

Noel James MONSON & Robert Stephen McGEE

The State Coroner assisted by Sergeant Peter Harbison held an inquest into the circumstances of the deaths of Noel James Monson and Robert Stephen McGee. Both men died following single vehicle collisions at suburban roundabouts. In each case the deceased was the only person involved and was the driver of a motorcycle.

Noel James Monson died on 13 September, 2001 at the intersection of Kingsway with Evandale Road/Ashdale Boulevard, Darch. He was 43 years of age

Robert Stephen McGee died on 7 February, 2002 at the intersection of Chisham Avenue, and Tanson Road Parmelia. He was 23 years of age.

Each of the deceased men died of multiple injuries after colliding into a small limestone wall built around a central circular section within a roundabout.

Evidence was received from Road Safety Auditors commissioned by Main Roads WA whose reports focused on road environment factors which might have contributed to the crashes.

In each case the construction of the roundabout was unsafe in that there was insufficient warning of the location of the roundabout for an approaching motorist and in each case there was an unnecessary central wall which formed a potential non-frangible hazard which was especially dangerous for motorcyclists. Both roundabouts did not conform with recommendations of Austroads Part 15 and Australian Standards. In one case the only street lighting near the roundabout was not illuminated on the night of the crash and was still not repaired 15 months thereafter.

These two traffic accidents occurred in different shires within the metropolitan area of Perth, namely the City of Wanneroo and Town of Kwinana. The City of Wanneroo had considered recommendations made by the Road Safety Auditor and removed the limestone retaining wall from the central island prior to the inquest being held The Town of Kwinana had not adopted the recommendations made by the Road Safety Auditor.

The State Coroner made a number of recommendations as follows –

1. I recommend that local government authorities not install limestone walls or other non-frangible hazards on roundabouts unless there is a very clear need to do so.

This recommendation does not apply to trees or other verticle elements used to provide roundabouts with presence and visibility.

2. I also recommend that road authorities pay particular attention to the use and availability of lighting in the area of roundabouts. In this context Australian-New Zealand Standard ASNZS 1158.1.3 : 1997 Road Lighting, Part 1.3 : Vehicular Traffic (Category V) Lighting – Guide to Design, Installation, Operation and Maintenance at page 37 notes that roundabouts will normally need lighting additional to the road lighting on the approach roads.

The use of uplighting to supplement street lighting by highlighting verticle elements was considered to be one method of providing clear warning of the presence of a roundabout.

3. I recommend that the contributors to Austroads give consideration to altering the set out in their Guide documents so as to more clearly and simply identify hazards which should be avoided by local government.

In this case representatives of local government had expressed concerns that the guidelines were not easy to follow or apply.

4. In my view it would be most helpful if road safety audit reviews were prepared in respect of every fatal case as they would then provide an excellent source of information in relation to road environment hazards throughout the state.

In this case the road safety audit evidence was extremely helpful both for the purposes of the inquest and to provide guidance for local government as to action required.

5. In situations when the standard roundabout designs would not be appropriate, I recommend that road safety audits be conducted prior to construction of roundabouts to identify safety issues.

It was suggested that guidelines should identify standard roundabout designs which could be used by local government in most cases but where these do not apply expert assistance should be sought.

6. It is important that to the extent possible, roundabout design includes stand-alone safety measures.

In one of the cases a sign had been removed and in the other lighting was not working, in both cases the problem resulted in an unsafe environment – stand-alone safety measures are helpful as these are designed to avoid one problem impacting on other safety measures.

7. I recommend that lighting be treated as an important issue to be addressed in every case prior to the construction of any new roundabout.

Light problems were of major factor in both cases and according to the evidence these were not isolated incidents. It appears that often roundabouts are constructed using existing lighting which does not highlight the presence of the roundabout. Lighting issues need to be addressed as part of the planning process for every new roundabout.

The State Coroner received a letter from the Minister for Local Government and Regional Development who advised that the recommendations would be included in an article in the next edition of its "Update" magazine highlighting those


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Warning on safety of roundabouts

LOCAL Governments are encouraged to take note of recommendations on roundabouts and road safety following the release of findings by the State Coroner.

The Coroner examined the death of two motorcyclists who collided with the constructed centrepieces of suburban roundabouts.

The centrepieces consisted of a low limestone walls. In both cases the Coroner found that the deaths arose by way of accident, but he commented on the lack of visibility, both with lighting and signage.

In his report on the deaths, the Coroner made the following recommendations:

- Local governments not install limestone walls or other non-frangible hazards on roundabouts unless there is a very clear need to do so;
- Road authorities pay particular attention to the use and availability of lighting in the area of roundabouts and that the lighting conform to the appropriate standards;
- The contributors to Austroads give consideration to altering the set-out in their guide documents so as to more clearly and simply identify hazards that should be avoided by local government;
- In situations where the standard roundabout designs would not be appropriate, road safety audits be conducted before construction of roundabouts to identify safety issues; and
- Lighting be treated as an important issue to be addressed in every case before the construction of any new roundabout.

The Minister for Local Government and Regional Development has urged all local governments to take into account the recommendations of the Coroner when considering building roundabouts.

recommendations. He further advised that the "Update" magazine is circulated to all local governments and their elected members.

Morgan SPRATT

The Deputy State Coroner assisted by Mrs Felicity Zempilas, counsel assisting, held an inquest into the suspected death of the death of Morgan Spratt at the Fremantle Court House and Central Law Courts on 21-23 October, 2003 and 11 December, 2003 and 23 March, 2004.

Morgan Spratt (the deceased) was a 22 year old male aboriginal. At the time of his death his mother resided in Northam which is where the deceased also lived when he was not in Perth.

Due to the deceased's extensive mental health issues he was frequently in Perth and on the occasions he was not in custody or in a mental health facility, he usually chose to reside at the Swan Valley Nyungah Community Aboriginal Corporation in Caversham (the Lockridge Campsite). Other members of his immediate or extended family also stayed at the Lockridge Campsite from time to time.

In the last four years of the deceased's life he had 18 admissions to Graylands Hospital, many of them on an involuntary basis and often as the result of court orders for care or assessment. Where there was an option it seemed Graylands Hospital preferred to release him to his mother's care in Northam but in reality this entailed him initially going to the Lockridge Campsite before being transferred by volunteers to Northam.

Graylands Hospital diagnosed his difficulties as resulting from prolonged solvent and substance abuse from his early teenage years leading to chronic deficits of personality and intellectual and cognitive functions. It was determined he suffered organic and drug induced psychosis. As a result of his organic brain deficits he exhibited a disinhibition of aggressive behaviour from time to time which made it difficult to care for him.

The deceased was released from Hakea Prison on 4 September 2001 at 4:42pm to appear in court on 5 and 12 October 2001. He went to the Lockridge Campsite pending his court appearances. This appears to have been his choice. On other occasions his sister, Edna Bropho, indicated Morgan went to the Lockridge Campsite to be with her but on this occasion she was not at the campsite either at the time of his release or the time of his death. His decision appears to have been based on his preference at that time.

The Deputy State Coroner concluded that much of the time the deceased was at the Lockridge Campsite he was affected by substances of one sort or another. He appears to have spent most of his time with his younger cousin, Richard Bropho Junior (16 years). The Deputy State Coroner believed the pair used illicit substances or abused solvents whenever the opportunity arose.

A post mortem examination of the deceased occurred on 24 September 2001 and was undertaken by forensic pathologist Dr G A Cadden. At the conclusion of the initial investigation the cause of death given was "undetermined pending toxicological analysis".

Dr Cadden was concerned the deceased may have had an epileptiform seizure and was consequently interested to know something of the deceased's medical history. Dr Cadden became aware of the Graylands Hospital history of the deceased and the psychotic and paranoid ideation with diagnosis of organic psychosis (substance abuse) and drug induced psychosis. Dr Cadden sought information as to the possibility of further solvent abuse and whether or not there was any history of seizure activity. The original toxicological analysis did indicate levels of cannabis but not in such quantities as would have been of concern other than in the context of the deceased's reported psychotic difficulties.

It became obvious toluene was a likely concern and the toxicological analysis needed to be repeated targeting toluene on the understanding much would have been lost due to the elapse of time and the high volatility of the substance.

On 23 May 2002 the principle chemist of the forensic science laboratory, produced a report indicating the toluene levels in the deceased's blood were 9.6 mg/l. The fatal blood toluene range is 10 – 20 mg/l with a mean level of 13 mg/l.

With this additional information the cause of death was established on 30 May 2002 as Acute Toluene Toxicity.

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

Delays in the investigation of the death had allowed rumour and innuendo to flourish rather than being dispelled quickly.

The cause of death was not quickly established and by the time a cause of death was determined there was much speculation as to the events prior to his death and possibly causing his death. Six weeks after his death the *Susan Taylor Inquest* commenced and many allegations concerning the Lockridge Campsite were aired. This led to increased speculation and anxiety over the

circumstances of this death which could have been partly resolved if photographs had been taken of the scene as the police found it.

The speculation included a concern that the deceased had been bashed, a belief he was naked when he was found and an allegation of murder. Unfortunately these stories appear to have been handed from one person to another until it was not clear where the origin of the rumour arose.

The Deputy State Coroner made a number of recommendations and they are as follows -

1. *There be ongoing education of police officers as to the appropriate investigation of sudden deaths and practical implementation of the operation of the procedural requirements pertaining to scenes of death. Whether this be by targeting shift sergeants or by other means is an operational matter for the Police Commissioner.*

2. *There be ongoing education of police officers with respect to the misuse of volatile substances and their relevance as a factor in sudden deaths.*

The Protective Custody Act 2000 does give police officers wide powers which I understand they may be reluctant to use in view of concerns with the apprehension of young persons and allegations of harassment. However, if used properly should foster an understanding of an attempt to protect young persons in possession of intoxicants, or believed to be intoxicated.

3. *Western Australian Police Service, Department of Health and Department of Community Development need to ensure appropriate facilities to care for intoxicated children or young persons in need of protection need to be adequately:*

   (a) provided for, and
   (b) funded

On 13 July, 2004 by letter the Minister for police and Emergency Services, Hon. Michelle Roberts MLA, responded to the recommendations of the Deputy state Coroner. That response included the following information –

> *"...Specific learning outcomes incorporating the recommendations made by the Deputy State Coroner have been disseminated to all District Training Officers across the State. Furthermore, the Principal of the Police Academy has directed the Operational Training Faculty to amend the curriculum so as to improve all future training in matters touching upon the issues raised by the Deputy State Coroner".*

On 3 June, 2004 the Minister for Health, Hon. Jim McGinty MLA, responded to the recommendations of the Deputy State Coroner. That response included the following information in respect to recommendation 3 –

> *"I note the Coroner's reference to the Protective Custody Act 2000 that provides for the nomination of such facilities. A facility in the inner-city area that provides this service is provided by Mission Australia. The Drug and Alcohol Office also contracts a statewide network of sobering up services. These services have the potential to provide care of intoxicated children. However, they are not yet able to do so due to their physical layout and the inappropriateness of mixing adult and children populations. I have asked the Acting Executive Director of the Drug and Alcohol Office to examine the possibility of these facilities being adapted for this purpose over time".*

Roy FENTON

The State Coroner assisted by Sergeant Geoff Sorrell held an inquest into the suspected death of the death of Roy Fenton at the Perth Coroners Court on 18 August, 2002.

An inquest was held into the circumstances of the suspected death of Roy Fenton in order to determine whether it could be concluded that his death had been established beyond all reasonable doubt.

In the early hours of 18 August, 2002 the catamaran Wave Cheetah III partially sank. As a result two occupants of the vessel, Mr Fenton and Mr Haeusler, lost contact with it and Mr Fenton was never located in spite of extensive searches which were subsequently conducted.

The State Coroner found that the EPIRB which was fitted to the vessel was not activated and that although a helicopter flew overhead while Mr Fenton was possibly still alive the vessel was not seen as a result of lack of lighting.

The vessel was subsequently found to be structurally intact and it appears likely that a valve to allow water into live fish tanks must have been left slightly open and the hose which should have connected from the valve to the fish tank was not connected at the time. The starboard hull filled with water causing the vessel to partially sink and forcing the occupants into the water.

The body of Roy Fenton has not been located. The State Coroner found beyond all reasonable doubt that Mr Fenton is deceased and that his death occurred at sea in the location of North Turtle Island, northeast of Port Hedland.

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

The State Coroner made recommendations with respect to the lifejacket worn by the deceased

I recommend that consideration be given to amending Australian Standard AS1512 to require provision to be made for a source of illumination to be fitted to lifejackets; or, alternatively, the WA Department for Planning and Infrastructure mandate the use of such lifejackets for watercraft being used outside of protected waters or more than 400 metres from any shore.

A copy of the State Coroner's finding was forwarded to the Minister for Planning and Infrastructure on 17 November, 2003 seeking advice as to implementation or otherwise of the recommendations. A response has not been received.

Kiara Jasmine SHAW

The Deputy State Coroner assisted by Sergeant Peter Harbison held an inquest into the death of Kiara Jasmine Shaw at the Perth Coroners Court on 27 and 29 January, 2004.

Kiara Jasmine Shaw (the deceased) was 11 weeks of age have been born prematurely at King Edward Memorial Hospital for Women at 34 weeks gestation as the result of an induction due to difficulties with her intero-utero development.

The deceased was very frail and underweight as a result of her Rothmund-Thomson syndrome.

The deceased had no reserves with which to physiologically contend with the difficulties experienced by a normally developing healthy child. Any variation in her metabolic rate due to infection or distress was likely to have an adverse outcome on her ability to withstand infection, injury, extreme temperature variation or other physically stressing factor. Both her parents and medical advisers were aware of these difficulties and monitored her closely to try and ensure some progress.

On 10 June, 1999 it became apparent that the fight to keep her positively gaining weight was not being achieved and she was admitted to Fremantle Hospital, in an attempt to encourage her weight gain and consequently her ability to withstand stressors. Initially the deceased appeared to stabilize but

her treating doctor was still not satisfied with her progress and it was considered she should be transferred to PMH for specialist attention.

Prior to this occurring the deceased developed an infection. The Deputy State Coroner found that the deceased's immediate carers did not fully appreciate the rapidity with which the infection was progressing.

The deceased's condition deteriorated rapidly and a crisis was experienced en-route to PMH from which she did not recover despite robust resuscitation.

A post mortem examination was conducted on 21 June, 1999 by Dr C T Cooke, Chief Forensic Pathologist who in his brief summary of his findings indicated that the deceased showed poorly developed subcutaneous fat and muscle, consistent with failure to thrive. There was congestion of her lungs. There was some concern with respect to apparent healing fractures to some ribs on the left side of her chest but Dr Cooke was later satisfied these were possibly due to birth trauma and her failure to thrive.

After further investigation Dr Cooke concluded on 9 September, 1999 the cause of death was probably Septicaemia in a child with Rothmund-Thomson syndrome.

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

Paul Andrew RAMSEY

The Deputy State Coroner assisted by Sergeant Peter Harbison held an inquest into the death of Paul Andrew Ramsey at the Perth Coroners Court on 17-18 February, 2004.

Paul Andrew Ramsey (the deceased) was a 42 year old male who on 21 February, 2002 obtained employment with Kailis Brothers Pty Ltd in their seafood-processing factory at Canning Vale. The deceased was expected to perform pick up produce from the distribution warehouse and deliver it to customers on a prescheduled run. The trucks would be loaded with the first to be delivered produced (drop) pallet preloaded on a small electric forklift trolley at the rear of the truck, closest to the rear access of the truck. The last to be delivered drop would be towards the front cab of the truck. Some delivery runs would entail a full drop to only one point, other runs would involve a number of different drops.

The Deputy State Coroner was satisfied that the deceased was the sole driver and delivery operator of a truck fitted with a Tieman tailgate hoist on the

10 April, 2002. The truck had been fully loaded at the beginning of the run and a Jungheinrich EME 12 electric pallet trolley was assigned to the truck to assist in off loading produce at the various outlets. The deceased completed the deliveries without reported incident during the course of that morning and was at the final drop off shortly after 1:00pm.

The Deputy State Coroner found that the deceased was aware the expected delivery, once the first two pallets had been off loaded, was in a forward position. The Deputy State Coroner could not determine why the deceased chose to reverse the loaded trolley onto the tail hoist, but the Deputy State Coroner found that it was obvious the reverse positioning was not as safe as bringing the trolley forwards onto the tail hoist and the deceased would have known more care was required for a reverse positioning.

The Deputy State Coroner found that having brought the trolley onto the tail hoist in a reverse position the deceased fell backwards from the tail hoist onto the ground. It was an unprotected fall and the deceased landed heavily on the back of his head and shoulders.

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

Leon Russell COOMERANG

The State Coroner conducted an inquest hearing, assisted by Sergeant Geoff Sorrell, into the circumstance surrounding the death of Leon Russell Coomerang at the Kununurra Court on 4 April, 2004.

At about 7:00 pm on Thursday 28 February, 2002 Leon Russell Coomerang (the deceased) a 29 year old aboriginal male pedestrian was struck by a motor vehicle travelling in a north easterly direction on Casuarina way, Kununurra.

The State Coroner heard evidence in relation to the street lighting from a Road Safety Investigation Engineer with Main Roads WA.

It was the view of the engineer that relevant lighting in Casuarina Way did not comply with the Australian/New Zealand Standard AS/NZ 1158.0:1997 for category B1 lighting (also known as Category P4 in other standards publications). After the collision an additional 125 Watt Mercury Vapour lamp had been installed at the junction of Casuarina Way and Melaleuca Drive which had resulted in that immediate stretch of Casuarina Way being compliant with the applicable standard, but the sections of Casuarina Way south of the next light pole were still not compliant.

The State Coroner found that it was clear that the lighting on the road in question was inadequate and did not comply with Australian Standards. The road in question is a suburban road which carries traffic between distributor roads and local roads. Vehicle volumes would have included a component destined for properties not abutting Casuarina Way.

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

The State Coroner made the following recommendation –

> *I recommend that all local government bodies ensure that new roads constructed are adequately illuminated and that the illumination is at least in excess of the Australian/New Zealand Standards and that in the case of existing roads regular reviews are conducted to ensure that all relevant standards are met and effective maintenance programs are in place.*

Following the inquest the Director Capacity building, Department of Local Government and Regional Development, on behalf of the Minister, advised that the State Coroner's recommendations would be implemented at the discretion of individual local governments as there is no legislative requirement that street lighting be provided on local roads, nor supplemental funding sources available to upgrade existing infrastructure.

The letter also advised that an article would appear in the Department's quarterly "Update" magazine advising of the State Coroner's recommendation.

Cheryl Lee EDMISTON

The State Coroner assisted by Mrs Felicity Zempilas, counsel assisting, held an inquest into the circumstances surrounding the death of Cheryl Lee Edmiston (the deceased) at the Perth Coroners Court on 20-30 April, 2004.

The deceased was a 41 year old woman who went to the Joondalup Health Campus with a very minor health problem.

A number of biopsies were performed by a most inexperienced registrar, which the State Coroner found were much deeper into the bladder wall than should have been the case and that in at least one site the depth of the penetration allowed for infection to go from the bladder through into the extra-peritoneal space into the peritoneal cavity. The deceased suffered from extensive inflammation in the abdominal cavity (peritonitis) which developed over the course of the following two days.

Unfortunately although the condition of the deceased deteriorated over the day of the procedure and the early morning of the next day, it was not until the morning of 13 February, 2003 that the deceased was seen by medical practitioners.

By that stage the deceased had experienced a pain score of 8, a temperature as high as 39^0C, there had been an absence of urinary output, nausea, vomiting and an anomaly in bladder scans.

The State Coroner found that the infection had gone from the bladder through into the intraperitoneal and extraperitoneal space and by that time it would have been necessary for a laparotomy to be conducted to take out the infected fluid from the abdomen and repair the defect in the bladder at the earliest practicable opportunity.

Before the laparotomy could be conducted it was necessary for the deceased to have received intravenous fluids and antibiotics to get her into the best possible clinical condition for the laparotomy to take place.

Even before the results of the CT cystogram were known, it was clear that intravenous fluids were required as were antibiotics and these had both been ordered. Unfortunately there were significant delays in the adequate provision of both the fluids and the antibiotics.

The State Coroner found that the delay in taking aggressive action in this case was inexcusable and resulted in the death.

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

The State Coroner found that in this case a number of mistakes and omissions had been identified in respect of the three medical practitioners, namely, Dr Stephanie Chetrit, Dr Arif Valibhoy and Mr Robert Thomas, Senior Ugologist. These mistakes were of such a nature, in the State Coroner's opinion, which might lead to the Medical Board to at least inquire into the conduct of those practitioners. The State Coroner considered it appropriate to make a reference in accordance with section 50 of the *Coroners Act 1996*.

The State Coroner made three recommendations and they are as follows –

1. Better writing of Medication Charts

Although I am of the view that the problems in this case arose primarily as a result of the actions and inactions of individuals and not as a result of systemic problems, it does appear that there are, or may be, widespread deficiencies in respect of the correct writing up of Medication Charts.

It is clearly a core function of medical practitioners to prescribe medications and it is of fundamental importance that Medication Charts are correctly written up.

As indicated previously in these reasons Medication Charts should be written up to indicate when the first medications are to be given and then also written up to indicate when regular doses are to be given, specifically indicating whether there is to be a variation in the regular delivery immediately after the first dose.

> *I recommend that all hospitals in Western Australia conduct routine audits of Medication Charts to ensure that these are correctly written up and that any medical practitioners newly appointed or transferred are familiar with the particular charts in use and know how to correctly fill out those charts.*

2. *The need for a Morbity-Mortality Conference Procedure at Joondalup Health Campus*

Following their review of the practice of Mr Robert Thomas, Mr Heathcote and Mr Cleeve observed that there was no Morbity-Mortality Conference Procedure at Joondalup Health Campus and recommended –

"This should be a minimal requirement at a busy surgical hospital. It would help to identify patterns of complications and to aid in the early identification of impaired surgeons who may then benefit from available help".

In a response provided by Director of Nursing on behalf of Joondalup Health Campus (exhibit "60") it was suggested that such a Conference Procedure was not required at the hospital as Joondalup Health Campus is not a teaching hospital and the urology registrar position is not a urology teaching position. It was also stated that the hospital has in place a number of different ways in which it can monitor clinical morbity and mortality by collection of clinical indicators.

In my view even though Joondalup Health Campus may not be a "teaching hospital" it is certainly a busy surgical hospital and it does have registrars who are learning at the hospital. Dr Valibhoy in this case was such a person.

In my view a Morbity-Mortality Conference would be a helpful, possibly non-threatening or blame directed mechanism for identifying mistakes and encouraging best practice.

In the present case it would appear that Mr Thomas suffered from family problems and clinical depression and the early identification of the possibility of such problems affecting his work would have been an important benefit.

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I recommend that Joondalup Health Campus put in place a Morbity-Mortality Conference Procedure.

3. Hospital Contracts with Consultants

In this case there was a contract between Mayne Health (Joondalup Health Campus) and Mr Thomas and the terms of that contract were detailed in a letter dated 27 November, 2001 and signed on 11 December, 2001 in which the terms of Mr Thomas' reappointment were detailed.

The terms and conditions of appointment did not require Mr Thomas to advise the hospital of any medical or psychiatric conditions from which he might have been suffering, or any medications which he might have been taking, which could have affected his performance.

In the present case there was evidence that Mr Thomas had been diagnosed as suffering from clinical depression and had received anti-depressant medication. In these circumstances it is my view that that information should have been provided to the hospital which then would have been better placed to monitor his surgical performance.

In my view it is extremely important for a hospital such as Joondalup Health Campus to have sufficient information about the condition of its specialist practitioners to be able to ensure that patients receive high quality treatment.

I recommend that in future contracts entered into by hospitals in Western Australia with consultants and other medical practitioners the terms and conditions of appointment specifically require the provision of information as to any medical condition, including any psychiatric diagnosis, which could be relevant to the performance of that practitioner. The terms and conditions should also require provision of information about any medication, such as anti-depressant medication, which could impact on the ability of a practitioner in question.

Paul John LONG

The Deputy State Coroner assisted by Sergeant Peter Harbison held an inquest into the circumstances surrounding the death of Paul John Long at the Perth Coroners Court on 25-26 May, 2004.

Paul John Long (the deceased) was 37 years of age, divorced and had two children with whom he had no contact. The deceased was a diagnosed schizophrenic and had a significant alcohol dependency.

On the 27 May 2002 the deceased was assessed by a psychiatric registrar with prior knowledge of him and his history. The immediate concern was accommodation as he was homeless and destitute. A senior social worker for Avro Clinic rang and arranged immediate accommodation for the deceased at St Bartholomew's House Inc (St Bartholomew's) in East Perth.

The deceased was popular with staff at St Bartholomew's and he was offered a cleaning job. This addition income supplemented his pension. However, his desire for alcohol soon consumed his extra funds. The deceased's persistent intoxication during this time caused both staff and residents problems at St Bartholomew's.

The Deputy State Coroner found that the deceased was able to mask his mental state by the consumption of excessive amounts of alcohol. People dealing with the deceased on a daily basis were of the view that his behaviours were accounted for by his alcohol abuse.

The deceased's auditory hallucinations were controlled with the use of Quetiapine and it was important he remain within therapeutic range.

On 1 November 2002 the deceased went to the Avro Clinic pharmacy and obtained a medication prescription. The pharmacist was aware of previous controls on dispensing the deceased's medication and contacted the deceased's mental health team to inquire about a change of plan. The deceased's usual key work was unavailable and the call went through to a Mr Malcolm Hayman who was aware that the deceased was vulnerable to impulsive overdosing. He contacted St Bartholomew's.

Mr Hayman discussed the desirability of removing the month's supply of medication from the deceased until the Avro Clinic team were satisfied he was entirely stable, he was unaware that St Bartholomew's were unable to hold medication on behalf of residents or a requirement that residents be self-medicating. Staff at St Bartholomew's did discuss with the deceased whether he would like them to hold his medications but he declined.

The Deputy State Coroner was satisfied on the evening of 3 November, 2002 that the deceased took some of his Quetiapine medication. A Staff member of St Bartholomew's became concerned about the deceased's and on searching the deceased's room located empty Clonazepam bottle. Advice was sought from ADIS and PETS and on being informed an overdose was a medical emergency she called for an ambulance.

The Deputy State Coroner found that upon arrival of the ambulance the deceased was aggressive in his refusal of medical assistance and the ambulance officers were not in a position to override his wishes.

The Deputy State Coroner was satisfied that the deceased retired to bed and took the rest of his Quetiapine tablets.

The Deputy State Coroner made an Open Finding into the manner of death of the deceased.

The Deputy State Coroner made a number of recommendations and they are as follows –

St Bartholomew's Hostel

I recommend management endeavour to provide a forum in which policies with respect to medication be discussed with staff to explain the relevant sections of the St Bartholomew's Operations and Procedure Manual and the realities of the hostel's position.

The Avro Clinic

I recommend the Avro Clinic pharmacy in conjunction with the mental health teams consider the benefit of checks prior to the dispensing of potentially harmful amounts of medication.

St John Ambulance

*I recommend St John's Ambulance ensure its officers consider the possibilities of requesting the assistance of police in potentially life threatening situations involving intoxication. [*Police may then apply *section 10 of the Protective Custody Act 2000]*

Health Department, Police Service and Department of Community Development

I recommend the Western Australian Police Service, Department of Health and Department of Community Development ensure there are appropriate facilities to care for intoxicated persons in need of protection from themselves which need to be adequately;

(a) provided for, and
(b) funded

If the Protective Custody Act 2000 is to achieve in practice the objectives set out in theory.

Following the inquest the following advice was received.

St Bartholomew's

On September 3 and 10, 2004 the majority of staff attended a full day training and education session in which policies and procedures, documenting changes in resident behaviour and reporting of unusual incidents was stressed.

The session was followed by a session on medication management and a session on mental illness and the management of residents with particular disorders

The Avro Clinic

The Avro clinic advised that the following steps have been instituted in response to the Coroner's findings:

"1. The prescribing doctor takes ultimate responsibility for the amount of medication dispensed.
2. It is essential that a doctor review a patient's notes prior to prescribing/dispensing any medication (but notes may not always be available).
3. It is preferable that the pharmacist be involved in the dispensing of all medication (but it was recognized as not possible given the limitations of pharmacy hours).
4. Patients receiving medication in limited quantities (for any reason including self-harm and/or abuse) will be flagged:

1. *On the STOCCA program (on the pharmacy computer)*
2. *On the PSOLIS database (the treating doctor will place an alert against the patient).*
3. *In the patient's medical record.*
   A communication book will be commenced in pharmacy in which the above information will be noted.

5. No more than 3 days medication will be prescribed/dispensed by a doctor unless the patient is known to the doctor".

The Department of Community Development

A range of protocols have been developed for the State Supported Accommodation Assistance Program involving Government Departments and the Department is supportive of working collaboratively with the WA Police Service in its administration of the *Protective Custody Act 2000*. The Department will continue to support St Bartholomew's in providing services for homeless single men.

A letter from the Minister for Community Development dated 5 August, 2004 responded to the recommendations of the Deputy State Coroner. That response included the following information –

"Please be assured that the State Government and the Western Australia Police Service continue to support measures to provide appropriate facilities to care for intoxicated people through various interagency collaborative forums where such issues are relevant, particularly the Gordon Implementation Senior Officers Group, the Council of Australian Governments' (COAG) Priority Project Tjurabalan site, and planning and implementation of the Aboriginal Justice Agreement. These interagency forums while having focus on the aboriginal community, have broader community influence".

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 charts 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 where there was a concern that section 22(1)(b) might apply, the following is a summary of the Inquest Findings. It was ultimately determined that only one case came within this category.

Wesley YAMERA

The State Coroner assisted by Mrs Felicity Zempilas, counsel assisting, held an inquest into the circumstances surrounding the death of Wesley Russell Yamera at the Fitzroy Crossing Court House on 10 November, 2003 and then adjourned to Broome Court House on 11-14 November, 2003.

Wesley Russell Yamera (the deceased) was a 17 year old boy who died on 22 December, 2002 as a result of injuries which he suffered on 18 December, 2002.

On 18 December, 2002 the deceased was the driver of a Toyota Hilux utility in which there were at least four passengers when he was followed by a police Toyota Landcruiser utility containing two police officers from the Fitzroy Crossing Police Station.

The deceased did not stop when it was clear that police officers wanted him to do so and he was followed for about 11 kilometres before finally stopping. The deceased was taken from the vehicle, handcuffed and placed in a cage attached to the Toyota Landcruiser.

The cage door was closed but not secured by a padlock and as the police officers drove the deceased back towards the Fitzroy Crossing Police Station, the door to the cage opened and the deceased fell onto the dirt road surface approximately 3.8 kilometres from the Police Station. It is not known whether the deceased fell immediately after the door opened or whether the door was open for some time before the deceased fell out.

Police did not discover the deceased had left the vehicle or that the door was open until the vehicle approached the Police Station. Police then located the deceased on the road surface and at that stage his condition was extremely serious. The deceased at this time still had his hands handcuffed behind his back.

A post mortem examination was conducted by Dr K A Margolius who determined that the medical cause of death was head injury. Dr Margolius stated that the injuries suggested that the deceased had come out of the vehicle backwards striking the back of his head, his shoulder and his hands. The fall was an unprotected fall and with his hands behind his back he was unable to reduce the impact to the back of his head.

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

The State Coroner made a number of recommendations and they are as follows -

The police Service review all security vehicles in its fleet with a view to –

- *Maximising the ability to conduct a visual inspection of cages from the cab area;*
- *Providing a visible and audible warning inside the cab area to alert the driver and passenger when the rear door is not correctly secured;*
- *Providing for communication to occur between the rear cage and the cab area;*
- *Ensuring that recycled cages are inspected adequately for signs of wear and that undue reliance is not placed on the potential use of padlocks;*
- *Providing for some cover on areas designed for seating so as to increase friction and make it easier for prisoners to sit upright even on unsealed roads and to reduce, at least to some extent, the likelihood of an intoxicated prisoner with his hands handcuffed behind his back suffering injury as a result of an unprotected fall against a metal surface; and*
- *Assessing the suitability of different types of security vehicles and cages for use at remote locations where the extent of travel on rough, unsealed surfaces may be greater than at metropolitan and less remote areas.*

The State Coroner received advice dated 8 December, 2003 from the Deputy Commissioner (Operations) that steps had been taken by the WA Police Service to lessen the risk of an incident such as this occurring again; specifically the following matters had been or are being implemented –

- Amendments to the COPS Manual relating to the use of padlocks and the checking of prisoners in transit have been forwarded to Legal Services prior to being put before the Minister;
- Kits have been forwarded to those stations with cage type vehicles so that the mesh size on the rear door can be reduced;
- A ready-use "spring-clip" is now being attached to the rear doors of cage type vehicles giving the operator an alternative to the use of a padlock in certain situations;
- Training for recruits regarding the use of padlocks on security vehicles is to be introduced;
- A search for a more effective proto-type vehicle is underway with NSW Police going out to industry. This agency is in close liaison with NSW Police in this regard;
- Modification to mesh screens to all police security vehicles of the type used at Fitzroy Crossing will be completed within the next two weeks;

- The Director, Asset Management, is addressing other modifications to police security vehicles suggested by you and a program for suggested modifications is being developed.

On 19 April, 2004 the Minister for Police advised the State Coroner of the following –

- Amendments to the Commissioners Orders and Procedures Manual relating to the use of padlocks and the checking of prisoners in transit have been made;
- The mesh size on the rear doors of 138 vehicles at 104 stations has now been modified and the total cost of the modifications was $53,000.
- The above modification included a "snap lock" device as a secondary back up should the padlock be unable to be operated; the cost of this modification is included in the above figure;
- Training for recruits re the use of padlocks on security vehicles has been introduced;
- The NSW Police Service has recently researched the industry seeking proposals on a new purpose built security vehicle. It is expected that the vehicle will be available for viewing April 2004. The WA Police Service is in close liaison with NSW Police in this program;
- The WA Police Service conducted a technical assessment of other modifications suggested by you. The one off cost of modifying existing vehicles is $1.5 million, with an additional recurrent cost increase of $350,000. Implementation options are being considered.

Ross Andrew CAUST

The State Coroner assisted by Mrs Felicity Zempilas, counsel assisting, held an inquest into the circumstances of the death of Ross Andrew Caust (the deceased). The death occurred on 4 March, 2002 in bush area near Hinchinbrook Avenue, Merriwa as a result of Ligature Compression of the Neck (Hanging). The inquest hearing was conducted at the Perth Coroners Court on 22 July, 2003.

The deceased was a 29 year old man who had been involved in a domestic dispute and had failed to stop for police when called upon to do so. Following a short pursuit he had evaded police by driving into a bush area shortly after 7:00pm.

The State Coroner concluded that the deceased was not coping with a breakdown of his relationship. He had briefly attended a counseling service at which time had had expressed concerns about a work related back injury,

recent unemployment and unstable accommodation. Over a period leading up to his death it appears that the deceased experienced thoughts of self-harm and on a number of occasions appeared to be considering taking his own life.

The State Coroner found that the deceased was not a person held in care and his death was not caused, or contributed to, by any action of a member of the Police Service. Police officers made extensive attempts to contact the deceased and to locate him in circumstances where he clearly did not wish to be found.

The State Coroner concluded that the deceased had consumed a considerable amount of alcohol and following an emotional and violent incident he evaded police, drove to an area of bush land at night and used a rope extending over the branch of a tree to his vehicle as a ligature to take his own life.

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

Lionel Paul JUMBURRA

The State Coroner assisted by Sergeant Geoff Sorrell held an inquest into the circumstances surrounding the death of Lionel Paul Jumburra at the Derby Coroners Court on 5 April, 2004.

Lionel Paul Jumburra (the deceased) was a 17 year old aboriginal male who was located on 12 September, 2002 in the driveway of the house where he was staying under a carport. At the time the deceased was slumped in a child's pram with his back leaning against a metal support pole of the carport.

The deceased was living and working at a station and appears to have taken his own life for no known reason during a relatively short break he was spending in Derby.

Toxicology analysis of blood taken from the deceased at the time of the post mortem examination revealed that his blood alcohol reading was 0.176% and that there was Tetrahydrocannabinol and Carboxytetrahydrocannabinol present. It is likely that the effect of the alcohol and cannabis which the deceased had consumed would have been sufficient to contribute to any depression from which he may have been suffering and may have caused him to be more impulsive than he would otherwise have been.

The State Coroner found that the actions of the police officers in taking the deceased home were appropriate and he was not in custody at that time. The State Corner was also satisfied that the actions of the officers did not

contribute to the death and noted that when the deceased was left at his residence he did not wake any of his relatives at that address to raise any concerns about the police or their conduct.

The State Coroner found that the deceased appeared to have acted on his own shortly after being left by the police and his death appears to have come as a surprise to his family and to the police officers who last saw him alive.

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

Inquests – Deaths In Care – Ministry of Justice

During the year 11 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 as in each case the Record of Investigation into the Death is publicly available, but a brief summary is as follows.

Michael Roy VAUGHAN

The Deputy State Coroner assisted by Sergeant Peter Harbison held an inquest into the circumstances surrounding the death of Michael Roy Vaughan at the Fremantle Court House on 22-23 July, 2003.

Michael Roy Vaughan (the deceased) was a 57 year old male whose death occurred on 17 February, 2002 at Cell 9, A Wing, Unit 4 Hakea Prison. He had been sentenced to 12 months imprisonment with parole eligibility on 1 February, 2002.

A post mortem examination was conducted by Dr C T Cooke, Chief Forensic Pathologist, who gave the medical cause of death as being Ischaemic Heart Disease and Coronary Arteriosclerosis with Thrombosis. Dr Cooke attended the scene on 17 February, 2002 and confirmed that there was generalized, very stiff rigor mortis, consistent with that observed by a nurse. Dr Cooke confirmed there was nothing about the deceased which would indicate he had died, other than peacefully in his sleep.

The Deputy State Coroner was satisfied that the deceased was in his bed in his cell when he suffered a cardiac arrest as a result of his underlying Heart Disease. There was no evidence he complained of ill health while in custody although it was noted that he was unwell for a short time on the evening of 16 February, 2002 but refused medical assistance.

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

Donald James WAYMAN

The Deputy State Coroner assisted by Sergeant Peter Harbison held an inquest into the circumstances surrounding the death of Donald James Wayman at the Perth Coroners Court on 5 June, 2001.

Donald James Wayman (the deceased) was a 34 year old male who died on 9 May, 2002 in his cell at Casuarina Prison Complex. At the time of his death the deceased had been sentenced to a term of imprisonment of five years followed by an indefinite term. Immediately prior to sentencing he had been assessed by a Department of Justice psychiatrist who recommended that the deceased's psychiatric supervision and monitoring be continued because he suffered from a delusional disorder. The deceased was well known by the prison system to be a prisoner with potential for psychiatric disturbance.

The Deputy State Coroner was satisfied in the days immediately preceding his death the deceased was experiencing an escalation in his psychotic illness, masked to some extent by the realities of his circumstances while in custody.

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

The Deputy State Coroner made a recommendation as follows –

> *"I recommend the psychologist responsible for the Multi Purpose Unit, or its equivalent in any prison, read the relevant prisoners' medical files whenever a prisoner is transferred into their unit. In the case of prisoners with a significant incident in their past that psychologist should ensure the prisoner's presence, on transfer, is noted to the psychologist responsible for the Unit to which the prisoner is transferred".*

The Department of Justice advised the State Coroner's Office on 20 April, 2004 that the Department supported the recommendations made by the Deputy State Coroner. It further advised that a procedure had been in place for all

Prison Counselling Service contacts in the Multi Purpose Unit at Casuarina Prison since December, 2003. While the procedure is in place the written procedure is still in draft form since it will be incorporated into a finalized Prison Counselling Service Manual. All sections of the manual will be revised prior to the Manual being released as a completed set.

Tyron Raymond RILEY

The State Coroner assisted by Mrs Felicity Zempilas, counsel assisting, held an inquest into the circumstances surrounding the death of Tyron Raymond Riley at the Bunbury Court House on 28-31 October, 2003.

Tyron Raymond Riley (the deceased) was a 21 year old male who died in his cell at the Bunbury Regional Prison on the morning of 18 June, 2001.

For some time in the year 2000 the deceased suffered from a serious mental illness which continued until the time of his death. Though the severity of the symptoms of the deceased fluctuated from time to time it appears clear that from time of his arrest on 30 January, 2001 until his death the deceased suffered from a very severe illness, possibly schizophremia, which was never adequately controlled and as a result of which he experienced hallucinations, including voices telling him to kill himself.

While in Bunbury Regional Prison the deceased was assessed as being at moderate risk of self-harm and as such he was reviewed daily by psychologists at the prison and on one occasion was seen by a visiting psychiatrist. The deceased also suffered distress as a result of a belief which he had been "sung".

On the day of his death the deceased was seen by a prison officer writing a letter to his mother which was in fact a suicide note. The deceased was later discovered hanging from a point near upper windows by a sheet in his cell. After a short delay the deceased was cut down, but in spite of the resuscitation attempts by a nurse the deceased passed away.

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

The State Coroner made five recommendations and the Department of Justice provided responses on 2 July, 2004 –

1. I recommend that the Department of Justice review its approach for assessing the risk of self-harm, supervision and provision of psychiatric services to seriously mentally ill prisoners.

2. I recommend that the Department of Justice review its risk assessment procedures as they apply to mentally ill prisoners.

The Department supports the recommendations.

The Department has referred these recommendations to the Manager, Suicide Prevention who is coordinating various reviews of the Department's management of at-risk prisoners.

Prison Counselling Service (PCS) and Health Services staff undertake the risk assessment of mentally ill prisoners for the Department of Justice. PCS have a policy and procedure manual which outlines the requirements for suicide risk assessments. This manual will be updated to include relevant requirements for the assessment of risk relating to mentally ill prisoners. In addition, the Health Services Directorate also have a policy and procedures manual relating to their work. Offender Services will work with Health Services to develop a protocol that is relevant for both PCS staff and health services staff.

Staff awareness of the nature of suicide risk in mentally ill prisoners is also crucial in addressing this recommendation. The Suicide Prevention Project is currently providing the Gatekeeper suicide prevention training to both PCS and health services staff. This course includes a module on mental illness and how this relates to suicide risk and assessment.

3. I recommend that the Department of Justice review procedures to ensure regular direct interaction between psychological and psychiatric services.

The Department supports this recommendation.

This recommendation has been referred to the Manager, Offender Services and the Director Health Service to identify opportunities for interaction between psychiatrists and Prison Counselling Services (PCS) staff. PCS staff have been advised of the need to liaise with psychiatrists in relation to psychiatrically disturbed prisoners and that there will be ongoing monitoring to ensure this occurs.

In relation to the belief that the deceased had that he had been "sung" the following recommendation was made and response received:

4. I support the work that is being conducted in this regard and recommend that steps be taken to reduce the number of bureaucratic procedures required so as to enable prompt action to be taken in cases of real need.

This recommendation is supported by the Department and this issue was an important focus of a Discussion Paper as discussed in Court. The paper has since been finalized and forwarded to the Manager, Suicide Prevention for more extensive distribution and comment prior to being included as a particular client group issue under the banner of suicide prevention.

5. I recommend that the Department of Justice put in place training procedures or drills specific to the prevailing circumstances of each prison with a view to ensuring that prison officers are familiar with the most timely and efficient urgent response which they should make in the event of discovery of a self-harming prisoner.

This recommendation is supported by the Department of Justice. Standing Order A4 Emergency Procedures has been amended to require superintendents to ensure that staff are familiar with the timely and urgent responses, which they may be required to undertake in an emergency. The Standing Order requires all types of emergency situations that operational staff may be confronted with are practiced. This includes serious medical emergency such as self-harm attempts.

Marie Linnea HATCHER

The Deputy State Coroner assisted by Sergeant Peter Harbison held an inquest into the circumstances surrounding the death of Marie Linnea Hatcher at the Fremantle Court House on 2-3 December, 2003.

Marie Linnea Hatcher (the deceased) was a 45 year old female died who died at the ICU of Royal Perth Hospital. At the time of her death the deceased was serving a term of life imprisonment for the willful murder of her two younger children at Bandyup Women's Prison.

A post mortem examination was conducted on the deceased on 12 March, 2002 by Dr C T Cooke, Chief Forensic Pathologist, who determined the cause of death to be brain swelling and myocardial ischaemia following ligature compression of the neck (hanging).

The Deputy State Coroner was satisfied that the deceased suffered from a significant depressive disorder for a number of years. The Deputy State Coroner concluded that the first two months of 2002 disclosed a number of objectively destablising incidents which should have alerted prison welfare personnel to the fact that the deceased required ongoing consideration as a vulnerable prisoner and relevant monitoring.

The Deputy State Coroner was satisfied that at the time of the lock-down on the evening of 6 March, 2002 the deceased had decided she would make a serious attempt at self-harm. The Deputy State Coroner however was unable to say she did this with an intention to end her life or with the intention of receiving a much-increased level of support.

The Deputy State Coroner made an Open Finding as to the death of the deceased.

The Deputy State Coroner made six recommendations and these together with the responses made by the Department of Justice as advised on 2 July, 2004 are as follows –

1. Redesign of the Self Care Units cell ventilation systems to prevent access to ready suspension points.

The Department of Justice has been addressing the issue of reducing ligature points in prison cells on a number of fronts. A functional brief for prison cell accommodation to reduce opportunities for suicide has been completed. The brief has identified standards and features for cell design that can and will be used as a basis for the development of new cells and the modification of existing facilities. The reduction of self-harm is the key objective.

The cells in each prison are currently being assessed with a view to reducing all other obvious ligature points, taking into consideration the ligature points utilized by prisoners who have died in custody in Western Australian prisons. It is noted that in some cases, the ligature points have been addressed at each prison following a death or near death in custody.

It is proposed that once both assessments are completed, cells in prisons will be modified on a prioritized basis.

2. Unlock officers in Bandyup Women's Prison Self Care Units to carry hoffman knives or reasonable equivalents with their personal pouches at unlock.

This recommendation is not supported by the Department of Justice. Self Harm Kits are located in the control room of each Unit and are readily located in an emergency. These kits contain 1 pair Marigold Gloves, 4 pair latex gloves, 1 chux cloth, 1 pocket mask, and 1 Hoffman knife. Hoffman knives are considered a dangerous piece of equipment that, if carried as a routine practice, places staff at risk. Prison officers not wearing knives on personal belts at unlock at Bandyup Women's Prison is consistent with the practice at other prisons.

3. Prison officers to be competent in up to date resuscitation techniques in an emergency.

The recommendation is supported by the Department of Justice. Prison officers are trained in First Aid and CPR. Bandyup Women's Prison has a training schedule developed for 2004, which includes CPR Training and First Officer Response Training.

4. CRP and/or EAR to be commenced by prison officers where it is not clear as to the status of a patient, and continued until trained medical personnel give an instruction it is to be discontinued or they are in a position to take over without interruption.

This recommendation is supported by the Department of Justice. It is an expectation from persons trained in CPR that they commence CPR immediately and do not desist until trained personnel can take over. This is the expectation of officers attending a prisoner whose status is unclear.

5. Prison officers to be trained to appreciate the significance of various events on prison/er stability and consult with properly informed health/welfare works.

The recommendation is supported by the Department of Justice.

Staff receive refresher training in ARMS, suicide prevention and mental health issues from various expert personnel both internal and external to the prison. A schedule of training has been developed for Bandyup staff for 2004 that includes both Operational Services training as well as issues related to the management of women in custody. Modules include Drug and Alcohol issues, Mental Health, Family Violence and Child Abuse. These will be provided in three week blocks on a Friday morning.

6. Positive steps be taken for psychological and psychiatric review when requested or/and recommended and appropriate notes be completed with respect to all such contacts.

Considerable improvement have been made to the At Risk Management System (ARMS) the maintenance of the Disturbed and Vulnerable List (D&V) and review by the Prisoner Risk Assessment Group (PRAG).

Staff have received training in ARMS and refresher training has been provided to staff by Bandyup Prison Counselling Service (PCS) staff. The PCS Team membership is consistent at Bandyup and has increased to three full-time and one part-time team members. Further, there is a PCS staff member who is available for weekend on call needs. The observation schedules for ARMS at

Bandyup are reported to be of a higher intensity than implemented at other prisons. PCS now provides preventative contact on a weekly basis with the women living in self care. If a PCS member is going on leave they provide a handover of their client list to the remaining members.

There is a Mental Health Nurse at Bandyup who maintains a dynamic register of people who are being psychiatrically treated, medicated, or are considered to present with ongoing or chronic mental health issues. Bandyup receives the services of a psychiatrist who attends on a weekly basis. The appointment list is prioritized by the Mental Health Nurse using an assessment scale of 1-10, and includes those people for whom a follow up appointment was requested. The D&V list is reviewed by the Mental Health Nurse, in consultation with the visiting Psychiatrist once a fortnight when attending the prison for consultation.

There is a PRAG meeting every day at Bandyup, chaired by the Operational Manager, and attended by PCS, Unit Managers, the Mental Health Nurse and the Prison Support Officer. The minutes of PRAG are maintained by PCS staff, and are distributed to key stakeholders within the prison. Prisoners assessed to be at moderate to high risk are reviewed daily and prisoners assessed to be at low risk are included in the review on a Monday and Thursday.

Prisoners can self refer to Prison Counselling Service. PCS use the computerized Registrar system to record client contact. Reports can be generated from Registrar that any PCS staff member can recall on any prisoner. Further, all contact notes are maintained on Registrar so that team members can track the history of contact by other members.

The Mental Health Nurse at Bandyup provides triage for people who wish to see the psychiatrist. The psychiatrist attends Bandyup on a weekly basis. The Mental Health Nurse now works on a system of issuing appointments to prisoners and maintains a card system where appointments can be readily tracked.

Dylan Robert GREEN

The State Coroner assisted by Mrs Felicity Zempilas, counsel assisting, held an inquest into the circumstances surrounding the death of Dylan Robert Green at the Perth Coroners Court on 3-4 February, 2004.

Dylan Robert Green (the deceased) was a 26 year old male who at the time of his death was a remand prisoner at the Hakea Prison Complex, Canningvale.

The deceased was last seen alive at his cell in Unit 9 at approximately 7:00pm on Thursday 11 July, 2002 when the evening prison muster was undertaken. At approximately 10:35pm that evening prison officers undertaking the evening "body check" discovered the deceased hanging by the neck from a torn bed sheet which was tied to bars of the window in his cell.

The bars were obvious hanging points and were located in a relatively newly constructed cell (construction of units 9 and 10 had commenced in 1999 and was completed in 2000).

Efforts were made to resuscitate the deceased without success and he was subsequently certified life extinct by Dr Chapman at 11:35pm that evening.

A post mortem examination was conducted on 15 July, 2002 by a forensic pathologist, Dr G A Cadden, who concluded that the deceased died as a result of Ligature Compression of the Neck (Hanging).

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

The State Coroner made a number of comments and recommendations. Those recommendations and the responses from the Department of Justice are as follows–

1. The Hanging Points

As indicated above it is most unfortunate that the deceased, a young man who had suffered from serious mental illness, should have been placed in a cell containing obvious hanging points.

It is surprising that a cell containing such obvious hanging points, accessible to the occupant of the cell, had been constructed as recently as 1999.

The Designated Superintendent of the Prison, Mr Jennings, stated that units 9 and 10 had been constructed with relative haste as a result of muster problems and that the units had been constructed in accordance with past designs without input from himself.

While it must be accepted that prevention of suicide in prison should not be focused only on issues such as hanging points, it is clearly most important to ensure that there are no obvious hanging points in newly constructed cells and that any such obvious hanging points are removed from existing cells with a minimum of delay or are at least screened so as to be difficult to access. This was a matter addressed by the Royal Commission into Aboriginal Deaths in Custody (the Royal Commission) (see for example recommendation 165).

It is disappointing to note that the Department of Justice did not comply with recommendation 165 of the Royal Commission's recommendations in the construction of the cell which would have required careful scrutiny with a view to eliminating and/or reducing the potential for harm.

Hakea Prison is a prison which houses a large number of remand prisoners (more than half of the present muster comprised remand prisoners) and in such a prison it is obviously particularly important to ensure that there are no obvious hanging points available.

The failure of the Department of Justice to adequately address this issue at the time of the construction of the cell in question or subsequently is even more remarkable in the context of the number of deaths by hanging which had occurred from the time of the Royal Commission until the time of the death.

The following is a list of deaths by ligature compression of the neck (hanging) in cells in Western Australia, from 1991 until the date of the inquest.

No.	Date of Death	Prison
1.	27 December 1991	Casuarina
2.	26 October 1992	CW Campbell Remand Centre
3.	19 April, 1993	Casuarina
4.	5 September, 1994	CW Campbell Remand Centre
5.	14 September, 1994	CW Campbell Remand Centre
6.	14 September, 1994	CanningVale
7.	13 June, 1995	Casuarina
8.	12 January 1996	Casuarina
9.	7 April, 1996	Casuarina
10.	24 April, 1996	CW Campbell Remand Centre
11.	29 July, 1996	Wooroloo Prison Farm
12.	30 July, 1996	Broome Regional Prison
13.	20 October, 1996	Casuarina
14.	23 January 1997	Casuarina
15.	6 April, 1997	Casuarina
16.	6 August, 1997	Casuarina
17.	24 November, 1997	Casuarina
18.	7 January, 1998	Greenough Prison
19.	25 January, 1998	Canningvale
20.	3 February 1998	Greenough Prison
21.	15 February, 1998	Canningvale
22.	8 April, 1998	Casuarina
23.	9 April, 1998	Casuarina
24.	17 May, 1998	Casuarina
25.	31 May, 1998	Canningvale
26.	15 July, 1998	Albany Prison
27.	8 October, 1998	Casuarina
28.	12 March, 1999	Canningvale
29.	19 August, 1999	Casuarina
30.	6 January, 2000	Canningvale
31.	6 January, 2000	Roebourne Prison
32.	7 May, 2000	Casuarina
33.	23 May, 2000	Albany Prison
34.	5 June, 2000	Casuarina

35.	15 June, 2000	CW Campbell Remand Centre
36.	25 June, 2000	CW Campbell Remand Centre
37.	5 December, 2000	Casuarina
38.	13 March, 2001	Hakea Prison
39.	22 May, 2001	Karnet Prison
40.	18 June, 2001	Bunbury Prison
41.	20 August, 2001	Casuarina
42.	27 August, 2001	Bandyup Women's Prison
43.	8 March, 2002	Bandyup Women's Prison
44.	19 September, 2001	Casuarina
45.	11 July, 2002	Hakea Prison
46.	31 January, 2003	Hakea Prison
47.	5 April, 2003	Hakea Prison

At the inquest hearing a document entitled "Functional Brief for Standard Cell Accommodation" was provided to the court. It was submitted that action is to be taken by the Department of Justice in the relatively near future to address the safety of prison cells. It was contended that there are difficult issues involved including balancing the need to protect prisoners from self harm while not dehumanising a basic cell to such a point that a prisoner would become frustrated with its sterility.

These issues are hardly new. Commissioner Elliott Johnston QC wrote in 1991 in the National Report of the Royal Commission, Volume 3 at p. 235 –

> *"Thus, striking a balance between minimising the opportunity for a prisoner to cause harm to himself and exacerbating the stress and isolation which a prisoner may experience in custody requires a considerable degree of thought".*

While it is appreciated that there is a need to provide light and ventilation to cells, there are numerous security companies which provide screens to the general public which are secure and provide ventilation. It would be a simple matter to obtain expert information as to various options available applicable to each of the different types of cells in the prisons throughout Western Australia. It is noted that successful screening of suspension points from a security point of view had been undertaken at the time of the Royal Commission in 1991 (see e.g. National Report Vol. 3 at p.234).

In the context of issues relating to the providing of light and ventilation to the cell it is noted that there was a screen in place in the window of the cell in this case but it was on the outside of the bars. While that screen may not have

been of security strength the same provision of light and ventilation could have been provided by a suitably strengthened screen on the inside of the bars.

Although the following recommendations add nothing new and should not be needed, in the light of the failure by the Department of Justice to adequately address these issues to date and to reinforce the importance of taking timely action, I make the following recommendations –

I recommend that the Department of Justice take immediate action to assess cells in the various prisons throughout the state with a view to identifying possible hazards such as obvious hanging points. Many of these hazards are obvious to untrained observers and their identification does not require expert reviews – what is required is action.

The Department of Justice supports this recommendation.

I further recommend that the Department of Justice includes minimisation of obvious hanging points as an instruction in the design of all cells to be constructed in the future.

The Department of Justice supports this recommendation.

2. The Decision To Remove The Deceased From The ARMS System

A decision was made by the PRAG group on 4 July, 2002 that the deceased should be removed from the ARMS system.

That decision was in part as a result of the recommendation by Ms Traupman, but there would have been input from a senior officer from the unit and from the mental health nurse.

While Ms Traupman holds Bachelor of Arts (Psychology) and Bachelor of Social Work degrees, her knowledge of psychiatry is limited. In the entire period while the deceased was at Hakea Prison Complex, while Ms Traupman monitored his risk status, she had no direct contact on any formalised basis with the psychiatrist monitoring his mental health, Dr Wu.

It is clear that Dr Wu's availability at the prison was limited as he only attended for 3 ½ hours per week and so it would not have been practicable for him to attend PRAG meetings which were held regularly. It is nevertheless most unfortunate that there was never any direct interaction which would have enabled Dr Wu to provide information to Ms Traupman or other members of the

FCMT which would have helped them to better understand the mental health problems suffered by the deceased.

Dr Wu in his evidence stated that the deceased suffered from serious mental illness. The evidence of Ms Traupman suggests that she did not fully appreciate the extent of the deceased's illness or the potential dangers associated with psychosis at a time when he was not suffering from obvious delusional beliefs or hallucinations.

In Western Australia a very high proportion of prisoners who take their own lives suffer from mental health problems and so it is particularly important that those persons responsible for monitoring the risk status of prisoners have a good appreciation of the mental health problems involved.

I note that information provided to the court by counsel for the Department has indicated that psychiatric services to Hakea Prison have increased since the date of death from four to five 3 ½ hour sessions per week and that a further increase to six sessions is proposed. It would be most helpful if this increased commitment could allow for some direct psychiatrist interaction with FCMT members (now called PCS Prisoner Counselling Service).

I recommend that the Department of Justice review procedures with a view to promoting direct interaction between psychiatrists and psychologists, social workers and others involved with the monitoring of prisoners.

> *This recommendation has been referred to the Manager, Offender Services and the Director Health Service to identify opportunities for interaction between psychiatrists and Prison Counselling Services (PCS) staff. PCS staff have been advised of the need to liaise with psychiatrists in relation to psychiatrically disturbed prisoners and that there will be ongoing monitoring to ensure this occurs.*

3. The Failure To Retain ARMS Files At The Prison

The deceased was a person who in Dr Wu's opinion was chronically at risk of self harm and it was obvious that during his stay in custody his At Risk status would be likely to fluctuate.

On two occasions ARMS files were created, but on each occasion when it was considered that the deceased was no longer at acute risk of self harm, the file was completed and apart from a backing sheet retained with the file, the remainder of the ARMS documentation was forwarded to the Department of Justice head office.

The ARMS documentation provides part of the history of the treatment of a prisoner who is at risk of self harm and until the prisoner is discharged from

prison at least a copy of that documentation should be retained at the prison where he is housed.

I recommend that the Department of Justice review ARMS procedures so that ARMS documentation is available at a prison where a prisoner is housed until the completion of his or her sentence.

> *This recommendation has been referred to the Manager, Suicide Prevention who has been coordinating a review of the Department's At Risk Management System. The Coroner's recommendation is being considered as part of the Review. It will be incorporated into a discussion paper which will be forwarded to relevant staff in the Department for comment, prior to a determination of future direction and practice.*

4. *The Failure Of The Deceased To Take Medication Between 5 July, 2002 And 11 July, 2002*

The deceased was prescribed both anti-psychotic and anti-depressant medication by Dr Wu but at the stage when he was removed from the ARMS system and was subject to less intense supervision he discontinued taking his medication. This failure of the deceased to take his medication clearly increased his risk status but was not identified until after his death.

I recommend that the Department of Justice review procedures to ensure that when a prisoner fails to take medication which is important to the well being of the prisoner, that failure is identified and reported to the relevant personnel.

> *The Department supports the intent of this recommendation.*
>
> *The Director of Health Services has advised that procedures and protocols exist to overlook the issue of medication to prisoners. A review has indicated that these procedures and protocols are adequate. Health Services is currently looking at ways to monitor the manner in which the relevant procedures and protocols are adhered to, and to identify health centers and personnel who do not meet the required standards.*

COMMENT ON MATTERS CONNECTED WITH PUBLIC HEALTH PURSUANT TO SECTION 25(2) OF THE CORONERS ACT 1996

In this case the deceased was admitted as an involuntary patient on 13 March, 2002 at Fremantle Hospital but was discharged by order of Psychiatrist, Dr Bailey, on 27 March, 2002.

No treatment order was made and immediately following his discharge the deceased failed to comply with a follow-up plan.

The fact that the deceased failed to comply with the plan came as no surprise to Dr Bailey who said in evidence that he expected the deceased to become non-compliant in respect of his medication and also expected that it was likely that he would become psychotic again shortly after his discharge. In addition Dr Bailey expected that it was likely that the deceased would recommence consuming marijuana and alcohol following his discharge rendering a likelihood of his psychosis returning extremely high.

Dr Bailey stated that he did not make a treatment order in respect of the deceased because he was of the view that for psychiatric treatment to be effective it was important for the patient to feel that he was not subject to excessive restriction as successful treatment was more likely to result from voluntary action on the part of the patient. He also expressed the view that a treatment order was not likely to assist greatly in making the deceased take his medications and said that such orders were rarely made.

.....

I recommend that the Health Department consider having a review of the practical application of the Mental Health Act 1996 as it relates to community treatment orders with a view to determining whether community treatment orders are serving the purpose for which they were intended and, if not, with a view to determining whether the Mental Health Act 1996 requires amendment to avoid any perceived practical difficulties relating to the making of or enforcing of such orders.

Natasha Leanne QUARTERMAINE

The State Coroner assisted by Mrs Felicity Zempilas, counsel assisting, held an inquest into the circumstances surrounding the death of Natasha Leanne Quartermaine at the Fremantle Court House on 24-26 February, 2004.

At about 1:28pm on 27 August, 2001 Natasha Leanne Quartermaine (the deceased) a 25 year old female prisoner at Bandyup Women's Prison was located by other prisoners hanging in her cell.

The deceased was hanging from a radio cassette electrical cord which had been tied to the frame of a bunk bed in the cell.

On 30 May, 2001 the deceased was sentenced to 18 months imprisonment in the Perth Court of Petty Sessions in respect of stealing, stealing a motor

vehicle, burglary and no motor driver's licence offences. She was incarcerated at the Bandyup Women's Prison. This was the sentence she was serving at the time of her death.

The deceased had extensive contact with psychiatric services around Perth and was described by Dr Hames, Acting Director of Health Services, as suffering from psychotic illness, a personality disorder and poly-drug abuse problems. Her psychosis was described as "atypical presentation" and at times was diagnosed as schizophrenia or as "atypical psychosis".

During her last term of imprisonment the deceased self-harmed to a superficial extent on two occasions, on 2 July and 12 August, 2001. The At Risk Management System (ARMS) was implemented following each of those incidents. The ARMS form in respect to the last incident on 12 August, 2001 was closed on 21 August, 2001.

The deceased remained on the ARMS register until 21 August, 2001 at which stage her ARMS file was closed. At that stage it was determined by the PRAG that she was no longer at risk of self-harm.

On 27 August, 2001 the deceased was seen in a grossly distressed condition, possibly as a result of the fact that she had not received a visit from family members on the weekend.

Although the deceased was initially so distressed that she was unable to talk and repeatedly spoke of killing herself, no Department of Justice employee took any steps to have her placed on the ARMS system, a system designed to assist persons at risk of self-harm.

No action was taken to advise prison officers responsible for her direct management of the condition of the deceased.

The State Coroner found that shortly after having told prison authorities of her suicidal thoughts the deceased entered her cell alone and tied a cord to the frame of a bunk bed and around her neck with the intention of taking her own life.

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

The State Coroner made comments and recommendations in this matter.

The following is a recommendation made by the State Coroner and the response from the Department of Justice -

I recommend that the Department of Justice give consideration to implementing a system which would provide health centres in prisons with copies of at least pages 1 and 2 of an ARMS file immediately following the raising of the file.

This recommendation has been forwarded to the Manager Suicide Prevention who has been coordinating a review of the Department's At Risk Management System. The Coroner's recommendation has been considered by the Working Party and the suggestions of the Working Party, with respect to this and other issues, will be forwarded to relevant staff in the Department for comment prior to a determination of future direction and practice.

Donald Lenard KEEN

The Deputy State Coroner assisted by Sergeant Peter Harbison, held an inquest into the circumstances surrounding the death of Donald Lenard Keen at the Perth Coroners Court on 9-11 March, 2004.

Donald Lenard Keen was an 18 year old aboriginal male at the time of his death.

On 16 August 2002 the deceased was charged with violent offences by Wembley Detectives. He appeared in the Perth Court of Petty Sessions on 16 August 2002. He was given bail but the terms and conditions were such that they could not be met by him or his family. He was admitted to Hakea Prison Complex (Hakea) on the evening of 16 August 2002. All prisoners received into the Hakea Remand Centre are assessed to determine their current medical status and any past history which may be relevant to prison management. The deceased was assessed, however, his relevant juvenile history was not requested or obtained at that stage. The reception form did indicate the admitting officer knew he had a juvenile history and there was self-harm potential. The details were not obtained. Consequently the nurse assessing the deceased relied on the deceased's input and he advised the nurse of his relevant drug and substance abuse, however, denied he had a history of self-harm or was a self-harm risk.

The deceased was seen by a psychologist from the PCS, on 19 August 2002 while he was in Unit 7. There was no evidence of suicidal or self-harm ideation, however, it was noted that the deceased had family members in Hakea which would provide him with support. In October 2002 the deceased's mother contacted the prison and stated she was concerned the deceased posed a self-harm risk after receiving notification of a requirement he was to appear in court as a witness.

The deceased was also visited by the psychologist from Banksia Hill Detention Centre in October 2002. There is no note on the deceased's medical file to indicate the results of the visit however in the report it is stated that the deceased was settled and appeared to have adjusted well to the prison environment.

On 1 November 2002 the deceased was placed in the Crisis Care Unit (CCU) by his unit manager as the result of a self-harm attempt following a distressing telephone call with his girlfriend.

By 24 January 2003 the deceased had difficulty in coping with stress and auditory hallucinations encouraging him to harm himself. Although he reported these difficulties he was not appropriately reviewed by way of psychiatric assessment. The deceased was unable to be assessed by a psychiatrist visiting the prison on 27 January, 2003. He was not placed on the appointment list for the next available date and there seems to have been no comprehensive long term review of his mental health status until he again sought help.

In the early hours of 25 February, 2003 the deceased sought help by pressing his cell call alarm button and advising the prison officers he was hearing voices telling him to harm himself. He was placed in a medical observation unit as a safe cell was not available. He was placed on ARMS indicating an acknowledgment of his self harm status. Again this did not result in psychiatric assessment.

The Deputy State Coroner found that some time after 8:00pm on the evening of 1 March, 2003 the deceased hanged himself using his shoe laces tied to his window grill attachment.

The Deputy State Coroner found that the death occurred by way of Suicide while the deceased was in a disturbed state of mind.

The Deputy State Coroner made the following comment in respect of the failure to psychiatrically assess the deceased:

> *"What was not of benefit was the failure of the prison system to appropriately psychiatrically assess the deceased's repeated calls for assistance as the result of his auditory hallucinations commanding him to self-harm. I consider it unacceptable a young male, first time in adult custody, and remand prisoner, not be seen by a psychiatrist when he had twice explained he was receiving commands to kill himself at night.*
>
> *I understand on both occasions the chain of events which led to his not being appropriately assessed. I would not wish to attribute fault to any*

individual when it is the system which allows this to happen which must be improved."

The Deputy State Coroner made a recommendation in respect of proper contemporaneous recording of problems:

I recommend all contacts with a prisoner by PCS or Mental Health Nurses be adequately noted in the progress notes on the day they occur. Fuller explanatory notes can be added later.

The Deputy State Coroner concluded that the supervision treatment and care of the deceased as a young vulnerable prisoner was lacking.

Austin Edward DODD

The State Coroner assisted by Sergeant Geoff Sorrell conducted an inquest hearing into the circumstances of the death of Austin Edward Dodd at the Perth Coroners Court on 16-18 March, 2004.

Austin Edward Dodd (the deceased), a 57 year old male, died on Saturday 21 December, 2002 at the Casuarina Prison Complex where he was housed at the Prison Infirmary.

At the post mortem examination Dr Margolius discovered severe coronary artery disease. She commented that bypass procedures of 1992 had been extremely difficult to perform and that the deceased's diabetes was a very significant risk factor which would have greatly increased the likelihood of blockage of the bypass vessels. Dr Margolius also observed that the bypass graft vessels showed severe atheromatous change.

The thrombotic occlusion which caused death had occurred in the left anterior descending coronary artery bypass vessel which was the same vessel which had caused most problems at the time of the insertion of the grafts in 1992. Dr Margolius concluded that in the context of his pre-existing conditions the deceased was lucky to have survived as long as he had.

The State Coroner found that the cause of death was Natural Causes.

Lawrence Brian FLOWERS

The Deputy State Coroner assisted by Sergeant Peter Harbison held an inquest into the circumstances surrounding the death of Lawrence Brian Flowers at the Perth Coroners Court on 4-5 May, 2004.

Lawrence Brian Flowers (the deceased) was 48 years of age. The deceased had an extensive history in the criminal justice system first coming to the attention of the authorities at the age of 16.

The deceased was admitted into Hakea Prison Complex on 14 November, 2002 as a remand prisoner and the Deputy State Coroner was satisfied that the deceased was suffering a low grade lung infection as the result of prior aspiration. The deceased was assessed and arrangements made for him to be admitted to Royal Perth Hospital immediately on 28 November, 2002.

The deceased's lung abscess ruptured some time prior to the afternoon of 12 December, 2002 releasing bacteria and metabolic toxins into the plural cavity but this was not appreciated until the morning of 13 December, 2002. Before the deceased's plural cavities could be drained to remove toxins from his chest cavities he deteriorated rapidly and he died prior to surgical intervention.

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

The Deputy State Coroner made a number of recommendations as follows –

1. *The Department of Justice support the implementation of appropriate health care plans for all prisoners in custody as a way of facilitating the implementation of appropriate medications and tests for all re-admittees into the prison system. Of its self this may be a way of educating a section of the community as a whole into appropriate health care.*

2. *Vulnerable prisoners with respect to medication be followed up within 24 hours of non compliance and the fact of follow up be annotated in the prisoner's progress notes to reflect attempts to persuade the prisoner of the benefits of compliance.*

Raymond Murray NEUMANN

The State Coroner assisted by Sergeant Geoff Sorrell held an inquest into the circumstances surrounding the death of Raymond Murray Neumann at the Perth Coroners Court on 9 June, 2004.

Raymond Murray Neumann (the deceased) took action to end his own life by hanging using an electrical extension cord attached to the branch of a small tree in bushland near Ryecroft Road, Glenn forrest on or about 1 February, 2003.

At the time of his death the deceased was a sentenced prisoner. The deceased had been released on 16 October, 2002 on a Work Release Order.

The deceased was last known to have been alive on the afternoon of 1 February, 2003 but his last contact with the Department of Justice Community Corrections Officer had taken place on 20 January, 2003.

During the period of his release the deceased had been involved in gainful employment and had generally been progressing in a relatively satisfactory manner although he had experienced difficulties in coming to terms with the Relationships Australia Program which he had been required to attend with a view to addressing issues which had resulted in his offending.

The State Coroner found that there was nothing suspicious about the circumstances of the death and found that the death arose by way of Suicide.

The State Coroner found that the obvious explanation for excessive dilution of two of the urine samples taken from the deceased while on work release was that the samples were not genuine and the results should have been investigated further.

The State Coroner made the following recommendation:

> *I recommend that in future cases if urine analysis results are in any way questionable, immediate action be taken to resolve doubt. In the case of prisoners serving sentences in the community they should be contactable by their Community Corrections Officers with a minimum of delay so that any such issues can be discussed and their welfare and compliance with their obligations reviewed.*

The following chart details the position in respect of all cases of deaths in care since January 2000 where the deceased was either in prison custody or there was police involvement.

Date of Death	Date of Inquest	Name of Deceased	Police/ Prison Custody	Place of Death	Medical Cause of Death	Finding
6/1/00	5-6/11/01	GARNER Adam Timothy	Prison	Canning Vale	Ligature Compression of the Neck (Hanging)	Suicide Recommendations
6/1/00	16-207/01 23-24/8/01 23/11/02	JOSEPH Phillip	Prison	Roebourne Prison	Ligature Compression of the Neck (Hanging)	Suicide
1/00	26-30/11/01	BROOKS Peter Anthony	Police	Como	Gun Shot Wound to Chest	Lawful Homicide
19/2/00	11-14/2/03	LOOHUYS Mark	Police Officer		Head Injury - Police pursuit	Accident
7/5/00	26-28/11/01	WESLEY Leslie	Prison	Casuarina	Ligature Compression of the Neck (Hanging)	Suicide
22/5/00		MATTHEWS Jason Paul	Prison	Casuarina	Coronary Artery Thrombosis in Association with Coronary Arteriosclerosis	Natural Causes
23/5/00	5-7/2/02	SAVORY Bradley	Prison	Albany Prison	Ligature Compression of the Neck (Hanging)	Suicide
26/5/00	3-4/4/02	LAWSON Kirk	Prison	Kalgoorlie Prison	Epilepsy in Association with Cerebral Cortical Dysplasia	Natural Causes
4/6/00	11-13/3/02	DAVIDSON Scott	Prison	Casuarina	Ligature Compression of the Neck (Hanging)	Suicide
7/6/00	22/1/02	RILEY Frederick Ronald Aka Frederick Steven Wilson	Prison	Casuarina	Ruptured Berry Aneurysm	Natural Causes
16/6/00	8-10/4/02	OTERO Simon	Prison	Canning Vale	Ligature Compression of the Neck (Hanging)	Open Finding
25/6/00	16/4/02	THERON Gerhardus	Prison	Canning Vale	Ligature Compression of the Neck (Hanging)	Suicide
1/7/00	6/11/01	FRAGOMENI Francesco	Prison	Casuarina/Murdoch Hospice	Prostrate Cancer	Natural Causes

5/12/00	29/4-2/5/02	CRAIG Alan McKenzie	Prison	Casuarina	Ligature Compression of the Neck (Hanging)	Suicide
8/12/00	16-18/4/02	MOORE Derek	Police	Pursuit	Multiple Injuries	Accident
8/12/00	DPP	MOORE Christopher Peter	Prison	Wooroloo Prison	Heroin	Subject to prosecution
9/12/00	1-3/4/03	UGLE Mark Amelo	Police	East Perth Lock-up	Heart Attack	Natural Causes
28/12/00	6-7/8/02	AUSTIN Alan Edward	Prison	Casuarina	Natural Causes	Natural Causes
11/2/01	30/4/02-2/5/02	PRIDHAM Steven Anthony	Prison	Pardalup Prison Farm	Immersion	Accident
13/3/01	18-20/2/03	SLATER Evan Charles	Prison	Hakea Prison	Ligature Compression of the Neck (Hanging)	Suicide
4/4/01	10/9/02	YAPPO Mervyn	Prison	Hakea Prison	Liver and Kidney Failure	Natural Causes
22/5/01	4/9/02	BECKETT Richard John	Prison	Karnet Prison	Ligature Compression of the Neck (Hanging)	Suicide
18/6/01	28-31/10/03	RILEY Tyron	Prison	Bunbury Regional	Ligature Compression of the Neck (Hanging)	Suicide
20/8/01	3-5/8/04	JOHNSON Parata Peter	Prison	Casuarina Prison	Ligature Compression of the Neck (Hanging)	Suicide
27/8/01	24-26/2/04	QUARTERMAIN Natasha Leanne	Prison	Bandyup Women's Prison	Ligature Compression of the Neck (Hanging)	Suicide
19/9/01	10-11/6/03	HOLCROFT Gary John Williams	Prison	Casuarina	Ligature Compression of the Neck (Hanging)	Natural Causes
9/10/01	5-6/2/03	TANADI Pangky	Prison	Albany Prison	Ischaemic Heart Disease	Natural Causes
22/12/01	28/2/03	BOYLE James Hughes	Prison	Casuarina	Aspiration Pneumonia & Meningitis	Natural Causes
29/12/01	25-26/11/02	PALMER Yola	Police		Stabbing (self inflicted) in police presence	Suicide
17/2/02	22-23/7/03	VAUGHAN Michael Roy	Prison	Hakea Prison,	Ischaemic Heart Disease & Coronary Arteriosclerosis with Thrombosis	Natural Causes

5/3/02	22/7/03	CAUST Ross Andrew	Police	Bushland	Ligature Compression of the Neck (Hanging)	Suicide
8/3/02	2-4/12/03	HATCHER Marie	Prison	Bandyup Women's Prison	Ligature Compression of the Neck (Hanging)	Suicide
18/3/02	28/2/03	CASSIDY Michael Patrick	Prison	Fremantle Hospital	Emphysema/Cancer	Natural Causes
9/5/02	6-7/8/03	WAYMAN Donald James	Prison	Casuarina Prison	Asphyxiation – Plastic Bag	Suicide
17/5/02	18-21/1/2005	QUARTERMAINE Kevin Gregory	Prison	Fremantle Hospital	Natural Causes	
11/7/02	3-4/2/04	GREEN Dylan Robert	Prison	Hakea Prison	Ligature Compression of the Neck (Hanging)	Suicide
23/8/02	9-11/9/03	TAYLOR Louis Bernard	Police		Stabbed himself in police presence	Suicide
3/9/02	Not listed	WILLIAMS Thane Anthony	Police	Kalgoorlie	Conveyed home by police after scuffle in pub	
12/9/02	4/4/04	JUMBURRA Lionel Paul	Police	Broome	Ligature Compression of the Neck (Hanging) after police conveyed him for loitering	Suicide
24/11/02	9/11/04	WARE Marileen	Home Detention	Perth	Natural Causes	Natural Causes
12/12/02	4-5/5/04	FLOWERS Larence Brian	RPH	Hakea Prison	Pneumonia in association with lung abscess in a man with documented chronic alcohol misuse	Natural Causes
21/12/02	16-18/3/04	DODD Austin Edward	Prison	Casuarina Prison Infirmary	Natural Causes	Natural Causes
22/12/02	10-14/11/03	YAMERA Wesley Russell	Police	Fitzroy Crossing	Head Injury	Accident
31/1/03	30/11/04-2/12/04	GROOTHEDE Jan Hendrik	Prison	Hakea Prison	Ligature Compression of the Neck (Hanging)	Suicide
1/2/03	9/6/04	NEUMANN Raymond Murray	Karnet Prison Farm (Parole)	Bushland Glenn Forrest	Ligature Compression of the Neck (Hanging)	Suicide
5/4/03		GARLETT Damien George	Prison	Hakea Prison	Ligature Compression of the Neck (Hanging)	Suicide

6/5/03	13-16/9/04	GAMBLE Charles Raymond	AIMS	Prison Van	Ligature Compression of the Neck (Hanging)	Suicide
17/5/03		HERRICK Michael John	Prison	Acacia Prison Sir Charles Gairdner Hospital	Severe Liver Failure	
23/9/03	Adj sine die	SAMSON Peter Darryl (aka) Leyley	Police Lockup	Derby Police Station		
26/11/03		POWER Edward Charles	Prison	Casuarina Prison	Heart problems	
28/11/03		HAMBRIDGE David Lee	Prison	Eastern Goldfields Regional Prison	Ligature Compression of the Neck (Hanging)	
6/12/03		O'NEILL Reginald Brian	Prison	Karnet Prison Farm		

Deaths Referred to the Coroners Court
1 July 2003 – 30 June 2004

A total of 2,092 deaths were referred to the coronial system during the year.

Of these deaths, in 697 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 995 Coroner's cases and in the country regions there were 400 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, 2003 - 30 June, 2004

Natural	510
Suicides	202
Accidents	126
Traffic	91
Homicide	22
Open	9
Misadventure	0
Inconclusive	33
No Jurisdiction	1
Subsequent referral to Coroner	2
TOTAL	**995**

Deaths referred to a Coroner for investigation for the Country area

1 July, 2004 - 30 June, 2004

Natural	160
Suicides	69
Accidents	47
Traffic	88
Homicide	9
Open	5
Inconclusive	22
Misadventure	0
SUB TOTAL	**400**
Total Number of Reportable Deaths	**1395**