Office Of the State Coroner

Annual Report

2008 – 2009

State Coroner Western Australia

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

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

Our Ref : A-1

The Honourable Christian Porter
BA(Hons)BEc LLB(UWA) MSc(Dist) LSE 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, 2009.

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

Yours sincerely

Alastair Hope
STATE CORONER

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State Coroner's Overview

The Coroner's Court has been experiencing serious resourcing problems over a number of years to such an extent that in the Annual Report for 2006-07 I was obligated to advise that "...as a result of inadequate resources being provided to the Coroner's Court by the Department of the Attorney General, it is possible that I will not be able to adequately perform the functions of the State Coroner as set out in section 8 of the *Coroners Act 1996* and I may not be able to ensure that an adequate counseling service is available as required by section 16 of that Act".

The additional resources were not provided and that prediction proved to be accurate. In the following year I was unable to adequately perform those statutory functions. During the first half of 2008-2009 this unsatisfactory situation continued.

On 14 August 2009 this issue was partially addressed. On that date the Attorney General announced that an additional $822,000 in funding would be provided to the Court and of that sum approximately $622,000 was to go to salaries. While that sum provided the first significant increase in staff levels for over a decade, the funding was not made recurrent and in respect of all additional staff who were employed, the term for their employment was limited to the end of the financial year and was subject to ongoing review.

The Law Reform Commission of Western Australia is conducting a review of the *Coroners Act 1996* and the provision of the additional funding was made subject to the outcomes of that review. This meant that in respect of all new positions, these had to be created, advertised and the normal public service process gone through, but all positions were subject to review.

These problems were aggravated by the fact that for much of the relevant period the Coroner's Court did not have access to a dedicated courtroom as a result of problems associated with relocation of the court to the Central Law Courts building and ongoing problems with completing the upgrade of courtrooms in that building.

On a positive note, however, throughout this period and up until the time of writing this introduction in 2010 (the annual report was delayed pending resolution of some of these issues) the Coroner's Court has enjoyed the support of the Attorney General, Mr Christian Porter MLA,

who has consistently advocated in favour of the court being adequately resourced.

In the context of recent advice to the effect that the final report of the Law Reform Commission is unlikely to be available until at least late 2011 or early 2012, the Attorney General has advised that he is supportive of all present temporary positions with the court being made recurrent and the provision of adequate additional resources to enable the court to better address issues of delay generally, to enable proper planning and listing of inquests to take place and to provide a better quality of service.

In this context a comprehensive recurrent budget initiative has recently been prepared to address these resourcing issues and with the support of the Director General, Ms Cheryl Gwilliam, and the Director, Court and Tribunal Services, Mr Michael Johnson, it is anticipated that by mid 2011 the court will be better resourced and much better placed to perform its functions.

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.

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. Including those cases, 2,442 deaths were referred to the Coroner's Court.

Deaths Referred to the Coroners Court from 1 July 2008 - 31 December, 2008

	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	Total
Death Certificate issued although the body was admitted to the Mortuary	21	14	16	16	8	23	12	10	9	11	20	16	176
Immediate post mortem ordered (usually these are homicide cases)	2	3	0	1	2	0	2	6	0	1	3	4	24
No post mortem because body missing etc.	2	0	2	2	5	3	0	0	0	1	1	0	16
No objection to post mortem examination	115	143	125	160	136	133	138	132	134	118	111	122	1567
Objection received by the Coroners Court	17	11	11	6	15	23	12	9	12	7	8	10	141
TOTAL NUMBER OF DEATHS	157	171	154	185	166	182	164	157	155	140	144	182	1927

Developments in Cases where an Objection was initially received

	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	*Total*
Objection withdrawn prior to a ruling being given by a Coroner	**3**	**2**	**2**	**0**	**2**	**7**	**4**	**3**	**0**	**4**	**2**	**2**	**31**
Objection accepted by a Coroner and no post mortem ordered	**10**	**7**	**8**	**5**	**12**	**16**	**8**	**4**	**12**	**3**	**6**	**8**	**99**
Objection over-ruled by a Coroner	**4**	**2**	**1**	**1**	**1**	**0**	**0**	**2**	**0**	**0**	**0**	**0**	**11**
TOTAL	**17**	**11**	**11**	**6**	**15**	**23**	**12**	**9**	**12**	**7**	**8**	**10**	**141**

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

In the majority of cases where an objection was received the decision which was ultimately made was in accordance with the wishes of the family. There were a total of 141 objections of which 31 were withdrawn prior to a ruling being given by a Coroner and 99 were accepted by a Coroner and no internal post mortem examinations were ordered. In only 11 cases where an objection had been received 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.

Counselling Service

Over the past year the staffing situation at the Coronial Counselling Service was stabilized with the permanent appointment of the second counsellor. After five years and seven changes in the one position, the permanent appointment resulted in the service being able to respond in a more timely and consistent manner to the needs of grieving families.

As a consequence, the provision of office counselling and home visits was re established, while the phone counselling service continued to be utilised by both country and metropolitan clients. Although referral to community agencies was still required in some cases, pressure was taken off those agencies, many of whom did not have specialist grief and bereavement counsellors and had minimal understanding of coronial procedures. The counselling service also facilitated and supervised many coronial file viewings with families and began providing community education and training sessions again.

In July 2008 the Australian Federal Police (AFP) honoured the dedication and professionalism of two coronial counsellors who provided valuable assistance to the families of the 16 Western Australians that died in the Bali Bombing of 2002. The coronial counsellors were each presented with the Australian Federal Police Operations Medal for their work in ante mortem interviews conducted with families by the Western Australian Police. This collaboration allowed police to focus on the collection of

evidence while the counsellor provided information and support to the family at this traumatic time. The counsellors also liaised between the ongoing identification process and the family, as well as facilitating referrals to other community agencies as and when required.

The experience of the Bali bombings and the South East Asian Tsunami prompted the Coronial Counselling Service to train and coordinate a team of professional counselling staff who could be called upon to work alongside police in a disaster incident. Over the last few years, the counselling service recruited and trained a pool of 20 counsellors for a disaster incident counselling team. The specially trained team operates on a roster system and is ready to respond immediately in the event of a disaster involving the death of Western Australians, either here or overseas.

REFERRALS - CORONIAL COUNSELLING SERVICE
1 July, 2008 – 30 June, 2009

Total New Contacts (Including client self referrals, police and community agencies)	Counselling Provided (Phone, Office and Home)	Letters Sent for Offers of Support	Other Services (Liaison, referral and file viewings)
8,242	4,754	462	3,026

Coronial Ethics Committee

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

The considerable efforts of the Ethics Committee during the year are very much appreciated by the Coroner's 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

The members of the Committee are as follows:

Dr Adrian Charles	*Chairperson* Pediatric Pathologist, Princess Margaret Hospital
Associate Professor Jennet Harvey	Department of Pathology, UWA
Dr Celia Kemp	*Secretary* Lawyer, Coroner's Office
Ms Evelyn Vicker	Deputy State Coroner
Dr Jodi White	Forensic Pathologist, PathCentre
Ms Martine Pitt	Executive Director, Communicare
Mr Jim Fitzgerald	Lay member
Ms Heather Leaney	Lay member
Mr Neville Collard	Aboriginal 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
8	6	2

Counsel to Assist Coroners

Mrs Felicity Zempilas, after 7 years working in the Coroner's Court as Counsel Assisting, was appointed as a magistrate. Mrs Zempilas will be based at the Kalgoorlie Magistrates Court and will continue coronial work in her capacity as district coroner for the Goldfields region.

Ms Catherine Fitzgerald, through the assistance of the DPP, was seconded from that office from 15 September 2008 until 6 November 2009.

In addition the Police Service continued to provide assistance to the Coroner's Court by making available two police officers who in addition to a range of other tasks, on occasions acted as officers assisting. These were Sergeant Geoff Sorrell and Sergeant Lyle Housiaux. These officers brought a wealth of experience and relevant knowledge to the task.

In a number of more lengthy inquests 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 in private practice.

After 23 years of court service Sergeant Harbison retired at the end of 2009 after clearing his outstanding leave entitlements. Sergeant Harbison has acted as police counsel assisting during inquest hearings as part of his duties.

On behalf of fhe Coroner's Court I wish to acknowledge Sergeant Harbison's length of service and sincerely thank him for his assistance and wish him well in his retirement.

Inquests

A chart follows detailing the Inquests conducted during the year.

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

INQUESTS FOR THE YEAR 1 JULY, 2008 - 30 JUNE, 2009

Name Of Deceased	Date Of Death	Date Of Inquest	Number Of Sitting Days	Coroner	Court Sitting	Finding	Date Of Finding
*ROCHFORD Simon **	19/5/06	9-17/7/08 22-25/7/08	8	Deputy	Albany and Perth	Suicide	3/10/08
*PARRE Donald **	1/5/06	17/7/08	1	Deputy	Albany	Natural Causes	3/9/08
ALLEN Kobey	3/7/04	29-31/7/08 14-15/8/08	5	Deputy	Perth	Misadventure	18/10/08
MORRIS Ethan	3/8/05	31/7 and 12-13/8/08	3	Deputy	Perth	Natural Causes	12/9/08
**MOLONEY Courtney **JOHNSON Scott	18/12/06	14-15/8/08 19-20/8/08	4	State	Northam Perth	Accident	29/8/08
DATTILLO Caterina	20/2/04	8-10/10/08	3	Deputy	Perth	Natural Causes	7/11/08
KOCH Dayle	13/5/06	14-17/10/08 21-23/10/08	7	State	Perth	Accident	28/11/08
**INMAN Mark	25/7/06	28-30/10/08	3	State	Carnarvon	Accident	30/10/08
**STARR Peter	1/8/07	29/10/08	1	Deputy	Perth	Natural Causes	30/11/08
**EVANS Nathan	18/8/05	29/10/08	1	Deputy	Perth	Accident	30/11/08
CATCHPOLE Andrew	5/10/97-10/10/07	7/11/08	1	State	Perth	Open Finding	17/11/08
**KAVAEFAIFI Ikafa-Ao	Not deceased	7/11/08	1	State	Perth	Not established beyond all reasonable doubt	7/11/08
SADLER Hugh	9/5/07	5/11/08	1	State	Perth	Natural Causes	7/11/08
**QUINN Mark	3/2/06	10-13/11/08	4	Deputy	Perth	Accident	10/1/09
VASIC Debroslav	3/10/06	2/12/08	1	Deputy	Perth	Suicide	19/12/08
*BRIGGS Lenny	2-3/10/06	8-11/12/08	4	State	Perth	Suicide	22/12/08
KABLE-RIDING Sandra	11/3/05	16-17/12/08	2	Deputy	Perth	Natural Causes	21/1/09
FOX Kenneth	13/4/06	13-14/1/09	2	Deputy	Perth	Natural Causes	9/2/09
*VOJINOVIC Slavoko	20/6/07	20-21/1/09	2	Deputy	Perth	Accident	28/1/09
TRENCH Michelle	9/8/01	11-13/1/09	3	Deputy	Perth	Unlawful Homicide	8/5/06
ADCOCK Daniel	3/10/07	17/2/09	1	State	Perth	Accident	25/2/09
CHRISTIE Susan	15-16/11/01	17/2/09	1	State	Perth	Unlawful Homicide	25/2/09
BLACKMAN John	30/4/07	17/2/09	1	State	Perth	Accident	24/2/09
**MUIR Daureen	8/2/07	18-19/2/09 adjourned 19-20/8/09		State	Perth		
HALFORD Lee	28/2/97	24-26/09 30/3/09	4	Deputy	Perth	Natural Causes	24/4/09
*WARD Ian **	10-20/3/09 11-14/5/09	27/1/08	14	State	Warburton Kalgoorlie Perth	Open Finding	12/6/09

**GREEN Edward **WRIGHT Norman **PTICHERS Glenn	26/5/07	23-27/3/09	5	Deputy	Esperance	Accident	27/3/09
GUEST Brian	27/12/08	3/4/09	1	State	Perth	Accident	3/4/09
**GREEUW Vicki	13/5/07	7-8/4/09 20/7/09	3	State	Albany	Misadventure	12/8/09
CHARLES Kathryn	4/2/06	21-23/4/09	3	Deputy	Perth	Suicide	22/5/09
**POORE Michelle	31/12/06	28/4-1/5/09	5	Deputy	Busselton	Accident	27/5/09
SMITH Tobias	11/5/05	25-28/5/09	4	Deputy	Perth	Natural Causes	26/6/09
*NUNDLE Lee	27/4/07	5/6/09	1	State	Perth	Natural Causes	6/7/09
*GALLOP Benjamin	26/8/07	5/6/09	1	State	Perth	Accident	8/7/09
HESLOP Amanda	7/1/07	11/6/09	1	State	Perth	Suicide	8/7/09
**MORTON Andrew	22/9/06	22-23/6/09 26/6/09	3	State	Kalgoorlie Perth	Accident	9/7/09

Mr Hope heard 19 Inquests 50 sitting days Ms Vicker heard 18 Inquests 56 sitting days	Total Inquests heard 37 Number of Sitting Days 106 5 Prison Deaths In Custody conducted 14 Country deaths conducted by the State Coroner and Deputy State Coroner
* Death In Custody (DIC)	** Country death

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

Courtney Moloney and Scott Johnson

Courtney Anne Moloney and Scott Kirby Johnson both died on 19 December 2006 at Quairding as a result of head injury and multiple injuries including head injury respectively. The inquest hearing was held at the Northam Coroners Court on 19-20 August and the findings were delivered by the State Coroner on 29 August 2008.

The State Coroner concluded that Courtney Anne Moloney and Scott Kirby Johnson both died as a result of a motor vehicle crash which occurred when a Ford Falcon Sedan being driven by Allan Estreich left an unsealed road, Dorakin Road, and collided with a tree close to the road.

No other vehicles were involved and there was no evidence of any animals or any other exterior influences contributing to the crash although the possibility that there was an animal on the road immediately before the crash cannot be excluded.

All of the persons in the vehicle were young and all were relatively inexperienced drivers of motor vehicles.

Prior to the crash the same vehicle had been driven by one of the deceased, Scott Johnson, at an excessive speed.

The State Coroner found that, sadly, in this case a number of young persons were together in a motor vehicle being driven by an inexperienced driver when the vehicle was involved in a collision with a tree. The evidence would suggest that the vehicle was being driven at an excessive speed, particularly in the context that the road surface was not sealed and the road was relatively narrow with a number of trees growing close to the road.

What had been a fun day for four young persons was suddenly transformed into a disaster for all concerned and two fine young persons died as a result.

The State Coroner noted in his finding that it appeared clear from the tyre marks located at the scene that for some unknown reason the driver turned the vehicle sharply to the right at a speed which was excessive for the steering input. This resulted in a state of "yaw" with the vehicle taking a curved path with its wheels, while not locked, scuffing sideways. The vehicle then struck a tree with considerable force and the two deceased persons died as a direct result of the crash.

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

In his findings the State Coroner made comments and recommendations as follows -

COMMENTS ON MATTERS RELATED TO PUBLIC SAFETY AND THE ADMINISTRATION OF JUSTICE

Evidence Capture

After the crash and the initial police attendance the scene was not preserved and no effort was made to accurately mark and photograph the scene until 1:45pm on the next day. This was in spite of the fact that an officer attached to the Major Crash Investigation Section had attended at the scene at about 10am on that morning.

The State Coroner also noted that Western Australia Police does provide scene attendance guides for the benefit of officers involved in investigating crash scenes and these specify that if the crash occurred at night or during poor lighting conditions officers should return as soon as possible during daylight hours and obtain further photographs of the crash scene. This clearly did not occur on this occasion.

The guides also provide that tyre marks should be adequately photographed and that the photographs should include close-up photographs showing any changes in appearance of those marks and close-up photographs of the commencement of tyre marks. That was not done on this occasion.

The State Coroner went on to comment -

While it appeared that the crash scene was not significantly damaged in the intervening period and the evidence of Senior Constable Magorian was to the effect that even if the quality of photographing had been better, he still would not have been able to give expert opinion as to the speed of the vehicles, it is most unfortunate that these limitations in respect of evidence capture were allowed to occur.

It was not known on the morning of 20 December 2006 that the evidence of witnesses as to the driving would be as limited as it ultimately turned out to be and so there was at least a possibility on that morning that serious charges might have been laid. In that context good evidence capture at the scene was potentially important. Even if the scene evidence was not sufficient to allow for expert opinion evidence to be given as to speeds, it was important objective evidence as to the movement of the vehicle immediately prior to the fatal crash.

Close-up photographs of the commencement of tyre marks are important for a number of reasons including assisting in providing objective evidence to support the drawing of inferences as to the location of a vehicle on a road immediately before loss of control.

Contrary to the submissions on behalf of the Commissioner of Police, this case had demonstrated that not all police do ensure that as far as reasonably practicable all fatal crash scenes are preserved, protected and recorded as soon as possible.

The State Coroner made the following recommendation.

Recommendation 1
I recommend that Western Australia Police should take steps to ensure that fatal crash scenes are adequately preserved and photographed and that officers are aware of the scene attendance guides and the need to obtain adequate photographs. If a fatal crash has occurred at night or during poor lighting conditions, it is important that officers return to the scene as soon as possible during daylight hours to obtain reliable photographs of the crash scene.

The State Coroner made the following observation and recommendation in his finding as follows –

The Vehicle Crash Report

While the Vehicle Crash Report prepared by Senior Constable Magorian was of an excellent quality, it was not completed until 17 August 2007, eight months after the crash and at least three months after the decision was made not to prosecute the driver with a serious offence, such as the offence of Dangerous Driving Occasioning Death, in respect of the collision.

While it was said by the officers that there was discussion in respect of the provision of an expert report and it was determined that in the context of the collision occurring on a gravel road, expert opinion evidence would not have been forthcoming in respect of the speed of the vehicle which could have been used in a criminal trial, in a context where family members were understandably distressed as to the outcome, it would have been helpful if there had been some record of that discussion and an explanation readily available as to the reasons for the lack of forensic evidence.

While I accept that in cases where a report may not assist a possible prosecution it may be considered that preparation of a full report would not always be an appropriate use of limited resources, it would have been helpful if there was at least on file some documentation which would record whether or not any assessment had been made as to whether it was possible to make any determinations as to the speed of a vehicle based on objective forensic evidence.

Recommendation 2

It is recommended that for traffic crashes which result in the loss of life but the driver has survived (particularly where speed is a factor) police should prepare a Forensic Vehicle Crash Report as a matter of routine at the earliest opportunity. While the report which would be prepared in a case where speed could not be determined with precision might not be as comprehensive as a report where such a determination could be made, there should be at least some form of documentation which would identify to anyone reading the police file the reasons for the lack of availability of such evidence.

The families of the deceased persons raised concerns in respect of the penalty provisions available pursuant to section 50 of the *Road Traffic Act 1974*. The State Coroner addressed those concerns as follows –

While it is accepted that in respect of many offences of failing to comply with a leaner's permit the present penalty provisions are adequate, in other cases, particularly where a failure has resulted in injury or death, it may be appropriate for a penalty to be imposed which would prevent the driver from driving a motor vehicle for a specified period after such a conviction.

Recommendation 3

I recommend that the penalty provisions pursuant to section 50 of the Road Traffic Act 1974 should be reviewed to determine whether they should allow for possible imposition of a penalty which would restrict the ability to drive of the person who has committed the offence for a specified period or until specified conditions have been satisfied.

The Commissioner of Police responded to the above recommendations made by the State Coroner. In a letter dated 9 September 2008 to the State Coroner the Commissioner advised the following –

> "I note in your findings that you refer to the penalty provisions under section 49(1) of the Road Traffic Act 1974 for which the first offence is 6 penalty units and recommend that section 50 of the Road Traffic Act 1974 be amended to prohibit or restrict a person who had committed an offence from driving for a specified period. I am informed by the Traffic Policy Unit that the amendments to the Road Traffic Act 1974 and the introduction of the Road Traffic (Authorisation to Drive) Regulations 2008, specifically regulation 50, would result in a conviction for an offence against section 49(1)(1) of the Road Traffic Act 1974. The driver then comes within the scope of section 51(5a) of the Act, resulting in an automatic disqualification from driving for a minimum of 3 months or a longer period if determined by a court.
>
> This legislative reform addresses the initial concerns of the family of the deceased prompting a review of "whether there should be an increased penalty, possibly including mandatory learner's permit disqualification, for offences of this type".
>
> I under that the Director General of the Department for Planning and Infrastructure also intends writing to you on this matter."

As of the date of the Annual Report the Office of the State Coroner had not received any advice from the Director General of the Department for Planning and Infrastructure.

Dayle Carlee Koch

Dayle Carlee Koch died on 13 May 2006 at Kelmscott as a result of butane toxicity. The inquest hearing was held at the Perth Coroners Court on 14-17 October and 21-23 October 2008 and the findings delivered by the State Coroner on 28 November 2008.

The deceased was a charming and popular 16 year old teenager who unfortunately had experimented with butane on a number of occasions prior to her death.

On 13 May 2006 she went to a party at 11 Blantyre Way Kelmscott, an address where relatively young people were in charge and there were no rules. It was a place where teenagers could consume alcohol or drugs with relatively impunity.

At the party the deceased consumed butane which she had purchased and then subsequently joined Kass Stuart, Michael Brandis and Ms R in Mr Stuart's car for a drive.

The State Coroner found that the evidence indicated that Mr Stuart was interested in the deceased, but his interest was not reciprocated.

At the park butane was provided to the deceased, consumed by her and caused her to collapse.

The deceased was not taken to a nearby hospital which was only minutes away but was taken back to the party at 11 Blantyre Way. At that address many of the people were teenagers who were intoxicated and in no fit state physically or emotionally to respond to the emergency situation.

Vital minutes were lost while ineffectual attempts at resuscitation were made, particularly when the deceased was wet with a garden hose and subsequently placed in a bath in the house and washed down.

As a result of consuming the butane the deceased immediately suffered ventricular fibrillation, her heart stopped and she was deeply unconscious. At that stage the deceased was in a desperate condition and for her to have any hope of survival, immediate effective resuscitation measures were required.

Effective resuscitation was not conducted and the deceased was not taken to hospital. When she was eventually taken to Armadale Kelmscott Memorial Hospital the deceased had already passed away.

This was a tragic and unnecessary death. The initial collapse was caused by inhalation of a dangerous volatile substance, butane, and there was then no immediate effective response to the emergency situation.

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

The State Coroner made the following comments and recommendations.

COMMENTS ON MATTERS CONNECTED WITH THE DEATH INCLUDING PUBLIC HEALTH, SAFETY AND THE ADMINISTRATION OF JUSTICE

The Availability of Butane

Butane is a potentially intoxicating hydrocarbon and it can be found in a range of retail outlets including supermarkets, newsagencies, hardware stores and camping stores. In this case the butane was in cans designed for cigarette lighter refill.

Professor Joyce in his evidence at the inquest stated that butane can cause death by way of ventricular fibrillation at recreational dosages. It can cause the heart to stop resulting in deep unconsciousness and then death within a matter of minutes. It is, therefore, a potentially extremely dangerous substance and a concerning aspect of the evidence in the present case was the fact that a number of young persons, under the age of 18 years, stated that they regularly purchased butane for the purpose of self-intoxication.

Recommendation No. 1

I recommend that the sale of butane in the form of cigarette lighter refills be prohibited to persons under 18 years of age and that retailers be required to ensure that any such products on display are either behind a counter or in locked display cabinets.

A response to the above recommendation was received from the Minister for Water; Mental Health by letter dated 10 February 2009 as follows –

> "Thank you for your letter dated 4 December 2008 to the Hon Troy Buswell MLA requesting advice on any action which is proposed to be taken by the Government as a result of your recommendation arising from the inquest into the death of Ms Dayle Koch. The matter has been referred for my direct reply in my capacity as Minister with responsibility for alcohol and other drugs.
>
> I understand that pursuant to Section 27 of the Coroners Act 1996 the Annual Report to the Attorney General on deaths which have been investigated throughout the year is to be submitted to both Houses of Parliament.

One of the recommendations made by the Western Australian Taskforce on butane Misuse in October 2006 was to monitor the appropriateness of legislation to restrict the sale of butane to minors. The Taskforce recommended that the need for legislation was not indicated at that time. It was further recommended that the Drug and Alcohol Office revisit the issue in 12 months and provide further advice in light of circumstances in Western Australia at that time. In place of legislation, the Taskforce recommended active promotion of a voluntary Code of Practice for retailers of butane products.

I have considered your report and its findings, the original Taskforce Report and other information about the misuse of butane and consider that continuing with efforts to strengthen adherence to the voluntary code of practice is the most efficacious course of action, at this time.

Regulation of butane is a complex issue and I believe the risks associated with legislation outweigh the benefits of such a measure. Butane misuse in WA is cyclical and episodic in nature and has continued to remain limited to a small number of young people since the investigation of the Taskforce. I have seen no evidence for a change to the Tasforce's view that legislation may promote the potential for butane to be used as a drug and its prohibition may be an attraction to some young people.

Prohibition for minors may also encourage predatory adults to supply the product to young people.

There are a wide range of butane products which are widely available in an estimated 6000 retail outlets. Retailer compliance and enforcement of such legislation would be problematic and logistically difficult. Additionally, legislation would not resolve the issue of secondary supply to people under the age of 18 years.

The outcome of the United Kingdom experience indicates that a range of factors contribute to butane misuse and mortality. Therefore, I believe that comprehensive multi-faceted response will be the most effective at this time.

The Drug and Alcohol Office is working closely with the Retail Traders' Association (RTA) to increase awareness and compliance with the existing Code of Conduct by :
Improving the database of retailers of butane products;
Consulting with industry about ways to improve compliance;
Producing new resources to address different retailer groups; and
Promotion by the RTA through various medium including industrial newsletters, electronic mailing, meetings and web based information.

Thank you for the opportunity to provide advice about the actions that will be taken to prevent and reduce the harms associated with the misuse of butane".

Mark James Inman

Mark James Inman died on 25 July 2006 at sea off Carnarvon at approximately 25^0 07 Latitude South, 113^0 29 Longitude East from unknown causes. The inquest hearing was held at the Carnarvon Coroners Court on 28-30 October and the findings delivered by the State Coroner on 30 October 2008.

The deceased was a 42 year old Aboriginal male who in July 2006 wished to obtain employment to provide for his family.

The deceased did not have educational qualifications and was in no position to negotiate in respect to his working conditions.

The deceased was employed by the Skipper of the vessel MW Murchison, Rodney Houghton. The deceased was required to enter into a "Share Fishing Voluntary Agreement". On 25 July 2006 the deceased fell off the vessel while attempting to reach the lazy line rope. To do so he was standing in an unsafe position from which he fell into the water. This was a hazardous activity.

Had the deceased been adequately instructed and supervised he would not have been involved in that activity, particularly as the same task could have been undertaken relatively safely by, for example, use of a boat hook.

When the deceased fell from the vessel it appears that there was an inadequate response to the emergency situation.

The deceased was not wearing a flotation device even though he had not been to sea in similar circumstances before. In the circumstance that he was fully clothed and was not wearing a flotation device he was not able to stay afloat for long although he did manage to remain above the surface for a significant number of minutes during which time he was calling for assistance.

There was no search light on board the vessel and as the night was particularly dark with no moon present, it was very difficult for the crew to see him once he was outside the light cast by the vessel's work lights. This failure to have a search light on board the vessel during night fishing was a serious breach of reasonable safety precautions.

Although the vessel did turn around quickly to retrieve the deceased and although his location was recorded, the vessel had moved away from him and he was unable to reach it. The fact that the vessel did not execute a Williamson turn, as specified in the vessel's Operations Manual, may have contributed to the failure to locate and retrieve the deceased from the sea.

It was the view of the State Coroner in the circumstances in which the deceased fell from the vessel were unsatisfactory and resulted from an inadequate approach to safety procedures on the vessel. The subsequent response to the emergency was also unsatisfactory and the fact that although the vessel was involved in night fishing there was no search light on board was inexcusable.

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

The State Coroner made a number of recommendations as follows –

Recommendation No. 1

I recommend that survey requirements for commercial fishing vessels involved in night fishing specify that those vessels carry search lights suitable for use in person overboard situations and that those search lights be ready and available for immediate use while the vessels are at sea.

Recommendation No. 2

I recommend that survey requirements for sea going commercial fishing vessels of this type require PFDs to be on board and available for use by all crew members. It should then be for the Skippers of the vessels to ensure that these devices are worn when appropriate and particularly that they are worn by all very inexperienced crew and by any crew members working in hazardous situations.

Recommendation No. 3

I recommend that skippers of fishing vessels engaged in night fishing should be required to demonstrate an ability to perform a Williamson turn at night and to pick up a person overboard in order to obtain the required Certificate of Competency. The demonstration should take place as part of a simulated rescue operation and not only be a theoretical exercise.

Recommendation No. 4

I recommend that consideration be given to reviewing the operation of the Occupational Safety and Health Act 1984 so that Act has application to the fishing industry in Western Australia and particularly so that Act provides some protection for persons working on fishing vessels.

In the context of the present case the Act should –

- Apply to skippers so they have a responsibility to provide a safe working environment for their crews; and
- Apply to vessel owners entering into share fishing agreements to require them to ensure that their vessels are supplied with appropriate safety devices and their vessels provide a safe working environment for crews.

A letter dated 8 December 2008 from the Deputy Commissioner (Operations) of the Western Australia Police was received at the Office of the State Coroner who advised that –

> "Thank you for your letter dated 7 November 2008 addressed to the Commissioner concerning responses to emergencies at sea. The Commissioner has noted your comments and referred the matter to me for a response.
>
> I have asked Assistant Commissioner Stephen Brown of the Traffic and Operations portfolio to review the marine search and rescue procedures generally to ensure that they reflect current best practice. As part of that process the Metropolitan Volunteer Sea Rescue Group will be consulted.
>
> Thank you for bringing these matters to my notice and I am confident that any matter that are identified will be resolved."

The Office of State Coroner received a letter dated 18 December 2008 from the Minister for Transport who advised the following –

> "Thank you for your letter of 7 November 2008 enclosing the Coroner's Findings regarding the circumstances surrounding the death of Mark James Inman.
>
> In response to recommendations from the State Coroner's investigation into the death of Mr Inman, WorkSafe has reconvened the Man Overboard Working Group (the Group). The Group consists of representatives from Worksafe, Department of Fisheries, Department for Planning and Infrastructure (DPI) and the industry. The four recommendations are being discussed at this forum to identify the operational practicalities involved in implementing them.
>
> The Group was originally created following the diving death of Mr Leeander Guyt in November 2003. The Group's discussion of the Coroner's recommendations arising from this fatality prompted enhanced targeted education campaigns such as Boating Communities Newsletter, media releases, stickers, safety brochures and also, legislative amendments to reduce risk to public and industry. For your information, I enclose a copy of the new Marine Safety brochure, 'Diver Below', which incorporates the responses to the Guyt inquest.
>
> DPI will advise you of the outcome of the Group's discussion of the Coroner's recommendations as soon as it is available."

Further advice was received on the 18 September 2009 from the Minister for Transport; Disability Services in which the Minister advised the State Coroner that WorkSafe convened the Man Overboard Working Group.

The Minister advised –

> "The Group has created a draft 'Man Overboard' Code of Practice for the Western Australian Fishing Industry. This code of practice will include identification of hazards and risk management relating to man overboard and is in direct response to the Coroner's recommendations.
>
> The finalized draft Code of Conduct has been released by the Department of Commerce, WorkSafe Division for public comment."

A letter dated 22 December 2008 was received from the WorkSafe Western Australia Commissioner addressed to the State Coroner in the following terms –

> "I am writing in response to a letter dated 7 November 2008 addressed to the Hon Troy Buswell MLA, Minister for Commerce, from your Administrator, Ms Dawn Wright. The letter was about your finding into the 2006 death of Mr Mark James Inman. Ms Wright's letter has been referred to me for reply.
>
> Your Record of Investigation into Death and the four recommendations contained within it are noted.
>
> WorkSafe Western Australia and the tripartite Commission for Occupational Safety and Health (the Commission) recognize that commercial fishing is a high-risk occupation and are fully committed to ensuring the safety and health of people working in this sector.
>
> A major role of WorkSafe is to promote and provide information to industry and the community to assist in the prevention of work-related injury and disease. In recent years, both WorkSafe and the Commission have undertaken various initiatives aimed at improving occupational safety and health outcomes in commercial fishing industry. This has included working with the Western Australian fishing Industry Council to assist them to develop industry-specific guidance material on occupational safety and health; establishing a tripartite advisory committee to the Commission to advise and make recommendations on occupational safety and health matters affecting the commercial fishing industry; conducting targeted pre-season inspections of commercial fishing vessels; issuing annual pre-season media releases on cyclone preparedness; advising the industry of the existence of new technology such as the "Mobialert" man overboard system and the availability of personal floatation devices; and advising of the need to implement safe systems of work. In addition, WorkSafe provides input to the Ministerial Maritime Facilities Advisory Committee (formerly the Ministerial Fishing Industry Advisory Committee) through its representative on the Maritime Safety Sub-Committee.
>
> WorkSafe treats fatalities as priorities for investigation and appropriately makes information available to employers, the public and other agencies with an interest in the outcome. Following the tragic death of Mr Inman, in 2006 WorkSafe published a Safety and Health Alert making a number of recommendations to assist in the prevention of man overboard fatalities. These recommendations include developing and implementing vessel emergency procedures for persons overboard; the implementation of systems to quickly retrieve persons from the water once they are found; the provision of personal floatation devices; and the availability and use of appropriate search lights.
>
> Since 2006, WorkSafe and the Commission have continued to undertake initiatives which aim to improve occupational safety and health in the commercial fishing industry. Most recently, in October 2008 the Commission formed a working party to develop a code of practice on 'man overboard' incidents. It is intended the code will provide practical guidance on the prevention of man overboard incidents and how to respond to them when they occur. The working party is tripartite with representatives from industry, unions and government as well as experts. Your finding and recommendations and issues raised in the Record of Investigation into Mr Inman's death will be taken into account during the development of the code and in the consideration of recommendations to the Commission.

With particular reference to recommendation number four in the Record of Investigation into Mr Inman's death, in July 2008 the Commission endorsed a recommendation that consideration be given to amending the Occupational Safety and Health Act 1984 to bring share fishing arrangements within its scope. This is to ensure the general duties for safety and health apply to all parties involved in share fishing. In addition, you may be aware that there is currently a national review underway to develop model occupational safety and health legislation for implementation by all states and territories. WorkSafe made a submission to the first part of the review, which included reference to legislative coverage of share fishing. It is pleasing to note that the subsequent report of the review panel has taken this matter into account. WorkSafe will continue to pursue the proposal for legislative change through these processes.

Your report will complement and enhance the initiatives WorkSafe and the Commission are undertaking to improve occupational safety and health in the commercial fishing sector."

Mark John Quinn

Mark John Quinn died on 3 February 2006 at Ore Pass D886 Level 9645, Perseverance Mine, Leinster Nickel Operations, Leinster from multiple injuries. The inquest hearing was held at the Perth Coroners Court on 10-13 November 2008 and the findings delivered by the Deputy State Coroner in January 2009.

The deceased was a 32 year old male senior shot firer who was considered by all who worked with him to be competent, experienced and safety conscious.

On the morning of 3 February 2006 he was the senior member of a charge-up crew tasked to assist in removing a hang-up in D886 pass.

He was aware of a number of the options being considered and of those involving explosives, he considered the circumstances best fitted the use of a Quikdraw cannon. It would seem in the physical circumstances with which he was presented this was correct.

The Deputy State Coroner found that the evidence indicated the cannon was more rarely used than it had been in the earlier part of the deceased's employment as a senior shot firer at Perseverance Mine. Consequently he probably was one of the more experienced shot firers with use of the cannon. He certainly indicated by his activities on the day he was aware of the correct procedures for selecting an appropriate barrel and working at a suitable distance from the pass.

He supervised Mr Shepherd in the setting up of the cannon while being observed by the trainee, Mr Gibson. Unfortunately he did not reject the barrel he had attempted to clean when it proved difficult to pass the projectile into the barrel with ease. He appeared to believe tapping to "coax" the projectile into the barrel was acceptable, even when loaded.

The initial explosion did not bring down the hang-up and the deceased supervised re-setting of the cannon before leaving the area.

The second firing was again not effective in bringing down the pass and the deceased returned to D886 and continued working on methods to bring down the pass with explosives, under the supervision of the Operations Engineer and the Development Foreman. It was decided an attempt would be made to blast the pass with a poly-bomb but difficulty was experienced in the physical dimensions making use of the poly-bomb dangerous without the assistance of a Manitou.

While other methods to do with water control and horizontal drilling from adjacent passes were considered, and progressed, the deceased continued in his attempts to use explosives directly under the hang-up.

The Deputy State Coroner found that the evidence would seem to have indicated the deceased reconsidered use of the cannon once the poly-bombs had brought down one of the conveyor belt flaps previously obscuring vision into the pass. He reset the cannon and while waiting for return of the propelling chamber continued with loading a charged projectile into the barrel. He was heard to tap/hammer and the assumption is he was hammering the hard casing designed in a fin at the bottom of the projectile, up into the barrel.

The Deputy State Coroner further found that on the evidence of Mr Locke would indicate this was repetitive and as a result I am of the view the spring loaded fuse reacted to the increasing release of force by detonating on the prospective fifth tap. The deceased's injuries would indicate he was standing over the barrel, possibly with it between his legs as he hammered. There was an explosion which killed the deceased instantly.

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

The Deputy State Coroner made the recommendation with respect to the safe use of the quikdraw cannons as follows –

Recommendation No. 1

The Department require the supply of product information sheets with any supply of impact fuse devices to include –

a) information on the safe use of the device expressed in large and clear print so that it can be easily read and understood in an underground working environment;
b) a large diagram of the side profile of the impact fuse showing the internal mechanisms (i.e. the spring, anvil and percussion cap) and how they function; and
c) appropriate warnings about how to handle the device (and the assembled charges) carefully, particularly when the locking pin is removed, including a warning not to hit the assembled charge with a hammer to insert it into the mortar.
d) the devices themselves be printed with the reminder"spring loaded".

The Minister for Mines and Petroleum sent advice to the Office of the State Coroner in a letter dated 30 March 2009 –

> "The Department of Mines and Petroleum has taken a number of actions on the above matter. As an immediate response to the accident that led to Mr Quinn's death, on 20 February 2006 a Mines Safety Bulletin (No. 76) entitled "Use of explosive mortar devices for bringing down rockpass or drawpoint hang-ups" was issued.
>
> As part of an incident investigation of a subsequent and potentially fatal explosion on 2 March 2007 involving the same QuikDraw cannon, it became apparent that some plastic tailfins had manufacturing faults that caused the premature explosion of the booster charge while still in the steel launch barrel. The manufacturer was contacted and all such devices were checked across Australia and faulty items destroyed. Another Mines Safety Bulletin (No. 78) with the above title was issued and all state jurisdictions were notified. The manufacturer improved the quality control for the tailfins and found an alternative manufacturer to rectify shortcomings in the boosters.
>
> In reference to the recommendations contained in your Record of Investigation of Death, the Department has assisted the manufacturer of the QuikDraw cannon in drafting an information sheet, suitable for underground mine use, on the workings and potential dangers of the impact fuse. In addition, the devices will be stencilled with a printed warning "shock sensitive".
>
> In support of the above actions, the supplier, in consultation with the Department, has prepared a comprehensive training manual on the safe use of these devices. The Department will make it a condition of the supplier's licence that it must provide safety information and access to the training materials to all purchasers of these devices. The training material will also be placed on the department's web site.
>
> I believe that the lessons learned from this tragedy will be used by industry to void the reoccurrence of a similar incident."

Kenneth Fox

Kenneth Fox died on 13 April 2006 at Fremantle Hospital from acute gastrointestinal haemorrhage in association with acute on chronic peptic ulcerations. The inquest hearing was held at the Perth Coroners Court on 13-14 January 2009 and the findings delivered by the Deputy State Coroner on the 9 February 2009.

The deceased was a 62 year old male who had been suffering gastrointestinal problems for approximately 2-4 weeks prior to 12 April 2006. He had presented to his General Practitioner (GP) and the local hospital with abdominal pain and symptoms suggestive of constipation. He apparently self-medicated for the pain with aspirin and ibuprofen without advising any of his treating physicians he was taking large quantities of these medications. Certainly it is not recorded with respect to his GP, the RKDH notes, the ambulance records, or the emergency triage notes.

It is unclear as to why the deceased failed to mention the aspirin and ibuprofen when asked about his medications, however, he may have interpreted the question related only to prescribed medication and not understood the significance of the aspirin and analgesics without prompting by way of a direct question. In view of the fact there was concern he was suffering a gastrointestinal bleed of some type by the time of Fremantle ED triage these would have been relevant questions.

He was reviewed by Dr Nanda as the Registrar on duty and seen within 30 minutes; again with symptoms of a gastrointestinal bleed. Dr Nanda saw his symptoms as mixed upper and lower GI bleeds and sought further input from the Surgical and Medical Registrars.

Dr Cruse explained in his evidence there can be difficulties with determining whether or not a bleed originates in the upper or lower intestine and the relevance of the different teams. It is unusual for a patient to present with symptoms of both, however, it is not unheard of and the best diagnosis is by gastroscopy.

In view of the fact Dr Nanda had diagnosed the deceased as having had a massive GI bleed and being in shock, effectively hypovolaemic, the deceased needed to be stabilised and fluid resuscitation was appropriate. It would have also been appropriate to organise emergency endoscopy to diagnose the appropriate team admission.

However, all registrars seemed to believe the matter was not pressing enough to arrange overnight and believed it could wait until morning.

Dr Cruse was firmly of the view it would have been easier to find a person qualified to do emergency endoscopy during the night than it was later at hand over once the lists and working day had started.

There was some oscillation between the medical and surgical teams overnight without anything specific being arranged prior to the start of the working day on 13 April 2006.

Unfortunately, this timeframe was unforgiving in the deceased's circumstances. He deteriorated again, probably somewhere around 8:00am just as the hospital working day was commencing with organised commitments. He certainly became haemodyamically unstable. Dr Cruse arranged aggressive fluid resuscitation in an attempt to stabilise the deceased while attempts were made to locate a suitable physician and theatre for an emergency endoscopy. There was no one available and although every effort was made to stabilise the deceased, and prepare him for the endoscopy, he deteriorated and suffered cardiac arrest from which he could not be resuscitated.

Dr Cruse is quite adamant it is likely the deceased's life could have been saved had a diagnosis of the peptic ulceration been made earlier and steps taken to prevent a repeat bleed.

Despite a gastroenterologist eventually being located who could perform the endoscopy, he did not arrive at the hospital in time to save the situation for the deceased and he died at 10:36am on 13 April 2006.

The Deputy State Coroner found that the deceased died as the result of Natural Causes.

The Deputy State Coroner made observations and recommendations in the finding as follows -

Procedures Put In Place By Fremantle Hospital

The deceased died of a condition he was suffering prior to his admission to hospital, the effect of the death of a patient when that death was perceived as avoidable by his treating medics and nurses is a devastating experience for those professionals as well as the family.

The inquest heard evidence from Professor Fletcher, Head of the Department for General Surgery at Fremantle Hospital and also Clinical Director of Surgical Services at Fremantle Hospital. In April 2006 he was not the Clinical Director but was Head of the Surgical Department.

Professor Fletcher explained the hospital believed the difficulty experienced at approximately 08:00hrs on 13 April 2006 arose as the result of there not being a dedicated surgeon available to provide emergency cover once hospital theatre lists had commenced in the morning. Professor Fletcher explained there are a number of gastroenterologists who can perform an endoscopy without supervision. General surgeons can perform endoscopies but so can gastroenterologists who are Fellows of the Society of Gastroenterologists.

In April 2006 Fremantle Hospital had ten practitioners who could perform an endoscopy without supervision including some fellows. Professor Fletcher explained that while there were positions for additional staff in 2006 the recruitment procedures had not provided additional gastroenterologists who were capable of performing endoscopies without supervision. That is a situation which is beginning to improve.

As a result of the problems experienced with attempting to obtain an available surgeon for the deceased and similar problems; Fremantle Hospital, since January 2008, has implemented 'A General Surgeons Agreement' which appears to be working well and has been adopted by other tertiary hospitals.' It avoids the situation where all the gastroenterologists and surgeons were already committed to procedures in other theatres or at other hospital. The rostered Day Surgeon would be available to do an urgent endoscopy as he would be already present in the relevant hospital.

Specifically part 7 of the agreement provide 'Day Surgeons', who work form 08:00 – 18:00hrs, must be at the hospital during their rostered period. They must withdraw from any other commitment in the public or private sector whilst providing that surgical cover. They are only able to leave the hospital if the head of department is satisfied the day surgeon should leave in order to personally attend to an emergency at another facility where there is clear and present danger of life or limb. In those circumstances they are released from the hospital but only for the period reasonably required to attend the emergency and whilst cover is being arranged by the relevant head of department.

This differed from the situation in 2006 where there may have been a 24 hour roster period but it did not require a relevant consultant to be available in the hospital during working hours, in that whilst they were on call they could still be attending another hospital and working in a different location.

The January 2008 Agreement has been signed by the AMA and Director General of Health but is also signed by the individual surgeons. Each surgeon agrees to relinquish all other responsibilities at the time they are gong to be present in the hospital during the day. Currently it is only effective in the major tertiary hospitals as those hospitals are the only ones, to date, where the supply of surgeons can be controlled. Each tertiary hospital has a region for which it is responsible and the surgeons from those regions are included in the tertiary hospital roster commitment. Regional patients are transferred to the relevant hospital if necessary.

The situation works by the relevant day surgeon being required to be physically present at the relevant hospital from 8:00am to 6:00pm and a rostered on-call emergency surgeon to be available to the hospital from 6:00pm to 8:00am. The relevant hospital also insures that there is a theatre available with the relevant staff to assist the surgeon during his time at the hospital. Emergency cases which come in during the late afternoon tend to be done during the evening. There is a general trend away from operating at night as the result of international studies demonstrating the out come is generally less satisfactory for surgery performed completely out of hours. As a result it is the consultant surgeon who decides which cases require to be done immediately and the cases which can actually wait until the following morning. Part of the difficulty with the deceased was the different registrars being uncertain as to the diagnosis of an upper or lower gastrointestinal bleed and believing the situation could wait until the morning for review, rather than being able to consult with a rostered emergency on-call surgeon to decide on priority. The inquest was provided with 'Haemotemsis, upper GI bleed guideline' which was apparently first issued in June 2003 but revised in May 2008. It outlines the procedures and protocols to be followed in ED in cases of suspected upper GI bleeds and positions to be notified to ensure urgent gastroscopy, with a guide time frame depending on the severity of the bleed.

Dr Nanda stated in evidence he would have classified the deceased on admission to ED as having had a massive bleed due to his assessment the deceased was in shock. While that indicated the deceased needed to be stabilised it also, using the guide, wound detail notifying various relevant registrars (which was done) and organising emergency gastroscopy within two hours. Dr Cruse indicated arranging an emergency gastroscopy via an on-call surgeon would be much easier between 1:00am – 6:00am than it was at 8:00am under the system in force at the time of the deceased's death.

The general intent of the protocol was followed for the deceased in the emergency department; however, the difficulty was the decision between whether or not to involve the surgical or medical teams. The guidelines outline the investigations which should be undertaken and really do not focus on a particular team for admission but rather outline the timeframe for emergency gastroscopy and the procedures to undertake in preparation for that. This was not done due to the decision appearing to hinge on the relevant team. The guideline indicates General Medicine has primary responsibility for the management of the patient but consultation with other teams is required. The Endoscopy unit is responsible for endoscopy and its coordination while general surgery is required to see the patient on admission.

Professor Olynck, Head of Department of Gastroenterology also gave evidence. He was not Head of Gastroenterology at the time of the death of the deceased. It is his role and function to coordinate the gastroenterology service including the creation of the endoscopy roster for the hospital.

Professor Olynck also outlined the revised haemostasis/malaena protocol or guideline for the admission of a patient suspected of suffering a GI bleed. He also outlined a document referred to as "patient assessment" which is a working document physically placed on the patient's file14 and records the outcome for that patient as the protocol is followed.

Where it is suspected the gastrointestinal bleed is major then the on-call endoscopist is called as per the protocol but where it is massive then the patient is sent to theatre for an emergency endoscopy and operative intervention if required. Professor Olynck clarified the massive bleed required surgery regardless of whether or not it was on-going or ceased.

In the case of the deceased he was suffering hypovolaemic shock, as determined by Dr Nanda on admission, and stabilised. The situation would now be he would go to theatre, an endoscopy would be performed, followed by treatment or surgery as required. This requires additional facilities by way of a dedicated theatre in close proximity to an intensive care unit, or at the very least a higher dependency unit.

With specific reference to the situation facing the deceased, Professsor Olynck was of the view a high dependency unit with both nursing and medical staff attached, with fast access to the gastroenterology department would have prevented the outcome for the deceased. In conjunction with the revised protocols and surgeons agreement there would then have been the facility to perform the emergency endoscopy in

a theatre; where a laparotomy for surgical intervention could then proceed if warranted.

In Professor Olynck's view the endoscopy unit at Fremantle Hospital in 2006 was insufficient to properly care for the type of emergency facing the deceased. It had two procedure rooms which were small and while they were sufficient for the endoscopy procedure they were not appropriate in the event a laparotomy was also needed, there being no proper provision for anaesthetic support.

Professor Olynck indicated for a patient with a further massive bleed, such as the deceased's at approximately 08:00hrs, the need was an emergency endoscopy in an operating theatre where there was provision to move to surgery, with a surgeon capable of performing the required intervention. The provision of a high dependency unit or extended intensive care unit with good access from the gastroenterology unit would be the optimal situation.

The Court was advised that planning has already been proposed for such additions to Fremantle Hospital. Professor Olynck indicated larger and safer endoscopy rooms had been planned for Fremantle Hospital which would be capable of undertaking interventions, with appropriate anaesthetic and resuscitative supports, as those required in the case of the deceased.

Professor Fletcher also referred to the fact there were plans for an extended ICU which with the addition of the Day Surgeon agreement and a dedicated theatre would also have prevented the outcome with the deceased.

Both Professors are keenly aware of the current 3% budgetary spending cuts requested by government. Both are extremely concerned the already approved plans currently with Treasury, will be abandoned as a result of any cuts. The high dependency unit or extended ICU would be available for other emergency procedures, not just undiagnosed gastrointestinal bleeds. Fremantle Hospital is extremely anxious about the future of its planned extensions.

Recommendation No. 1

In view of the fact all consultant doctors involved with the care of the deceased were of the view the proposed extensions for the ICU with High Dependency Gastrointestinal Unit access would have avoided the outcome for the deceased; I recommend the proposed Fremantle Hospital expansions be excluded from the current budgetary cut back requirements.

The Office of the State Coroner received a report from the Director General dated 17 July 2009 the following in respect to the above recommendation made by the Deputy State Coroner –

> "A copy of the Finding has been forwarded to the Chief Executive of Fremantle Hospital and the State Health Executive Forum for consideration of the recommendations.
>
> To date there has not been an identified source of funding for the expansion of the ICU at Fremantle Hospital and Health services. Options for funding the ICU expansion from within Fremantle Hospitals own budget are been developed and will be discussed as part of the budget requests for 09/10 and outwit years."

Lee Rebecca Halford

Lee Rebecca Halford died on 28 February 2007 at Sir Charles Gairdner Hospital from multi system failure following acute onset (acute diabetic ketoacidosis) diabetes mellitus in a person with known lipoatrophic panniculitis. The inquest hearing was held at the Perth Coroners Court on 24-26 February 2009 and 30 March 2009 and the findings delivered by the Deputy State Coroner on the 24 April 2009.

The deceased was a 17 year old girl brought up in Esperance but obtaining her secondary schooling in Perth. She had generally been a happy healthy child other than developing a very rare autoimmune condition, C4 lipoatrophic panniculitis, when she was 12. Her treating physicians at that time did not automatically assume a predisposition to autoimmune conditions, which in hindsight, may have been indicated.

The deceased continued her schooling through her illness and progressed well. She and her family were health conscious and lived a typical healthy close-family life style. The deceased's mother was very aware of her daughter's general level of wellbeing.

The deceased was due to commence University in late February 2007. This was to be an exciting new phase for the deceased's life. She celebrated her mother's 50th birthday with the family and left for Perth the following day to attend lectures and tutorials on the Monday. The deceased, her family and friends attributed her tiredness and a passing headache to all the activities involved in the general excitement of that weekend.

The deceased became unwell on that Sunday (25 February) to Monday (26 February) night. She did her best to meet her university commitments but was severely distressed at vomiting in public at her new campus where no one thought to ask whether or not she was ill. She returned home and tried to rest her way to recovery.

She became more unwell and by Tuesday morning 27 February 2007 was still vomiting. Her sister and boyfriend organised a doctor's appointment and the deceased attended Dr Wright at Claremont General Practice. Dr Wright did not take a general medical history but he did take a history of her presenting symptoms and examined her while noting clinical signs. He did not record observations he considered to be in the normal range but took her temperature and assessed her hydration in view of her continued vomiting.

In Dr Wright's view the deceased's presentation was consistent with gastroenteritis or food poisoning. Both can be debilitating and hydration is an important factor which needs to be managed. Dr Wright administered an antiemetic and prescribed Stemetil tablets. He advised The deceased to sip fluids.

The deceased returned to the unit. She improved slightly then deteriorated to the extent she wished to go to hospital. Her parents, from Esperance, tried to facilitate this even though it was not a system with which they were familiar. In attempting to get the deceased to the nearest hospital it was suggested she return to the doctor she had already seen as he would have a clinical picture of her last presentation. It was arranged and Dr Wright saw the deceased at short notice.

The Halfords expected Dr Wright to admit the deceased to hospital. Dr Wright did not have the ability to do that, but more relevantly he did not view the deceased as ill enough to warrant hospital at that time. He viewed her ability to pass urine, along with the rest of her examination, as a sign her level of dehydration was still manageable at home. He considered her to be less hydrated than in the morning but still

manageable. He gave the deceased another injection and suggested a different oral medication to assist with appropriate hydration. He did not consider diabetes as a diagnosis because in his view there were no presenting signs. She was not complaining of tiredness, lethargy and, if she was thirsty, it would be accounted for by her vomiting. Her level of urine production masked her dehydration and by all accounts the deceased was alert and orientated and masking her level of unwellness efficiently. It is recognised young people often do.

The deceased returned home. Her mother flew up from Esperance and on seeing the deceased knew she was very unwell. She believed the most effective way to get the deceased into hospital without having to sit vomiting in an ED was through a GP. A locum service was called and Dr Lip attended. He examined the deceased, was satisfied she did not have food poisoning, but believed everything he was seeing was consistent with gastroenteritis. He did not see her presentation as indicative of the onset of diabetes and on Dr Hurley's evidence that was understandable. In Dr McBride's view there was enough of concern to warrant a recommendation the deceased go to hospital without diagnosis, however, she would have warned about the possibility of a wait in an ED due to the priority system.

Dr Lip did not see the deceased's presentation as of enough concern at that time to recommend hospital then and there. He did not appreciate the level of Mrs Halford's concern and the expectation he could admit the deceased to hospital. The deceased was participating in the conversation and aware of her surroundings. She was not exhibiting the level of unwellness a GP would expect with metabolic acidosis. He provided Mrs Halford with a note of his consultation, along with the required invoicing by the service he worked for, but did not go through the note with Mrs Halford and draw her attention to it in anyway, presumably because he did not believe The deceased to be severely unwell and he believed she would be taken to hospital if she deteriorated further.

According to Dr Hurley the deceased had a complex case of unusually fulminant type 1 diabetes. With the benefit of hindsight, the deceased should have been taken to hospital on the afternoon or evening of Tuesday 27 February 2007 for treatment of her vomiting and any resulting dehydration. Once there her illness would have been diagnosed and treated.

That did not happen. Instead the deceased's metabolic acidosis progressed to the extent she became unrousable and suffered cardiac arrest. An ambulance was called and she was resuscitated and taken to hospital.

Unfortunately the damage to the deceased's core body organs by that stage was irreversible and she died at Sir Charles Gairdner Hospital ICU on 28 February 2007.

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

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

Recommendation No. 1

This finding be sent to –
The Royal Australian College of General Practitioners. In an effort to elevate general practice awareness of differential diagnosis of sudden onset DKA in young people.

Recommendation No. 2

In view of the reportedly rising incidence of diabetes in young people, GPs not overlook the fact the ability to pass urine may mask developing dehydration due to the onset of DKA and use of a urine sugar test may be a useful tool in diagnosis.

Recommendation No. 3

GPs explain the unpredictability of ED admissions times as a necessary factor in prioritisation of medical care while explaining the benefits of access to specialist support in undiagnosed illness.

Recommendation No. 4

GPs consider that when a patient has suffered an autoimmune condition in the past it may indicate a propensity to other autoimmune conditions.

The Office of the State Coroner receive a report from the Director General dated 17 July 2009 the following in respect to the above recommendation made by the Deputy State Coroner –

"Inquest findings have been forwarded to –

- The Royal Australasian College of General Practitioners;
- Health Networks Branch
- Four Hour Rule Program Manager

An update will be provided in February 2010.

ONGOING".

The Office of the State Coroner sent a letter dated 26 April 2009 to the Royal Australian College of General Practitioners inviting them to comment on the recommendations made by the Deputy State Coroner. At the time of preparing this report the Office of the State Coroner had not received a response.

Michelle Jane Poore

Michelle Jane Poore died on 31 December 2006 at the Busselton District Hospital from Acute Drug (Amphetamine) Toxicity. The inquest hearing was held at the Busselton Court Coroners Court on 28 April – 1 May 2009 and the findings delivered by the Deputy State Coroner on the 27 May 2009.

On 30 December 2006 the deceased travelled to Dunsborough, with her boyfriend Mr Gudden, expecting to have a happy social weekend, with possibly some reservation about socializing with a group of old school friends, a number of whom she only knew by repute rather than personally.

In preparation for their celebrations the deceased and her boyfriend had purchased between them six ecstasy tablets known as “pink hearts”. They had purchased them jointly and the tablets were of different shades of pink.

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

The Deputy State Coroner made comments in respect to public safety and recommendations as follows -

Comments on Public Safety

The death of the deceased again highlights the uncertainty of the ‘party drug scene’. Due to the end of the line transactions being small it is very difficult to trace a source. This effectively serves to protect manufacturers and there are few ways of knowing exactly what one is consuming, irrespective of the individual metabolic effect also being unpredictable.

These drugs are dangerous, they can kill and often the circumstances in which they are taken are simply not protective of adverse individual responses.

Recommendation No 1

Where there has been a fatal drug overdose police ensure any remnants of drug are analysed to the maximum capacity in order to assist with both medical understanding of the death and police intelligence with respect to sourcing of the drugs.

Recommendation No 2

Where there has been a fatal drug overdose with hospital attendance the police seize any hospital admission blood which may have been taken for screening to assist with medical intelligence with respect to drug fatalities and police intelligence with respect to drug sourcing.

A letter was sent dated 17 June 2009 enclosing a copy of the Deputy State Coroner’s finding inviting the Minister for Police to comment on the above recommendations. At the time of preparing the Annual Report a respond had not been received.

Previous Inquests – Responses to Recommendations

Boyd Lyle Scotty Farrer, Esmay Alberts, Alicia Rex, Paul Stanley Mitchell and Patrick James Taylor (Oombulgurri)

These five deaths were inquested in one inquest pursuant to section 40 of the *Coroners Act 1996*. The inquest was held to explore the reasons for a large number of deaths over a short time period occurring in a relatively small Aboriginal community, Oombulgurri.

The fact that four of the five deceased persons the subject of this inquest had high blood alcohol readings and the evidence of many of the witnesses at the inquest, revealed that alcohol abuse has been having a devastating impact on the lives of many of the occupants of Oombulgurri for a significant number of years.

The State Coroner made a number of recommendations in the following–

Recommendation No. 1

I recommend that consideration be given to the making of regulations pursuant to section 175(1a) of the Liquor Control Act 1988 declaring the area of Reserve No. 3960 (the Community of Oombulgurri) to be a restricted area, restricting the bringing of liquor into, the possession of liquor in, and the consumption of liquor in that restricted area, and conferring powers on members of the Police Force in relation to seizure and disposal of opened or unopened containers of liquor.

The State Coroner during the inquest again highlighted problems with alcohol abuse and associated neglect of children referred to in the inquest into 22 Kimberley deaths, the findings of which were delivered on 25 February 2008, and repealed Recommendation No. 20 therein –

Recommendation No. 2

I recommend that consideration be given to possible means of limiting the impact of alcohol abuse on Aboriginal people (and other Western Australians) including –

Limiting access to full-strength takeaway alcohol over large geographic areas of the Kimberley (the possible extension of the restrictions currently in place in the Fitzroy Crossing area); and
Implementation of voucher systems in respect of certain government payments, particularly those intended to provide child support, which would limit the amount of money available for purchase of alcohol.

During the inquest the State Coroner identified that it was clear that for a substantial period of time the Department for Child Protection has not provided adequate protection for the children of Oombulgurri and evidence at the inquest would suggest that sexual abuse and neglect of children has been a regular occurrence over that period.

The State Coroner noted that the cases of child sexual abuse referred to at the inquest were not isolated events. Anecdotal evidence at the inquest revealed that sexual abuse of children was common during this period. It was also noted that at the time of the inquest that 10 male residents of Oombulgurri had been charged with a total of 20 child sex offences and were awaiting trial.

Recommendation No. 3

I recommend that the Department for Child Protection and Western Australia Police liaise to ensure that there are in future no closed communities in Western Australia where neglected or sexually abused children can be denied protection.

The State Coroner found that there is an obvious need for Oombulgurri to be assessed with the first consideration being whether or not the community is sustainable at its current location.

Recommendation No. 4

I recommend that the State and Federal governments devise a plan to assess the sustainability of indigenous communities in the Kimberley including Oombulgurri, and in doing so take account of the practical, historical and cultural factors impacting on these communities.

The State Coroner found that there was no strong leadership and in this context the State Coroner re-state Recommendation No. 1 of the findings into the 22 Kimberley deaths delivered on 25 February 2008 –

Recommendation No. 5

I recommend that the State and Commonwealth governments identify an individual or organisation to lead the efforts to close the gap between the well-being of indigenous and non-indigenous people. That individual or organisation should be given the power and resources to make decisions, region by region, throughout the Kimberley and to coordinate the response to the disaster of aboriginal health, suicide rates and living conditions.

On the 22 October 2008 the State Coroner received advice from The Hon Bob Debus, Minister for Home Affairs in response to the recommendations in the following terms –

> "Your findings in relation to this investigation are deeply disturbing. It is alarming to read not only of the circumstances surrounding the tragic deaths investigated, but also of the repeated incidences of alcohol and substance abuse, alleged child sexual abuse and poor governance in the wider Oombulgurri community.
>
> I note that recommendations two and five reflect those you made following the inquest into the circumstances of 22 deaths in the Kimberley, delivered on 25 February 2008. It is clear from these investigations, along with coronial inquests and government inquiries conducted in other parts of Australia, that the issues facing the Oombulgurri community are by no means isolated.
>
> As you are aware, States and Territories have the primary responsibility for services such as policing, corrections and child protection. However, Commonwealth Government is providing a leadership role, notably through the Council of Australian Governments (COAG), forging a national approach to reducing the unacceptable gap in key Indigenous life outcomes. These outcomes include life expectancy, child mortality, education and employment.

COAG realizes that these primary targets will not be met without improving the safety of Indigenous families and communities from violence. As your investigation of the five deaths in Oombulgurri demonstrates, this violence is often fuelled by excessive consumption of alcohol and other substances. As a result, COAG has asked its Working Group on Indigenous Reform to develop a proposal to improve family and community safety for Indigenous Australians.

Recommendations four and five call on State and Commonwealth governments to develop a plan to assess the sustainability of Indigenous communities in the Kimberley, and for a designated individual or organization lead a coordinated effort to coordinated effort to close the gap between the well-being of Indigenous and non-Indigenous Australians, To this end, COAG has specifically requested the Working Group on Indigenous Reform bring forward a reform proposal on remote service delivery for consideration as part of COAG's broader 'Closing the Gap' agenda.

Complimenting the COAG work, I am progressing the development of a National Indigenous Law and Justice Framework through the Standing Committee of Attorneys-General 9SCAG). It will focus on the core factors linked to Indigenous over-representation in the justice system, including the access to justice, community safety and the strengthening of Indigenous communities.

The Framework will also recognize that these issues are inter-linked with the need for improvements in health, housing, employment and education. Rather than accept previous fragmented approaches, the Framework will articulate a national, collaborative strategy for improving justice outcomes fro Indigenous Australians.

I am aware that culturally appropriate legal assistance and representation is crucial to improving law and justice outcomes for Indigenous Australians. The Attorney-General's Department provides funding for Aboriginal and Torres Strait Islander Legal Services to deliver legal assistance for Indigenous people in each jurisdiction. In 2007-08 the Department provided Aboriginal Legal Service of Western Australia (ALSWA) with an additional $1.3 million for the increased defence work arising from the Western Australian Indigenous Justice Tasforce investigations. A further $1,084,393 was provided to ALSWA for expensive cases, $2.85 million for property purchases and $126,850 for work in Aboriginal Community Courts.

I am confident that your recommendations will provide renewed impetus for all governments to work together to escalate efforts to improve the health, safety and well-being of all Indigenous Australians, particularly those in remote communities such as Oombulgurri."

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 while there were no inquests where it was found that section 22(1)(b) applied, three inquests were held where possible police involvement was an issue.

Slavoko Vojinovic

Slavoko Vojinovic died on 20 January 2007 at the Tonkin Highway, Oakford as a result of Multiple Injuries. The inquest hearing was held at the Perth Coroners Court on 20 January 2009 and the findings delivered by the State Coroner on 28 January 2009.

The deceased was a 39 year old male who died as a result of multiple injuries on 20 June 2007.

The injuries were suffered in a single vehicle collision which took place following a police pursuit, at a time when the deceased's vehicle had accelerated away from a pursuing police vehicle to such an extent that police officers in that vehicle could not see the deceased's vehicle or its lights.

At the time of the pursuit police officers in the pursuing vehicle were seeking to apprehend the deceased in respect of a Return to Prison Warrant. The deceased was significantly affected by illicit drugs, particularly amphetamines, and these played a large role in his risk taking behaviour.

It was the view of the State Coroner that as the pursuing police vehicle was out of sight at the time of the collision, it could not be said that the death was caused, or contributed to, by the police officers involved.

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

The State Coroner made comments on matters connected with the death as follows -

Immediately before the pursuit commenced Constable Whitney had attempted to spray the deceased with Oleoresin Capsicum spray. Before doing so Constable Whitney had learned that the deceased was the subject of a number of alerts which indicated that he had a history of violence and would use violence to police to avoid being returned to prison and also that he had been imprisoned for crimes, including the crime of attempted murder. The deceased had threatened Constable Whitney and had reached into his vehicle in a context where Constable Whitney was apprehensive that he could be reaching for a weapon.

It was the State Coroner's view that the use of the Oleoresin Capsicum spray in that context was not only appropriate, it was the best option available.

The deceased was inside his vehicle at the time and any other method of attempting to apprehend him would have, of necessity, involved a high degree of violence or the use of a firearm. In using the Oleoresin Capsicum spray Constable Whitney was intending to immobilise the deceased so as to effect his arrest with a minimum of violence.

It is unfortunate that the Oleoresin Capsicum spray deployment did not work as intended. As stated earlier in these reasons this may have been because only a relatively small quantity was deployed and the fact that very little of it appears to have made contact with the deceased. Had the Oleoresin Capsicum spray been effective, the deceased would have been apprehended, the pursuit would never have taken place and the fatal collision would not have occurred.

During the course of the pursuit Constable Jackson remained in regular contact with the Police Communications and that contact was recorded on the police radio channel. It is clear that she appropriately sought permission for the police vehicle to be driven in a pursuit and was given a "Priority 2" authorisation.

Constable Whitney, who was driving the police vehicle, appears to have driven that vehicle safely at all times and attempted to keep the vehicle speed within the authorised 20kph of the posted speed limit.

At the inquest hearing the State Coroner was impressed with the evidence of both of the involved police officers and he formed the view that they behaved in a professional manner.

Daniel John Adcock

Daniel John Adcock died on 3 October 2007 at Swan River, near Tanunda Drive, Rivervale as a result of Immersion. The inquest hearing was held at the Perth Coroners Court on 17 February 2009 and the findings delivered by the State Coroner on the 25 February 2009.

It appears that the deceased had been involved in criminal activity and had a past criminal record. In addition there were outstanding warrants for his arrest.

It is unclear why the deceased got into difficulty and submerged under the water, especially in light of evidence that he was normally a competent swimmer. It is possible that buprenorphine, which he had consumed, together with his past involvement in unhealthy living, caused him to be more susceptible to problems he encountered in the river. It is also noted that the deceased had not managed to take off his trousers which may have increased the difficulty of his swimming.

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

The State Coroner made comments on matters connected with the death in the following way –

The Police Involvement

There is no evidence which would suggest that police officers were in any way responsible for the death. The police officers concerned were attempting to apprehend the deceased in respect of offences of unlawful damage and stealing. The suspicion of police officers based on what they

had been told that the deceased had been involved in these activities was undoubtedly fuelled by his failure to stop when called upon.

The evidence indicates that the officers appropriately identified themselves as police and that the deceased was aware of that fact.

It is clear from the evidence of a large number of independent witnesses that neither of the police officers who followed the deceased ever came close enough to touch him and, therefore, no force was used against him.

When the deceased experienced difficulties in the water Senior Constable Scrimshaw made every attempt to rescue him and sought assistance of two recreational fishers who took him by boat to the location where the deceased was last seen.

It is clear that all reasonable steps were taken by the officers to attempt to rescue the deceased. I wish to particularly record that the actions of Senior Constable Scrimshaw in entering the water in an effort to locate the deceased and save him from drowning demonstrated considerable courage. Visibility in the water was extremely poor, Senior Constable Scrimshaw was not a strong swimmer and the environment in which he was looking for the deceased, a person attempting to escape from justice, was extremely hazardous. Senior Constable Scrimshaw dived into water which according to Water Police who later attended had a visibility of "zero".

I commend Senior Constable Scrimshaw for his bravery in attempting to save the deceased in these conditions.

Benjamin Ivan Bryan Gallop

Benjamin Ivan Bryan Gallop died on 26 August 2007 at Kalgoorlie as a result of Crush Asphyxia and Chest Injury. The inquest hearing was held at the Perth Court Coroners Court on 5 June 2009 and the findings delivered by the State Coroner on the 8 July 2009.

The deceased died as a result of being hit by a police vehicle in an open area near the intersection of Pirie Street with Shannon Street, Kalgoorlie. As the death was caused by an action of a member of the Police Force, it was necessary to hold an inquest into the circumstances of the death pursuant to section 22 of the *Coroners Act 1996*.

A post mortem examination was conducted on 29 August 2007 by a forensic pathologist who determined that the cause of death to be Crush Asphyxia and Chest Injuries.

A toxicology report showed the deceased had a blood alcohol level of 0.130%.

The State Coroner concluded that the deceased died as a result of being hit by a police car in an unlit area. At the time when he was hit the deceased was lying face down near a mound of dirt in relatively long grass. At the time he was hiding from the police officers in the police car, hoping to avoid apprehension.

The State Coroner found tragically the police officers were unaware of the presence of the deceased until too late and their attention was directed towards a second person who was also trying to avoid them.

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

In his comments pursuant to section 25(2) of the *Coroners Act 1996* the State Coroner found that in this case the actions of police in attempting to apprehend the deceased were justified. The deceased was driving his vehicle at an excessive speed and did not stop the vehicle when the lights and sirens were activated in the police vehicle.

The police vehicle was driven a relatively short distance in the pursuit of the vehicle driven by the deceased and then when that vehicle stopped, the police vehicle was driven in the direction of the passenger who had been in the deceased's vehicle and who was running away from the police.

The State Coroner found that the deceased was lying down in the grass hiding from the police officers when the police vehicle struck the deceased. As soon as the collision occurred the police vehicle was stopped and when the police officers discovered that the deceased had been hit they immediately called for assistance and every effort was made to get the vehicle off the deceased. The response by the police officers to the emergency situation was appropriate.

Inquests – Deaths In Care – Department for Corrective Services

During the year 5 Inquests were conducted into the deaths of persons who died while in the custody of the Department for Corrective Services.

The following chart details the position in respect of all deaths in care since January 2006 where the deceased was either in prison custody or there was police involvement.

Date of Death	Date of Inquest	Name of Deceased	Custody	Place of Death	Finding
1/5/2006	17/7/2008	**PARRE** Donald Edwin	Prison	Albany Regional	Natural Causes
19/5/2006	9-25/7/2008	**ROCHFORD** Simon	Prison	Albany Regional	Suicide
12/6/2006	8/2/2008	**ZUPEC** John	Karnet Prison	Fremantle Hospital	Natural Causes
14/7/2006	8-10/4/2008	**STEWART** Tanya Maree	Police	At her home in Girrawheen	Suicide
2/8/2006	8/2/2008	**BROWN** Robert Geoffrey	Prison	Bethesda Hospital	Natural Causes
3/12/2006	8-11/12/2008	**BRIGGS** Lenny Mark John	Prison	Casuarina Prison	Suicide
27/4/07	5/6/2009	**NUNDLE** Lee James	Prison	Wooroloo	Natural Causes
21/6/2007	20-21/1/2009	**VOJINOVIC** Slavko	Police	Police chase Thomas Rd Armadale	Accident
26/7/2007		**McDONALD** Charles Edward	Prison	Hakea Prison	
14/8/2007		**CONWAY** Mark Lewis	Police	Sally Port Fremantle Police Station	
26/8/2007	5/6/2009	**GALLOP** Benjamin Ivan Bryan	Police	Bush track Boulder	Accident
18/8/2007	14-16/7/2009	**LOVELESS** Simon John	Prison	Roebourne Regional Prison	Suicide
27/1/2008	10-20/3/2009 11-14/5/2009	**WARD** Ian	Prison	Transported in Prison van from Warburton to Kalgoorlie	Open Finding
28/4/2008		**BRENNAN** Declan John Paul	Prison	Acacia Prison	
15/6/2008		**GARDINER** Terrence Sydney Graham	Prison	RPH	
1/6/2008		**NJAMME** Dennis	Prison	Greenough Regional Prison	
22/8/2008		**WINMAR** Ian Frank	Prison	Albany Regional Prison	
18/9/2008		**REX** Justin	Prison	RPH	
20/9/2008		**TUCKER** Alan Murray	Prison	Casuarina Prison	
3/10/2008		**DARBYSHIRE** Glen **BUTCHER** Matthew John	Police	Chase at Boddington	
9/10/2008		**MORATO** Henrique Gregory	Prison	Hakea Prison	
7/11/2008		**MILLER** Matthew James	Police	Chase at Munster	
20/11/2008		**HIGGINS** Jarrod	Police	Chase at Koondoola	
14/8/2008		**SHEEHY** Andrew Michael Brian	Prison	Casuarina Prison	

A brief summary of deaths which have occurred in the care of the Department of Corrective Services and which have been inquested is as follows –

Simon Rochford

Simon Rochford died on 19 May 2006 at the Albany Regional Prison, Albany, as a result of incised Injuries to the neck and left arm. The inquest hearing was held at the Albany Coroners Court on 9 to 17 July 2008 and at the Perth Coroners Court on 22 to 25 July 2008 and the findings delivered by the Deputy State Coroner on the 3 October 2008.

A post mortem examination was conducted on 22 May 2006 by the chief forensic pathologist who determined that the cause of death was incised injuries to the neck and left arm.

The forensic pathologist concluded that the wounds were caused by a sharp instrument being drawn over the surface of the skin, consistent with a putty knife found in the bin of the deceased's cell.

The Deputy State Coroner found that in May 2006 the deceased, who had been a model prisoner, had only a relatively short period to serve of his sentence and had made significant efforts during his incarceration to provide a life for himself after his release. He was close to his family, particularly his mother, who was scheduled to visit on 20 May 2006 prior to going to live back in the UK, and was a person who liked to control his environment, as much as that was possible within a prison. He was known to like routine and order and generally had good coping mechanisms within the Prison, having never come to the attention of the Prison Counselling Service (PCS) during his sentence.

From 11 May 2006 the deceased knew he was under investigation for a serious offence. He was closely observed in a medical observation cell, for several days and all those who monitored him concluded he was coping with this additional stress in his life quite well.

After his release from the medical observation cell and then the At Risk Management System (ARMS) on 16 May 2006, those who knew him did observed subtle changes in his demeanour which suggested the deceased was experiencing some level of anxiety, but was dealing with it internally. This was not unusual for a person who was always considered to be intensely private.

The deceased gave no overt indication he was having thoughts of self-harm or suicide to any person, even the PCS counsellors.

On 16 May 2006 the deceased borrowed the putty knife which he later used to inflict the injuries causing his death. It is not known what his intention was at the time of borrowing the "knife", as he may have had innocent reasons for needing it at that time. It is also not known when he took it to his cell.

Between 16 May and 18 May 2006 the deceased made plans for obtaining legal advice in relation to his situation and was looking forward to seeing his mother. He otherwise engaged in his routine activities such as working in the garden, studying, practising piano and listening to music. It was clear he did not feel under threat in any way from other prisoners in his normal environment.

In the early evening of 18 May 2006 the deceased attempted to call his sister and left a message in which he sounded normal. At 7pm he watched the ABC news in which he was named as the new suspect in the murder of Pamela Lawrence. The deceased had no prior warning his identity was going to be made public in this way. He was annoyed he had been named and things from his past had been mentioned and he expressed this to staff.

The deceased was then locked in his cell.

At about 9.30pm the deceased was asked how he was, to which he replied "*I'm all right, thanks for asking*". During the night Prison Officers made note of his demeanour, which was not considered to be unusual, and he was believed to be asleep at 5.30am.

The Deputy State Coroner concluded that the deceased was certainly alive at 5.30am but was lying in bed in approximately the same position as he was later found. That was the last muster check.

At some point that night the deceased obtained the "knife" and placed the bin under his bed, almost against the wall. He obtained some plastic bags and sticky tape, probably in an attempt to catch the flow of blood.

Between 5.30am and 7.30am he placed himself in a position from which his actions were hidden from the observation hatch, by lying with his back to the door, and inflicted numerous, severe incised injuries probably firstly to his left wrist then to the right side of his neck in a deliberate attempt to take his own life.

The Deputy State Coroner concluded the deceased at the time he took this action was determined to succeed in taking his life and wanted no prospect of detection and successful resuscitation.

The Deputy State Coroner was of the view the public release of the deceased's name in connection with the murder of Mrs Lawrence, without prior warning to the deceased, precipitated his decision at that time.

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

COMMENTS AS TO THE CARE, TREATMENT AND SUPERVISION OF THE DECEASED

The Deputy State Coroner was satisfied with the placement of the deceased on ARMS and in the medical observation cell on 11 May 2006, following his interview by police officers, was appropriate.

The Deputy State Coroner was also satisfied his removal from the medical observation cell and return to his normal living environment on 15 May 2006 was appropriate. It had provided both the deceased and the Prison with an opportunity to assess the effect of the changed circumstances on the overall wellbeing of the deceased and to determine he did not appear to be at risk at that time.

The circumstances in which the deceased was removed from ARMS on 16 May 2006 were unorthodox, but appropriate in the circumstances. However, the exchange between Department of Corrective Service's staff, which occurred prior to any recommendation being made, demonstrated a breakdown in communication of potentially vital information.

The Deputy State Coroner commented that the availability of the putty knife to the deceased was a concern but was an issue already addressed at the prison by tighter tool control and auditing procedures.

The response taken by the Prison following release of the deceased's name on the ABC news, in the circumstances of when they became aware of it, was not unreasonable.

The checks done overnight on 18 May 2006 were not as requested by staff, however, even if they had been done two-hourly it is unlikely they would have prevented the deceased successfully ending his life as there would have been no additional check between 5.30am and 7.30am. Long term prisoners are well aware of the timing of checks and can plan their actions accordingly.

The prison did have the option of placing the deceased in a “safe environment" such as medical observations where he could be continuously monitored. However, they had to balance that option against that of leaving the deceased in the more familiar and potentially therapeutic environment of his own cell and unit.

COMMENTS AS TO THE ACTIONS OF THE WA POLICE

The actions of a police officer who, along with her husband, a former police officer, contravened a confidentiality agreement and released information to the media about the discovery of an identified palm print were the initial catalyst for what followed. Those actions seriously undermined the ongoing investigation into the murder of Pamela Lawrence. WA Police took appropriate measures to attempt to stop any such breach occurring but could not stop the irresponsible actions of these individuals.

When that information became known to the media, WA Police took appropriate action to try and control its release by speaking directly to the journalist and the editor. The Deputy State Coroner found in hindsight, perhaps more could have been done to negotiate with Channel 7, when it was suggested they also had the information. This may have provided the police with a few more days before having to interview the deceased.

Police conduct following the interview with the deceased at the Prison on 11 May 2006 in relation to the deceased’s potential risk of self-harm or suicide, in discussing the issue with the Prison, was appropriate.

Recommendation No. 1

Consideration be given by Minister for Police/Attorney General to giving WA Police legislative power to seek an order suppressing information which may seriously compromise an ongoing investigation into a serious offence.

Recommendation No. 2

The Department of Corrective Services recognises:

(1)Vocational and Education officers at prisons should be given a formal role in the ARMS and PRAG process where appropriate; *and*

(2)Orders/instructions issued remotely by a Superintendent/Assistant Superintendent to a Prison concerning prisoner welfare or prison security should be noted by the officer taking the instruction in the relevant occurrence book and read back to confirm its accuracy.

Recommendation No. 3

WA Police:

(1)Amend SOPS to incorporate a requirement where sentenced prisoners are being investigated for serious offences, consideration be given and action taken to inform the relevant prison of significant events in the investigation (i.e. interview of suspect, publication of name in connection with investigation);

(2)Use a more collaborative approach when dealing with media in cases generating intense media scrutiny to draw on experience of all involved i.e. media advisors and experienced investigators; *and*

(3)Where it is believed publication of information will seriously prejudice an ongoing investigation, formally request the publication not occur and explain why. If possible make such requests directly to the journalists and/or editors involved and record such requests.

On the 6 January 2009 a response was received from the Department of Corrective Services to the Deputy State Coroner's recommendations in the following terms –

1. Vocational and Education officers at prisons should be given a formal role in the ARMS and PRAG process where appropriate.

The Department of Corrective Services supports this recommendation in principle.

Donald Edwin Parre

Donald Edwin Parre died on 1 September 2004 at the Albany Regional Prison, Albany, as a result of ruptured abdominal aortic aneurysm. The inquest hearing was held at the Albany Coroners Court on 17 July 2008 and the findings delivered by the Deputy State Coroner on 3 October 2008. The Deputy State Coroner found that death arose by way of Natural Causes.

A post mortem examination was conducted by a forensic pathologist on 3 May 2006 who found evidence of an old myocardial infarction. The forensic pathologist found a large aneurysm extending down to the iliac arteries which had ruptured resulting in a significant haemorrhage into the abdominal cavity. These findings enabled the forensic pathologist to establish that the deceased died as a result of a ruptured abdominal aortic aneurysm.

The deceased was a 73 year old male who had a lengthy and serious medical history.

The Deputy State Coroner found that the deceased had been offered surgery at Royal Perth Hospital in 2004 and was advised of the associated risks both attaching to the surgery and the decision not have the surgery. The deceased decided not to have the surgery either at that time or in the event of a rupture.

The Deputy State Coroner was satisfied that the medical management of the deceased while a sentenced prisoner was appropriate.

On the 17 September 2008 a response was received from the Department of Corrective Services to the findings made by the Deputy State Coroner.

Lenny Mark John Briggs

Lenny Mark John Briggs died on 2 or 3 December 2006 at Casuarina Prison as a result of Ligature Compression of the Neck (Hanging). The inquest hearing was held at the Perth Coroners Court on 8-11 December 2008 and the findings delivered by the State Coroner on the 22 December 2008.

Lenny Mark John Briggs (the deceased) was a 20 year old male who at the time of his death was a prisoner housed at Casuarina Prison in Western Australia. At the time of his death the deceased was alone in his cell.

The deceased was last seen alive by prison officers at the time of a random check conducted at 8:35pm on 2 December 2006. At approximately 4:55am on Sunday 3 December 2006 at the time of a security check it was discovered that the inspection hatch to the deceased's cell had been covered with an obstruction.

The deceased's cell door was subsequently opened and the deceased was observed hanging at the rear of his cell with a jumper around his neck. The jumper had been twisted, with one end secured to the top external bar of the cell window and the other end secured around the neck of the deceased.

At the time of his discovery the deceased had been dead for a number of hours and rigor mortis was already present.

A post mortem examination was conducted on the deceased on 5 December 2006 by forensic pathologist, Dr C T Cooke, who determined that the cause of death was ligature compression of the neck (hanging).

Examination of the Medical Progress Notes for the deceased identified that as a juvenile he had self-harmed or threatened self-harm on multiple occasions.

Examination of the Medical Progress Notes and Incident Reports for the deceased between 3 March 2005 and his death on the evening 2/3 December 2006, has revealed that he had self-harmed and threatened suicide on multiple occasions

The deceased was a young man who was chronically at risk of suicide or self-harm at the time of his death on the evening of Saturday 2 December 2006 or the early morning of Sunday 3 December 2006.

At the inquest evidence was given by the Chief Psychiatrist for Western Australia, who reviewed the deceased's prison medical records and in a report dated 23 March 2007 expressed the view –

> "This patient posed a high risk for completed suicide given his history of previous attempts and self-harming behaviour".

Following the death in this case the Department for Corrective Services retained a general practitioner to conduct an independent review of the medical treatment provided to the deceased while he was in custody. In a report dated 21 December 2006, he noted the past history of self-harm and noted that the deceased's previous psychiatric history revealed that

he had an anti-social personality with major anger and poor impulse control.

At the time of his death the deceased was in a defacto relationship. They had been in a relationship for approximately three years and that relationship was described by the deceased as being volatile on occasions.

On 29 November 2006 the deceased saw a Prison Counsellor at his own instigation. He had in fact requested counselling assistance on 28 November 2006 but the counsellor was not able to see him until the next day.

According to the counsellor, the deceased discussed with her various scenarios which might arise following his meeting with his partner and she gave advice as to how he could respond to those scenarios.

In particular the counselor asked the deceased to indicate how he proposed to deal with the possibility that the visit might have a negative outcome.

The deceased was encouraged to request "time out" in the Crisis Care Unit if he felt unsettled following the visit.

At the conclusion of the meeting the counsellor considered that the deceased presented as settled and future focused. She noted that he appeared to have good peer supports in his unit and that he had indicated that he was prepared to contact the Prison Counselling Service if he felt unsettled in the future. She considered that though the deceased was at chronic ongoing risk of suicide or self-harm, he was not acutely at risk at that stage.

On 30 November 2006 the deceased again saw a prison counsellor, on this occasion it was with a Psychologist. It appears that the deceased had contacted another counsellor and had asked to see the Psychologist.

The Psychologist saw evidence of wounds on the deceased's forearm which he stated were self inflicted on Monday 27 November 2005. The deceased explained that on that evening he had spoken to his girlfriend who indicated to him that she might leave him. He said that he had self-harmed, as he had done on numerous occasions in the past, in order to help him cope with the feelings that this conversation caused.

According to the deceased, he had spoken to his girlfriend since the time of his self-harming and she had changed her mind and was no longer planning to leave him. He said that she was going to visit him on the weekend.

The Psychologist spoke with the Counsellor about the deceased and they decided that he was not a self-harm or suicide risk at that time. They came to that conclusion because of his claimed resolution of his conflict with his girlfriend, his then stable presentation, the fact that he gave them denials of any intent to self-harm or suicide, the fact that there were persons in his unit who could provide him with support and the fact that he appeared to have a future focus.

According to the Psychologist after speaking with the deceased he spoke to the Senior Officer who was in charge of Unit 1 in relation to the possibility of another prisoner being placed into the deceased's cell. He said that the Senior Officer stated that three new prisoners were due to arrive in the near future and the deceased would be doubled up with one of those persons. The Senior Officer was spoken to by investigators and he disputed this claim. He said that he could recall asking the Psychologist whether the deceased was to be placed onto the At Risk Management System to which the Psychologist stated that it would not be necessary for him to be placed on that system. He had no recollection of ever indicating that the deceased would be doubled up.

The deceased was not doubled up on any of the evenings from 30 November 2006 to 3 December 2006. In spite of investigations conducted by the department, it has not been possible to determine why this was the case and it appears that there must have been some misunderstanding between the Psychologist and Senior Officer in respect of this matter. It appears that no documentation was created by the Psychologist and his efforts to have the deceased doubled up with another prisoner were wholly on an informal basis.

The State Coroner heard that the deceased was involved in a relationship with his girlfriend for approximately three years and that relationship was an extremely turbulent and emotional one. On 2 December 2006 she visited the deceased in prison and although she claimed that at the end of the visit it was agreed that their relationship would continue, it is clear that at some stage during that visit she had told the deceased that she had intended to terminate their relationship.

The deceased was last seen alive by a Prison Officer at about 8:35pm on 2 December 2006. It appears that he subsequently spoke with a prisoner who occupied the cell immediately above the cell he occupied. Those conversations, however, concluded prior to midnight and after that time this prisoner obtained no response from the deceased.

The deceased was subsequently located during a routine cell check by a Prison Officer who first found the inspection hatch covered by an obstruction and subsequently saw the deceased through the medical hatch on the cell door, at that time the deceased was hanging at the rear of the his cell with a T-shirt around his neck. The deceased was already dead and had been dead for several hours.

A subsequent search of the deceased's cell revealed a number of notes including a note written by the deceased to his girlfriend dated 3 December 2006 and timed at 12am which referred to his love for her and a note to his mother apologising for past actions and advising that he would watch over her.

It is clear that on the night of 2 December 2006 the deceased wrote the notes, blocked the inspection hatch to his cell and then used a T-shirt as a ligature to hang himself from the bars on his cell window.

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

The State Coroner made a number of observations, comments and recommendations in respect to the care, treatment and supervision of the deceased while he was custody in the following manner –

1. The Hanging Points in the Deceased's Cell

As indicated earlier in these reasons the deceased was certainly a person chronically at risk of self-harm or suicide. He had previously self-harmed both inside correctional facilities and in the community and he had frequently come to the attention of prison officers and the prison counselling service staff members for at-risk management issues.

In addition it is noted that in the immediate period prior to his death the deceased had self-harmed or threatened suicide on multiple occasions and in the period 6 May 2005 to 27 November 2006 there were eleven occasions on which he was involved in such self-harming or suicidal behaviour.

In that context it is a most unsatisfactory situation that the deceased was housed in a cell with obvious hanging points. In that respect the quality of the treatment and care of the deceased fell well short of best practice.

The Royal Commission into Aboriginal Deaths in Custody was established in 1987 and reported to Federal Parliament in 1991. The Commission also published an interim report, which provided an indication of its concerns, putting issues on the table and enabling action to be taken prior to handing down the report in 1991.

The Commission identified that there was a limited understanding of the duty of care owed by the police and prison officers and that there were many systemic defects in relation to exercising care which directly contributed or caused the deaths in custody. One of the defects identified by the Commission was the presence of obvious hanging points in cells.

In 2006 the Australian Institute of Criminology analysed the figures compiled by the National Deaths in Custody Program over the fifteen year period following the decade investigated by the Commission, up until 2004. That analysis concluded that the number of deaths in prison custody had increased relative to the number of deaths in police custody and suggested that the decline in the number of deaths in police custody might be due, in part, to the redesign of police cells to reduce hanging or harming points. The fact that hanging and harming points remain in prisons so long after the Royal Commission recommendations and findings remains an alarming feature of custody in prison institutions.

At the inquest the Superintendent of Casuarina Prison, Robert Jennings, gave evidence relating to this issue.

According to Superintendent Jennings the design for Casuarina Prison was effectively "locked in" in 1987 and the prison was constructed by January 1991, although it was not opened until October 1991. In spite of the fact that the prison was designed and constructed during the period when the Royal Commission into Aboriginal Deaths in Custody was conducting its investigations and highlighting concerns in respect of issues such as hanging points in cells, the cells were all constructed with multiple hanging points, particularly accessible cell bars.

Superintendent Jennings advised that a program had been put in place by the Department of Corrective Services to remove ligature points in cells. A cell window review dated May 2004 has been prepared which identified the cost of modifications to all cell windows within Casuarina Prison at $930,600.00.

At the commencement of works a risk assessment was conducted which established that the priority units for modification were the Infirmary, the Special Handling Unit, Unit 5 and Unit 6. Unit 5 houses all new prisoners into Casuarina Prison, Unit 6 houses the disturbed and vulnerable prisoners while the Special Handling Unit houses prisoners who require special handling.

Superintendent Jennings stated that upgrades had been completed for Units 5 and 6 and the Special Handling Unit but no further funding has been allocated for capital works programs at the prison. No work has commenced on the main prison living units, Units 1 to 4.

It appears, therefore, that prisoners in Casuarina Prison who are at chronic risk of self-harm but who are not housed in one of the identified priority units, continue to be housed in cells containing obvious hanging points.

Unfortunately it appears that the costs associated with removing obvious hanging points from prison cells are extremely high and it is these high costs which have delayed implementation of the changes. Without having reviewed the costing of the program in any detail, it appears that a cost of almost $1million to replace cell window fittings is extremely high.

Recommendation No. 1

I recommend that there be an ongoing review as to the best means of removing hanging points from cells in Western Australia.

It is noted that throughout Australia recent statistics indicate that of in custody self-inflicted injury deaths, the overwhelming cause is death by hanging, in 98.4% of all cases.

Recommendation No. 2

I recommend that priority be given to funding a capital works project designed to remove obvious hanging points from cells in mainstream units of prisons in Western Australia. If there is to be a delay in achieving this objective, There should at least be some cells in these units without obvious hanging points in which prisoners at chronic risk of suicide can be housed in the relatively near future.

2. The fact that the deceased was not seen by a psychiatrist

One of the concerns raised at the inquest related to the fact that the deceased, who clearly had mental problems of some sort, was not seen by a psychiatrist during his last period of custody.

The deceased was in fact seen by a registered mental health nurse at the time of his admission to Hakea Prison on 4 March 2005, Registered Nurse Rachael Lowe.

On that occasion Nurse Lowe noted that the deceased had been diagnosed with anti-social personality with marked aggression and impulse control.

Nurse Lowe also noted that the deceased had previously been treated with medications, but she discussed this matter with him and he advised that he did not wish to have any medications at that point in time.

The deceased denied any current suicidal ideation or intention to self-harm to Nurse Lowe and at that point in time showed no signs of current mental illness. As the deceased had been seen by a psychiatrist approximately eight months earlier who had determined that he did not have a mental illness, Nurse Lowe saw no need for further psychiatric review.

The deceased was seen by a general practitioner, Dr Goss, on 7 September 2005, when consideration was given to whether he should be provided with anti-depressant medication. On that occasion Dr Goss concluded that no pharmacological agent would be of assistance and did not elect to refer him to a psychiatrist.

In addition, during the period of his incarceration the deceased was seen by the Prison Counselling Service counsellors on a total of 39 occasions and he saw the prison psychologist at Acacia Prison on a further 13 occasions.

It was, however, the view of the Chief Psychiatrist, Dr Rowan Davidson, that the deceased should have been referred to a psychiatrist at the stage when consideration was being given to providing him with anti-depressant medication.

This view was not supported by the Director of Health Services with the department, Dr Ralph Chapman, who expressed the view that there was no evidence that the deceased suffered from a mental illness which would require treatment with psychiatric medications. He expressed the view that the deceased's known problems of personality disorder, poor impulse control and anger control, could be better treated by support and counselling from psychologists, social workers and family.

Importantly in his evidence Dr Chapman provided the court with a bar graph which showed that there has been a dramatic increase in the provision of psychiatric services commencing in July 2008.

Dr Chapman explained that this improvement had resulted from a move from reliance on the Frankland Centre to provide visiting psychiatrists to the prison to a situation where psychiatrists have been directly employed to provide support to the prison system. This has resulted in a dramatic increase in the number of psychiatric sessions available at Casuarina Prison.

It is noted that while in the present case Dr Goss, for example, chose not to refer the deceased to a psychiatrist, that was in an environment where the number of psychiatrist sessions available to the prison were extremely limited. If the current level of psychiatrist sessions available at the prison had been in place at that time, it is possible that the deceased may have been referred to a psychiatrist.

In the above context I note that while there was a limited availability of psychiatrist services at the time of the deceased's incarceration, he was provided with a considerable amount of support and assistance in respect of his problems. Since the time of his death the availability of psychiatrist services has improved. In the above context I do not consider that it is necessary for me to make any further recommendations in that regard.

3. The Failure to Place Another Prisoner in the Cell with the Deceased

As indicated earlier in these reasons, after the deceased was seen by prison counsellor Mr Wszola on 30 November 2006 it was Mr Wszola's view that the best way to address his level of risk was for the deceased to be "doubled up" with another prisoner, at least over the weekend, as a precautionary measure for managing his self-harm and suicide risk.

According to Mr Wszola he raised this possibility with the Senior Prison Officer in charge of Unit 1, Prison Officer Stepan Szumskyj, who stated that the deceased would be "doubled up".

The fact that the deceased was not "doubled up" on any of the evenings from 30 November to 3 December 2006 in spite of this request is unfortunate.

There is no documentation available on the file which records Mr Wszola's request and it appears that the request was either misunderstood or forgotten.

This case has highlighted the fact that when such a request is made, even if it is made on a informal basis, it is important that the request should be documented to increase the likelihood that it will be acted upon even in the event of changes in staff or other intervening events which may otherwise result in communication difficulties occurring.

Recommendation No. 3

I recommend that when a prison counsellor believes that it would be beneficial for a prisoner to be "doubled up" and wishes to communicate that fact to the senior officer in charge of a unit, that the request should be documented for future reference.

On the 23 February 2009 the Department of Corrective Services responded to the State Coroner's findings and recommendations in the following manner –

> "The Coroner made the following three recommendations in relation to the death of Mr Briggs:
>
> *Recommendation 1 - I recommend that there be ongoing review as to the best means of removing hanging points from cells in Western Australia.*
>
> The Department of Corrective Services supports this recommendation in principle. The Department continues to support the Cell Ligature Minimisation Program and is committed to removing the identified hanging points from prison cells. All future infrastructure work undertaken will be in accordance with best practice principles, with regards to cost effectiveness, appropriateness of design and security within prisons. As part of the Department's standard project review process, the Strategic Asset Services section will continue to regularly review the Cell Ligature Minimisation Program for its suitability. Furthermore, the Department is committed to further reviewing the Cell Ligature Minimisation Program, should new standards become available in the future. No additional action is proposed in respect of this recommendation.
>
> *Recommendation 2 - I recommend that priority be given to funding a capital works project designed to remove obvious hanging points from cells in mainstream units of prisons in Western Australia. If there is to be a delay in achieving this objective, there*

should at least be some cells in these units without obvious hanging points in which prisoners at chronic risk of suicide can be housed in the relatively near future.

The Department of Corrective Services supports this recommendation. As stated above, the Cell Ligature Minimisation Program remains a priority for the Department. A request for a rolling program of funding, totalling $47m over the next ten years is currently before Treasury. A sum of $2.5m has been requested for the 09/10 financial year. If funding is not approved by Treasury, the Department intends to reallocate funds from the annual Infrastructure Upgrade allocation, to enable the Cell Ligature Minimisation Program to continue. More specifically, if additional funding is not forthcoming, the Department intends to utilise reallocated funds to enable the removal of all obvious hanging points from a number of cells in each mainstream living unit across all prisons. This would ensure the availability of such cells for prisoners identified to be a chronic risk of suicide.

Recommendation 3 - I recommend that when a prison counsellor believes that it would be beneficial for a prisoner to be "doubled up" and wishes to communicate that fact to the senior officer in charge of a unit, that the request should be documented for future reference.

The Department of Corrective Services supports this recommendation in principle. The requirement to document information relating to the use of "double-up" as a placement option for prisoners identified as at-risk to self is formalised in *Policy Directive 32 – Managing At Risk Prisoners.* In addition, procedures are in place for the documentation and distribution of recommendations arising from counselling sessions conducted by the Prison Counselling Service (PCS), or consultation with other staff. *Policy Directive 32* is available electronically to all staff and the relevant procedure relating to documentation requirements is available to all PCS staff via the Offender Services' Portal Community. PCS staff have also been reminded of their obligations in terms of documenting and distributing information and recommendations pertaining to risk management. It is worth noting that the documentation of PCS recommendations does not necessarily translate to the recommendation being accepted or acted upon, as operational and security requirements also need to be considered. The placement of prisoners is ultimately determined by unit/prison management. Compliance with PCS documentation procedures will be verified by the Clinical Governance Unit (CGU) (Suicide Prevention) via routine auditing and monitoring of ARMS/PRAG processes. No additional action proposed in respect of this recommendation."

Ian Ward

Ian Ward died on 27 January 2008 at Kalgoorlie District Hospital, Kalgoorlie as a result of heatstroke. The inquest hearing was held at the Warburton Court on 10-11 March 2009 and adjourned to the Kalgoorlie Court House on 12-20 March and 11-14 May 2009. The State Coroner delivered his findings on the 12 June 2009.

The State Coroner prepared a 150 page document outlining his findings in respect to the evidence which was produced at the inquest hearing. Due to the length of the findings the State Coroner's Conclusions and

Comments on the Quality of the Supervision, Treatment and Care of the Deceased While in Care, together with all the Recommendations made are reproduced hereunder –

CONCLUSION

The deceased died on 27 January 2008 as a result of heatstroke which he suffered while in custody, being transported in the rear pod of a Mazda prisoner transport van.

The air-conditioning in the van was not working at the time of the deceased's death. He was being transported from Laverton to Kalgoorlie a distance of approximately 360kms which took almost 3¾ hours.

The failure of the air-conditioning was not some sudden, unforeseeable event. The air-conditioning in the vehicle for the pod in which the deceased was placed had been inadequate for use on such trips from the time of its first use and there had been a number of ongoing problems with it. The fact that failure of the air-conditioning in conditions of extreme heat would result in a dangerous situation for prisoners must have been obvious to all concerned.

At some stage in the trip the deceased fell or collapsed against the hard metal surfaces of the prisoner pod in which he was contained and suffered a laceration to his head.

Prior to his death the deceased collapsed onto the floor of the van where he suffered thermal injury on the side surface of his abdomen. The thermal injury was a contact burn, which appeared to be a full thickness burn. The area of the burn was irregular in shape and in the order of 9cm vertically and 6.5cm transversally at its lower aspect and 10cm transversally at its upper aspect. This was a large burn injury. It is clear that the surface temperature of the van was extremely great at the time when the deceased collapsed onto it.

The deceased's body temperature recorded at the hospital was 41.7°C; an extremely high temperature as the normal temperature is 36-37°C. Subsequent testing of the vehicle revealed that the temperature within the pod increased relatively slowly and in my view it is clear that for the temperature in the pod to have reached temperatures sufficient to cause the death of the deceased and the burn injury inflicted to his abdomen, the air-conditioning was not working in the rear pod for the entirety of the journey.

The deceased died from heatstroke.

For the reasons outlined earlier I have concluded that the Department, GSL, Mr Powell and Ms Stokoe all contributed to the death.

The deceased was conveyed in the pod of a vehicle which at the time of its constructions was not suitable for transportation of prisoners over lengthy journeys. Over the course of eight years of use the vehicle and all of its parts, including its air-conditioning system, which had been inadequate at the outset, deteriorated with use and wear.

I am precluded by section 25(5) of the *Coroners Act 1996* from making a finding which would appear to suggest that any person is guilty of an offence and so I am not able to determine whether the death arose by way of unlawful homicide or misadventure. It is in that context I make an open finding as to how the death arose.

COMMENTS ON THE QUALITY OF THE SUPERVISION, TREATMENT AND CARE OF THE DECEASED WHILE IN CARE

As the deceased was a person held in care for the purposes of the *Coroners Act 1996*, it is necessary to comment on the quality of the supervision, treatment and care which he received while in care.

The State Coroner noted that as part of submissions to the effect that his comments in this matter should be of limited ambit, counsel for the State of Western Australia (Department of Corrective Services) contended –

> The power to comment is not free ranging. It must be comment on a matter connected with the death. The powers to comment are inextricably connected with, but not independent of the power to enquire into death for the purposes of making findings. They are not separate or distinct sources of powers. ***Harmsworth v State Coroner*** [1989] VR 989, 996

The State Coroner commented –

> While there have been considerable developments in coronial law since Harmsworth (see e.g. ***WRB Transport and Ors v Chivell*** [1998] SASC S7002), importantly in this context the applicable legislation is different. The relevant legislation considered in Harmsworth was section 19(2) of the *Coroners Act 1985* (Vic) which provided –

> A coroner may comment on any matter connected with the death including public health or safety or the administration of justice.

Following the delivery of the Recommendations of the Royal Commission into Aboriginal Deaths in Custody, the *Coroners Act 1996* (WA), which was proclaimed in 1997, contained a specific provision, which was not contained in the Victorian legislation, dealing with deaths in custody, section 25(3) which provides –

> Where the death is of a person held in care, a coroner must comment on the quality of the supervision, treatment and care of the person while in that care.

This provision mandates the making of comments about the quality of the supervision, treatment and care of a person who has died in custody while that person was in custody. There is, therefore, not just a power to comment on matters connected with the death (see section 25(2)) there is a requirement to comment on the quality of the care generally.

In my view the correct approach in this state is described by Watterson R, Brown P and McKenzie J, ***"Coronial Recommendations and the Prevention of Indigenous Death"*** –

> The Royal Commission's National Report provided an impetus for more widespread reform and modernisation of the coronial jurisdiction. It was concluded by the Royal Commission that Australian coronial systems should accord coroners the status and powers to enable comprehensive and coordinated investigations to take place. These investigations should lead to mandatory public hearings productive of findings and recommendations that seek to prevent future deaths in similar circumstances. The Royal Commission recommended an expansion of coronial inquiry from the traditional narrow and limited medico-legal determination of the cause of death to a more comprehensive, modern inquest; one that seeks to identify underlying factors, structures and practices contributing to avoidable deaths and to formulate constructive recommendations to reduce the incidence of further avoidable deaths. The Royal Commission provides a timeless reminder that every avoidable Indigenous death calls upon us to identify its underlying causes, consider Indigenous

disadvantage, uncover the truth about the death and resolve upon practical steps to prevent others.

While the deceased was in the custody of police, the quality of the supervision, treatment and care was quite good. Over the night reasonably regular checks were conducted on his welfare and in the morning he was permitted to make himself a cup of tea in the kitchen area of the police station and was given two meat pies to eat. He was given several cigarettes to smoke and was permitted to have a visit from his son, Tyrone Ward, and a friend. On at least two occasions the deceased was permitted to leave his cell to go into the exercise yard.

When his custody was transferred from police to the Department, however, this situation changed dramatically and from the time when he was placed in the rear pod of the Mazda vehicle at Laverton police station the quality of his supervision, treatment and care was disgracefully bad.

It is also important to note that this transfer of custody would not have happened at all if police and the JP, Mr Thompson, had complied with relevant legislation. The transfer only took place because of the existence of a remand warrant signed by the JP in circumstances where there were multiple breaches of the legislation and a court should not have been convened at all. The fact that both the Deputy Registrar, Sergeant Denness, and JP, Mr Thompson, appear to have known almost nothing about their relevant roles and responsibilities is, at the very least, an embarrassment.

The quality of the deceased's treatment, supervision and care in the rear pod of the vehicle could hardly have been worse.

The deceased could, but for an inflexible rule imposed by GSL, have been placed in the forward pod of the vehicle. In that pod he could have sat on a padded seat facing the front and could have looked out of windows. There he would have been able to open a window when he became aware that the air-conditioning system was not working.

Instead the deceased was placed in the rear pod. The rear pod was of all metal construction apart from a window in the rear doors. Visibility through that window was severely restricted because of grills on the window of the outer door and there was no window which could be opened to allow air into the pod.

The bench seats were metal, slippery and inward facing. They were not padded or softened in any way. There were no grab handles or seat belts. At some stage during the journey the deceased fell onto the edge of one of the seats and sustained a bad cut to his head. This was a most unsafe environment for travel.

The vehicle was old and repairs could not make it safe. It was under-powered and could not overtake other vehicles safely. It had required repairs on a great many occasions.

The air-conditioning system for the vehicle was inadequate at the time of its fitting to provide a comfortable temperature in hot conditions. Over time it had deteriorated and prior to its complete failure, had been operating poorly for some time.

The quality of supervision of the deceased was very poor. The CCTV was inadequate and gave a poor picture which did not cover the whole pod even when working. It had not been working well for a lengthy period of time to the knowledge of GSL staff in Kalgoorlie.

As the condition of the deceased deteriorated in the enclosed, extremely hot rear pod there was no effective system of communication available to him.

There was no system of direct communication from the pod to the vehicle's cab and GSL staff appeared to have relied on prisoners shouting out or banging the walls of the pod to communicate distress. For much of the trip the deceased may have been unwell and incapable of making sufficient noise to be heard over the engine noise of the vehicle which police tests showed was extremely loud.

The only form of a duress alarm was an unlabelled button in the pod which, while pressed, caused a light to be illuminated on the dash of the vehicle. It is most unlikely that the deceased was aware of this button or its purpose as it was not pointed out to him when he was placed in the pod. Even if the deceased had been able to locate the button and guessed its purpose (which police forensic officers who inspected the vehicle after the death were not at first able to do) and even if he was able to press it and did press it, it is unlikely that the inadequate light on the dash was seen by the GSL officers in the cab, Mr Powell and Ms Stokoe, whose attention may have been directed elsewhere.

In spite of the obvious difficulties associated with monitoring the prisoners' welfare in the rear pod of the Mazda vehicles there were no written policies of GSL to require reasonably regular physical checks to take place on the welfare of prisoners and these had never been required by the Department. No welfare checks were conducted on the deceased by Mr Powell or Ms Stokoe and they did not stop the vehicle during the journey in spite of the obvious limitations they experienced in monitoring the prisoner's welfare and their knowledge of the poor reliability of the vehicle's air-conditioning.

The deceased was provided with only a meat pie and a 600ml bottle of water for sustenance on the long trip. At no time did Ms Stokoe or Mr Powell ask the deceased if he required more to eat or drink or offer him cold water in place of the bottle he had which must have become warm very quickly. Again there were no written procedures in place to ensure this occurred and none were required by the Department.

These failures reflected a lack of concern by all concerned for the safety and welfare of prisoners.

There was no toilet provided in the rear pod for the deceased's use. Comfort breaks were only permitted by GSL if there was an available police station with a sally-port with police in attendance. On this occasion no effort was made by Mr Powell or Ms Stokoe to ring ahead to the police stations at Leanora or Menzies to ascertain whether police would be in attendance to permit such a stop to take place. It appears that if the deceased had been able to communicate a toilet need he would have been given an empty bottle or jerry can for use. This failure to accommodate toileting needs reflected a lack of concern by all concerned for the dignity of prisoners.

The State Coroner found that he was satisfied that the Department, GSL, Mr Powell and Ms Stokoe each failed to comply with their duty of care obligations to the deceased and each contributed to the death. The State Coroner further observed that there could be no excuse for those failures.

In the submissions on behalf of Western Australian Police and the Department it was contended that it was not open for me to find that any person(s) caused or contributed to the death as such a statement would appear to determine questions of civil liability or suggest that a person(s) is guilty of an offence.

The State Coroner did not accept that submission. It was the State Coroner's view a finding that a person or persons caused or contributed to a death is often necessary in order to determine how a death occurred (see e.g. ***Perre v Chivell*** (2000) 77 SASR 282) and there is a gulf between such a finding and a determination of civil or criminal liability. I endorse the observations of Callaway JA in ***Keown v Khan*** [1997] 1VR 69 [16] –

> The findings by a coroner as to how a death occurred and the cause of death should, where that is possible, identify any person who contributed to the cause of death.

Western Australia is Australia's largest state comprising 2,525,500 square kilometres, and is about the same size as Western Europe. In that context it is clear that many prisoners, including many Aboriginal prisoners, have to endure being transported over vast distances often through remote areas, spanning extremes of climatic conditions, in order to be relocated from police lockups to prisons.

A question which is raised by the case is how a society which would like to think of itself as being civilised, could allow a human being to be transported in such circumstances.

A further question arises as to how a government department, in this case the Department of Corrective Services, could have ever allowed such a situation to arise, particularly when that department owned the prisoner transportation fleet including the vehicle in question.

The State Coroner found that it was not possible at this inquest to find adequate responses to these questions.

Report to the Director of Public Prosecutions : Section 27(5) of the Coroners Act 1996

Section 27(5) of the *Coroners Act 1996* provides in part –

A coroner may report to –

(a) The Director of Public Prosecutions if the coroner believes that an indictable offence has been committed in connection with a death which the coroner investigated;

(b) ...

Importantly in the context of considering any possible report, section 25(5) of the Act provides –

> A coroner must not frame a finding or comment in such a way as to appear to determine any question of civil liability or to suggest that any person is guilty of any offence.

In the context of section 25(5) of the Act the State Coroner did not consider that it is appropriate for him to review evidence in respect of possible criminal charges in any detail in these reasons.

The submissions on behalf of the family and on behalf of the Aboriginal Legal Service both contended that the State Coroner should make a report to the Director of Public Prosecutions in this case.

The State Coroner noted that section 27(5) does not require him to specify by whom he believed an indictable offence may have been committed or to review whether or not there is sufficient admissible evidence to establish a prosecution case.

In that context the State Coroner did propose to make such a report to the Director of Public Prosecutions.

The State Coroner accepted that in the context of this avoidable death, as stated in the submissions on behalf of the Aboriginal Legal Service, "there is anger, disbelief, emptiness and calls for justice". In that context he did not wish to create unrealistic expectations on the part of the family or the hope that they will see "justice" as a result of such a report being made.

As indicated earlier in these reasons, the death was contributed to by the actions of Mr Powell, Ms Stokoe, the Department and GSL.

In respect of the involvement of Mr Powell and Ms Stokoe, the State Coroner observed that it needed to be recognised that there are deficiencies in respect of the evidence which was obtained relating to their involvement and, in particular, they were not kept separate following the death and were able to spend a considerable period of time in each other's company during which time they had the opportunity to communicate to each other a version of facts. In addition, both were interviewed in the presence of their supervisor, Ms Jenkins, who was a material witness.

In the circumstance that Ms Stokoe and Mr Powell were the only two witnesses of the events which took place immediately prior to the time of the death, it was important that they should have been separated at an early stage and had no opportunity to collaborate on an account. There appeared to be no good reason for involving Ms Jenkins, particularly when, as the supervisor of the two witnesses being interviewed, it was

likely that she had some involvement in giving instructions to the witnesses and in decisions relating to the use of the vehicle.

Recommendation 35 of the Royal Commission into Aboriginal Deaths in Custody provides that police standing orders should require investigations to be approached on the basis that the death may be a homicide.

Detective Sergeant Robinson, the investigator in charge in the case, did give evidence that he approached the investigation in this way. In that context it is unfortunate that two persons who had involvement in the circumstances prior to the death were not kept separate. Detective Sergeant Robinson's running sheet contains an entry at 17:50 hours –

> Speak to GSL guards, ensure they no longer spoke with each other to avoid contamination of story.

In evidence Detective Sergeant Robinson stated that before he arrived at work they had not been separated, but when he arrived action was taken to keep the witnesses apart.

This does not appear to have happened in fact. Certainly, for whatever reason, the witnesses remained together in the supervisor's office and later in the detectives' staff room for a number of hours up until the time when they were interviewed.

As indicated earlier in these reasons, there are aspects of the evidence of the two witnesses which I do not accept as reliable and in that context it is most unfortunate that this situation was allowed to occur.

The State Coroner found that Detective Sergeant Robinson, from the stage when his report was provided to the Office of the State Coroner and throughout the inquest he responded promptly to all requests for evidence gathering. I make no criticism of Detective Sergeant Robinson in this regard.

The fact that aspects of the evidence of these witnesses is not credible does not provide a basis for conclusions as to precisely what did occur.

In respect of the involvement of the Department, there are obvious legal issues as to whether the Department could be charged. The submissions on behalf of the Aboriginal Legal Service contain the following –

> There is no doubt some complexity as to the proper defendant in relation to both GSL and the Department of Corrective Services, but

> the evidence available against each entity in relation to the alleged breaches of duty is sufficiently strong to justify a report to the DPP.

The State Coroner found that in the context of the Department's involvement this submission does not address the legal issue of how a government department could be charged with a criminal offence.

With respect of GSL, while section 69(1) of the *Interpretation Act 1984* states that provisions relating to offences apply to bodies corporate as well as to individuals, the involvement of the relevant entity in the CSCS contract was relatively short and the evidence at the inquest relating to its involvement was limited.

In summary, therefore, the State Coroner found that while the deceased suffered a terrible death which was not only preventable but easily foreseeable, issues relating to the involvement of the various individuals and organisations are complicated.

Breaches of Australia's International Legal Obligations

Australia has a number of specific international legal obligations pursuant to the International Covenant on Civil and Political Rights (ICCPR).

Article 7 of the ICCPR provides that –

> No-one shall be subjected to torture or cruel, inhumane or degrading treatment or punishment.

In addition to the prohibition against torture and cruel, inhumane treatment or punishment, Article 10(1) of the ICCPR imposes further positive obligations directed to the rights of detained persons. Article 10(1) provides –

> All persons deprived of liberty shall be treated with humanity and with respect for the inherant dignity of the human person.

The State Coroner agreed with the submissions on behalf of the Human Rights and Equal Opportunity Commission to the effect that the purpose of Article 10(1) is to impose on states a positive obligation towards persons who are particularly vulnerable because of their status as persons deprived of liberty.

The State Coroner further agreed with the submission to the effect that the state's duty under international law to provide adequate care to persons deprived of their liberty is non-delegable, as under the Australian

common law. In that context the State Coroner observed that privatisation of prisoner transport services cannot remove from a state the duty of ensuring that human rights standards are met by contractors.

The State Coroner observed that in the present case for the reasons outlined for determining that the quality of the supervision, treatment and care of the deceased in the hours before his death was disgracefully bad, The State Coroner was satisfied that the deceased was subjected to degrading treatment and he was not treated with humanity and with respect for the inherent dignity of the human person. There has been, therefore, a breach of the ICCPR.

The deceased was transported in a pod of a prisoner transportation vehicle which for the reasons outlined earlier herein was unsafe for the purpose. The deceased was injured, burnt and eventually died as a result of heatstroke in that pod.

In the context of the rear pod of the Mazda vehicle the State Coroner agreed with the observation of the prison administrator, whose comments were recorded in the report of the Inspector of Custodial Services in 2001, that the vehicle was "not fit for humans to be transported in".

The Lack of Action Following Reports by the Office of the Inspector of Custodial Services

As indicated in these reasons the State Coroner observed that many of the problems highlighted by this case had already been identified by the previous Inspector of Custodial Services who in unambiguous language had stressed the need for urgent action to take place for safety reasons. It was clear that the recommendations and observations of the Inspector were not acted upon in a timely manner and this failure to act resulted in the circumstances which contributed to the death.

The State Coroner accepted the submissions made on behalf of the current Inspector, Professor Neil Morgan, to the effect that the effectiveness of the WA inspections system relies on the professionalism of the inspection process and other ongoing activities, the clarity of the recommendations which are made and the willingness of the Department (and, where relevant, private contractors) to adopt the recommendations and it is not generally the Inspectorate's role to attempt to manage operational Departments. However, some matters which relate to human rights, safety and welfare are so fundamental that there is little room for debate and in such circumstances the Department should be obliged to respond to such recommendations.

While the State Coroner accepted that some form of "enforcement notice" may not be the best way forward, it did appear that it would be helpful if the Inspectorate could provide the Department or contractor with a written "Show Cause" Notice. Such a "Show Cause" Notice would require the Department to respond to particular questions and allow the office to set a timeframe in which responses were to be received. It would be important for this system to work that the Inspector should be able to require a response to specific questions as to plans, project timeframes etc.

In the present case such a notice could have required the Department in 2001 to explain why, in the relevant vehicle –

- there was no padding on the seats;
- seat belts were not installed;
- grab rails were not installed; *and*
- whether the Department agreed with the concerns expressed in the report about air-conditioning and ventilation, and what measures would be taken to address the problems.

This would have meant that the Office and Minister would have been better informed and better able to monitor progress.

Such a notice could also have been used in respect of recommendation 1 of Report No. 43, referred to previously, that journeys of more than 2½ hours should not be undertaken in short-haul vehicles such as the Mazda and would have required the Department to address that issue. If the Department had acted on the recommendation the deceased would not have died when he did.

Recommendation No. 1

I recommend that a statutory system be put in place which would enable the Inspector of Custodial Services to issue the Department of Corrective Services with a "Show Cause" Notice in cases where the Inspector is aware of issues relating to the human rights and safety of persons in custody.

It was noted that pursuant to the *Terrorism (Preventative Detention) Act 2006* the Inspector is given jurisdiction with respect to people detained under that Act. Under Section 39(1) detainees must be "treated with humanity and with respect for human dignity; and must not be subject to

cruel, inhumane or degrading treatment". The Inspector is charged with reviewing any detainee's detention to determine whether that section is being complied with.

The Inspector does not have a similar power of review in respect to persons detained who are not suspected terrorists. It is unfortunate that in this regard there is less protection for a person detained in respect of relatively minor traffic charges, such as the deceased, than there is for suspected terrorists.

These provisions provide a possible model for amendments to other legislation relating to prisons, prisoner transport and court security.

Such a power of review by the Inspector would provide a mechanism for monitoring the State's compliance with Australia's international legal obligations.

Recommendation No. 2

I recommend that the terms of section 34 and 39 of the Terrorism (Preventative Detention) Act 2006 be inserted in relevant legislation dealing with the Inspector's powers so that those protections be extended to all persons in custody and to all areas of the Inspector's jurisdiction.

Bail Issues

The State Coroner observed that it was an understatement to observe that the deceased was not well served by the Justice system.

There were a number of deficiencies in the initial approach to bail taken on the evening of 26 January 2007 by Sergeant Timmers, particularly his failure to provide the deceased with the prescribed information as required by section 8 of the Bail Act, but more alarming was the "court hearing" before Mr Thompson JP.

The Court was not convened in accordance with the law. The person who had been appointed as a Deputy Registrar, Senior Sergeant Shaun Denness, had no real knowledge or understanding of his duties and responsibilities. Sergeant Denness was not even aware of the letter of his appointment until it was shown to him at the inquest and had not read the attached documentation including the summary of powers of a Deputy Registrar and a copy of the *Magistrates Court Regulations 2005*.

The police officer who purported to convene the court was not a Deputy Registrar.

The *Magistrates Court Regulations 2005* specifically limited the circumstances in which a JP could constitute a court and in the context of this case a JP was not to constitute a court on a Sunday. That situation had been made very clear by the relevant local magistrate in a written direction which had been sent by the Kalgoorlie Court to the Laverton Police Station by facsimile transmission on 20 May 2005.

The above evidence displays a disappointing lack of concern on the part of the police officers involved in ensuring that they complied with their duties and responsibilities in respect of the convening of courts. In addition the evidence revealed broader systemic problems. Sergeant Denness and Senior Constable Chamings, for example, both appeared to believe that the deceased was ineligible for bail as a result of having breached a suspended sentence. Similarly, none of the other officers who gave evidence was familiar with the relevant procedural obligations under the Bail Act.

Recommendation No. 3

I recommend that WA Police review its training procedures to ensure that police officers have a better understanding of the *Bail Act 1982.*

Recommendation No. 4

I recommend that the Department of the Attorney General not delegate to police officers the powers of a Deputy Registrar of the Magistrates Court of Western Australia under section 26 of the *Magistrates Court Act 2004* unless the Department can be satisfied that those police officers do have an understanding of the powers and responsibilities of a Deputy Registrar.

The State Coroner found that the involvement of the JP in this matter is particularly concerning.

It was clear that the JP had a very poor understanding of his role and responsibilities as a JP. He had never undergone any training as a JP and had been exempted from having to complete the training which was usually provided because of the limited availability of JPs in Laverton and the fact that he claimed that he was busy.

The State Coroner found that the –

- The JP had not read all the relevant handbook or legislation and did not have direct access to relevant legislation such as the Bail Act.
- The JP did not know that he was required by Section 7(1) of the Bail Act to consider the deceased's case for bail whether or not an application for bail was made by him. The JP did not give any consideration to that issue.
- The JP did not provide the deceased with the prescribed information as required by section 8 of the Bail Act.
- The JP did not make any record of any reasons for refusal of bail as required by section 26 of the Bail Act.
- The JP understood his role as being only to assess whether the charges were of a frivolous nature.

In addition the events which took place at the deceased's cell on the morning of his death did not have the appearance of an independent court hearing. The JP received information about the deceased in his absence prior to attending the cell and the "hearing" took place at a cell door in circumstances not conducive to a perception of independence on the part of the JP.

It was the evidence of the JP and police officers at the inquest that other JPs also convened courts on a Sunday and conducted bail hearings at the cell doors.

The State Coroner found that in the above evidence it raised serious concerns about the use of JPs in country areas.

While it should be recognised that JPs over many years have performed an important role in regional areas in a voluntary capacity, this case has highlighted a need for change. In my view no JP should constitute a country court, either alone or with another JP, unless that JP has satisfactorily completed an adequate course of training. It does appear that the Department provides JPs with a comprehensive handbook and training was available. It is unfortunate that the JP in this case was not required to complete the available training.

Recommendation No. 5

I recommend that the Department of the Attorney General review the use of Justices of the Peace, particularly in remote locations, to ensure that Justices performing court duties have received training in their duties and responsibilities and have successfully completed assessments after such training.

The State Coroner found that this case raised concerns as to the extent to which the Department of the Attorney General monitors the performance of JPs. According to the witnesses the court at Laverton had sat on other occasions on Sundays contrary to the express direction of the magistrate. The fact that this was occurring should have been identified and the problem remedied. In addition, there should have been some form of audit which would have identified the fact that the JP had little understanding of his role and was, for example, not recording his reasons in writing.

Recommendation No. 6

I recommend that the Department of the Attorney General ensures that JPs who perform court duties are monitored regularly to ensure that they are performing their duties appropriately.

The State Coroner found it was clearly not an optimal situation where local members of a community act in a voluntary capacity as JPs conducting court proceedings in an environment where they are likely to know police officers and others in the court. In the 21st Century when immediate communication is available across the globe, it is most unfortunate that reliance has to be placed on local volunteers in remote communities to perform this essential service. In my view the time has come for increased use of technology, such as video conferencing and even telephone conferencing, to ensure that these court hearings wherever possible are conducted before qualified magistrates.

Recommendation No. 7

I recommend that the Department of the Attorney General review present procedures to extend the availability of video conferencing and, in the absence of available video conferencing, give consideration to increased use of telephone conferencing so that decisions, particularly those relating to the liberty of the subject, can be wherever possible made by qualified magistrates.

The State Coroner found that in the present case the deceased had strong ties with Warburton and could have been bailed to appear either at Laverton or, preferably, to his home town Warburton. The effect of the remand in custody in this case was that the deceased was transported approximately 360kms away from his home environment and he would

have spent at least three days in custody prior to his first appearance before a magistrate in Kalgoorlie. No one considered the deceased to be violent or, if sober, a threat to others. At a stage when he had sobered up after being in the Laverton lockup overnight, there seemed little benefit to be achieved by transporting him to Kalgoorlie.

The State Coroner found that this case highlighted the importance of avoiding unnecessary transportation of accused persons over long distances. Such transportation can be particularly distressing for Aboriginal persons who have a close affiliation with the land.

Recommendation No. 8

I recommend that the Department of the Attorney General review current court procedures with a view to limiting unnecessary transportation of accused persons over long distances.

The State Coroner found that it should be emphasised that the above recommendations relating to JP courts are made in a context of reducing the amount of time persons unnecessarily spend in custody, care needs to be taken to ensure that any changes which take place do not lead to the unintended consequence of increasing such time in custody, which would defeat the purpose of making such changes.

The Department of Corrective Services

The State Coroner noted that many of the vehicles in the prisoner transportation fleet are beyond repair and many were unsafe as constructed.

Recommendation No. 9

I recommend that the Department of Corrective Services replace the current fleet of prisoner transportation vehicles with vehicles which are both safe and humane.

Recommendation No. 10

I recommend that the Department of Corrective Services ensure that there is in place a replacement strategy and budget to ensure that in future vehicles are replaced on a regular basis and there are no old or unsafe vehicles in use.

The State Coroner noted that the State's duty both under Australian Common Law and under International Law is to provide adequate care to persons deprived of their liberty and that duty is non-delegable. While the Department had entered into a contract which resulted in privatisation of prisoner transportation, it remained the Department's duty to ensure that prisoners were transported in conditions of safety and that there was respect for the inherent dignity of the human person.

Recommendation No. 11

I recommend that the Department of Corrective Services conduct ongoing review of all G4S policies and procedures relating to the welfare of detainees and duty of care to ensure that procedures in place are sufficiently comprehensive and address the known risks.

The State Coroner noted that in this case it did appear that the Department had Contract Monitors who were well aware of the widespread deficiencies with the transport fleet. The regional reports for the six months prior to the death, for example, show that almost all of the vehicles required significant repairs or replacement. It is important that the Contract Monitors have the ability to effect changes in the fleet when prisoner safety is compromised and are able to review operations to ensure that G4S staff are complying with policies and procedures.

Recommendation No. 12

I recommend that the Department of Corrective Services ensure that there are sufficient contract monitors to regularly review operations in regional locations so as to ensure that the prisoner transportation fleet is maintained in a safe manner and that G4S staff are complying with the company's policies and procedures.

G4S

The State Coroner noted that the evidence at the inquest revealed that GSL staff (now G4S staff) received limited training. All of the staff who gave evidence had received some training when they commenced their employment which they described as mostly involving reading materials and subsequently being tested on what they had read. Little explanation was provided unless it was specifically requested. The only practical training which they received was in the use of restraints and the use of force. Most learned the practical aspects of the job by observing others.

It appeared that there was no specific training provided for supervisors apart from their attending an annual supervisors conference.

Recommendation No. 13

I recommend that all G4S staff should be provided with appropriately detailed practical training in respect of duty of care obligations and that such training be refreshed on a regular basis for all staff.

Recommendation No. 14

I recommend that G4S arrange training specific to the role of site supervisors in regional locations in respect of management skills and duties in particular in respect of monitoring staff compliance with policies and procedures relating to the welfare of detainees and duty of care.

On the 29 September 2009 the Attorney General Christian Porter publicly released the Government's response to the recommendations made by the State Coroner after the death of Mr Ward.

Mr Porter addressed each of the 14 recommendations made by State Coroner as outlined below -

> Recommendation No. 1
> I recommend that a statutory system be put in place which would enable the Inspector of Custodial Services to issue the Department of Corrective Services with a "Show Cause" Notice in cases where the Inspector is aware of issues relating to the human rights and safety of persons in custody.

Recommendation No. 2
I recommend that the terms of section 34 and 39 of the Terrorism (Preventative Detention) Act 2006 be inserted in relevant legislation dealing with the Inspectors powers so that those protections be extended to all persons in custody and to all areas of the Inspector's jurisdiction.

Response to Recommendation No. 1 and Recommendation No. 2
The Minister for Corrective Services supports these recommendations in principle.

To understand the significance of these recommendations, it is necessary to understand the manner in which the legislation to which the Coroner refers operates. The *Terrorism (Preventative Detention) Act* 2006 (WA) (**Terrorism Act**) was enacted to allow persons to be detained without trial where it was suspected that they were involved in terrorist activity. Given the extraordinary nature of that legislation, it was judged necessary to give persons detained under that Act broadly worded protections. It is feasible for the Office of the Inspector for Custodial Services (OICS) to have direct oversight over every person detained under the Terrorism Act, because it was never contemplated that a large number of persons would be subject to preventative detention. Indeed, no person has yet been detained pursuant to the Terrorism Act.

In the context of the approximately 10,000 persons going into detention in various forms of custody in Western Australia each year, protections of the nature provided by the Terrorism Act would be largely symbolic. To merely insert the terms of sections 34 and 39 of the Terrorism Act into the relevant legislation dealing with the Inspector's powers would not oblige the Inspector to do anything with those names, or provide him with any investigatory powers or additional resourcing. Indeed, this approach would not provide the Inspector with any information to which he does not already have effective access, given that the Inspector can and does access information from the Total Offenders Management System (TOMS) database which details all persons going into custody

To give effect to what the Coroner has identified as an issue of concern, and honour the spirit of Recommendations 1 and 2, the Minister for Corrective Services, will pursue legislation to enhance the role of the Inspector for Custodial Services as follows.

Proposed legislation will be designed to empower the Inspector to audit a certain proportion of the total population of persons in custody every year.

This auditing power recognises that tragic, avoidable circumstances such as those which led to the death of Mr Ward, can occur as a result of process failures spanning several different agencies and organisations and further recognises that these deficiencies are not always readily apparent from static inspections of facilities or equipment.

The enhanced powers will allow the Inspector of Custodial Services to audit the passage of persons through the custodial system to ensure that persons are treated safely and humanely at every stage of their contact with the custodial aspects of the criminal justice system.

A key feature of such an auditing process would be the creation of a statutory power for the Inspector to issue "Show Cause" notices to the Department of Corrective Services (DCS) and to require responses where the audit process has disclosed risks to the health, wellbeing and safety of persons in custody.
The provision of additional resourcing to OICS to allow the Inspector to undertake this enhanced role will be the subject of a business case that will be considered as a part of, and subject to, the normal budgetary processes.

Recommendation No. 3
I recommend that WA Police review its training procedures to ensure that police officers have a better understanding of the Bail Act 1982.

Response to Recommendation No. 3
The Attorney General supports this recommendation in principle.
The Department of the Attorney General (DotAG) will immediately commence a review into the *Bail Act 1982* (WA) to ensure that Western Australia's bail processes are appropriate and workable, particularly for people living in remote communities.
In addition, and irrespective of the outcome of the review, the Attorney General has written to the Minister for Police to seek his support for a review of training procedures to ensure that police officers operating under the present terms of the *Bail Act* have a better understanding of the operation of and their responsibilities under this legislation.

Recommendation No. 4
I recommend that the Department of the Attorney General not delegate to police officers the powers of a deputy registrar of the Magistrates Court of Western Australia under section 26 of the Magistrates Court Act 2004 unless the Department can be satisfied that those police officers do have an understanding of the powers and responsibilities of a deputy registrar.

Response to Recommendation No. 4
The Attorney General supports this recommendation.

DotAG and WA Police have together implemented changes to governance processes surrounding the appointment of police officers as deputy registrars. These changes are designed to ensure that police officers appointed as deputy registrars have a clear understanding of their powers and responsibilities.

These initiatives are currently being implemented within existing resources and consideration of further changes aimed at decreasing the need for delegation of the power of deputy registrars to police will occur if it is determined that the newly implemented changes to governance processes surrounding the appointment of police officers as deputy registrars has not significantly improved police understanding of their powers and responsibilities.

Recommendation No. 5
I recommend that the Department of the Attorney General review the use of Justices of the Peace, particularly in remote locations, to ensure that Justices performing court duties have received training in their duties and responsibilities and have successfully completed assessments after such training.

Response to Recommendation No. 5
The Attorney General supports this recommendation.

DotAG has already commenced work on revising the current, initial Justice of the Peace (JP) training model to:

- improve the cultural awareness of approved JP applicants through training;
- encourage all applicants to meet with Aboriginal Elders and Aboriginal community leaders from the local community to promote awareness of the principal persons within the region; and
- review and augment the JP handbook for distribution to all JPs.
- Ongoing training will be provided to safeguard against gradual loss of knowledge and keep JPs updated on developments within the justice system. This will be provided through:
- adequate completion of a justice system training module assessment; or
- attendance and participation at annual training seminars with other JPs, local magistrate/s and/or guest speakers, with a greater use of adult learning techniques such as role plays and case studies.

The implementation of an enhanced and targeted training model for JPs performing judicial functions may require additional resources. If necessary a business case will be considered as a part of, and subject to, the normal budgetary processes.

Recommendation No. 6
I recommend that the Department of the Attorney General ensures that JPs who perform court duties are monitored regularly to ensure that they are performing their duties appropriately.

Response to Recommendation No. 6
The Attorney General supports this recommendation.

DotAG will investigate the introduction of a two tier system of JP appointments by separating judicial responsibilities from administrative duties.

This systemic change would be designed to ensure that those JPs performing court duties are better trained and more easily monitored on a regular basis, and recognises that only a minority of all Western Australian JPs (13.5%) actually perform judicial functions. The creation of two tiers of JP appointments would recognise that the majority (86.5%) of the functions performed in the wider community are administrative in nature.

Under a two tier structure it would be proposed that all JPs would still undertake administrative duties, however judicial functions would only be performed by those JPs who had undertaken specialised training. This enhancement would also enable “second tier” JPs to be subject to more stringent monitoring in respect of their judicial responsibilities.

Should this two tier approach prove feasible, a business case will be developed for any additional resources required for the Implementation of a two tiered JP appointment and monitoring system.

Recommendation No. 7
I recommend that the Department of the Attorney General review present procedures to extend the availability of video conferencing and, in the absence of available video conferencing, give consideration to increased use of telephone conferencing so that decisions, particularly those relating to the liberty of the subject, can be wherever made possible by qualified magistrates.

Recommendation No. 8
I recommend that the Department of the Attorney General review current court procedures with a view to limiting unnecessary transportation of accused persons over long distances.

Response to Recommendation No.7 and Recommendation No. 8
The Attorney General supports these recommendations.

DotAG will investigate the feasibility of establishing a centrally located judicial service to be available via audio visual infrastructure to respond to the needs of regional and remote communities.

Under this proposal it is envisaged that a judicial roster system will be located in Perth to deal with simple matters, including bail and violence restraining orders using audio visual facilities. Additional resources would be required for such a system and the extent of these resources will depend on whether the audio visual court is convened by:

- registrars of the Magistrates Court of WA;
- registrars (legally qualified); or
- magistrates.

The resourcing of this proposed model will also depend on an evaluation of what time periods either registrars, registrars (legally qualified), or magistrates are to be made available. DoTAG will develop costings based on an after hours service being available from 4pm until 11pm each weeknight and from 10am until 11pm on weekends.

After costings and business cases of the different models have been developed, the Department will submit them to Government as part of the normal budgetary processes.

Recommendation No. 9
I recommend that the Department of Corrective Services replace the current fleet of prisoner transportation vehicles with vehicles which are both safe and humane.

Response to Recommendation No.9
The Minister for Corrective Services supports this recommendation.

DCS commenced action to replace the original fleet as early as November 2004. The State Tenders Committee approved awarding of a contract in late 2005, however the contractor went out of business in January 2006. Negotiations then commenced with alternative providers, but it was not until late 2006 that sole provider status for SVM Queensland was approved. The first new prototype vehicle was delivered in November 2007 after significant consultation on the design of the vehicles. Two prototype vehicles were delivered, one in November

2007 and the other in January 2008. Following a three month trial an audit was undertaken by G4S, Easifleet and DCS in April 2008, which specifically reviewed the electrical systems, occupational health and safety considerations, and general pod design of the prototype vehicles. The improvements identified in the audit were incorporated into the production vehicle specifications.

DCS has assessed all vehicles to evaluate their suitability for ongoing use. This included considering the age of the vehicles, the service history, the distance travelled and the general condition of the vehicle. Ongoing monitoring and maintenance on the vehicle fleet occurs and only those vehicles deemed suitable remain in service. DCS also notes that consistent with the *Road Traffic (Vehicle Standards) Regulations 2002*, all fleet vehicles will undergo an annual inspection by the Department of Planning and Infrastructure for ongoing registration purposes. In addition, all existing fleet vehicles have had remote temperature monitoring and updated duress alarms fitted after the death of Mr Ward.

As at 31 August 2009, DCS has taken delivery of three new prototype vehicles and eight new production vehicles as part of the replacement program. Based on the current production schedule all original fleet vehicles will be replaced by December 2010.

Recommendation No. 10
I recommend that the Department of Corrective Services ensure that there is in place a replacement strategy and budget to ensure that in future, vehicles are replaced on a regular basis and there are no old or unsafe vehicles in use.

Response to Recommendation No. 10
The Minister for Corrective Services supports this recommendation and advises that DCS' budget in the current financial year and forward estimates period now includes full funding for ongoing replacement of the fleet. DCS' current vehicle replacement strategy includes the leasing of all cab chassis and vehicle pods, for all new vehicles, through State Fleet and the fleet management through Easifleet. This arrangement provides for the replacement of the vehicle cab chassis every five years and vehicle pod every 10 years, and, as noted above, is fully funded.

Recommendation No. 11
I recommend that the Department of Corrective Services conduct ongoing review of all G4S policies and procedures relating to the welfare of detainees and duty of care to ensure that procedures in place are sufficiently comprehensive and address known risks.

Response to Recommendation No. 11
The Minister for Corrective Services supports this recommendation and advises that contractor procedures relating to the conduct of escorts and duty of care implications were immediately reviewed and amended as required, following the Review of Prisoner Transport Services conducted by in February 2008.

The Review made 18 recommendations. These recommendations specifically sought to make improvements to:

- the governance framework;
- performance management;
- risk management;
- compliance management;
- financial management; and
- the secure vehicle fleet.

Implementation of the Review recommendations is continuing.

In addition to the abovementioned Review, DCS also conducted a review in 2008/09, in conjunction with the Contractor, of all other Contractor policies and procedures relating to the service, and amendments have been undertaken as required. These policies and procedures are now subject to annual review.

To provide a further level of scrutiny DCS' process for managing the approval of Contractor policies and procedures were also changed in 2008. The Contract Management Framework and associated Work Instructions in place in early 2008 required the Contractor to submit policies to DCS for assessment for compliance with legislation and suitability prior to their implementation. Any changes to policies required approval by Contract Management.

Following a review of the Contract Management Framework and associated Work Instructions, DCS now requires that each policy and procedure is reviewed consistent with the process identified below. This process is detailed within the Court Security and Custodial Services (CS&CS) Contract Management framework and associated Work Instructions.

The changes to the CS&CS Contract Management framework and associated Work Instructions were:

- The Contractor is responsible for developing Policies and Procedures in relation to the Services.
- Each procedure must be submitted to, and approved by, DCS Services prior to its implementation.
- All Contractor Policy and Procedures are assessed by Court Security and Custodial Services Policy Review Panel.
- The Contract Manager has delegated authority under the Contract for final approval of the policies and procedures.
- Each procedure is to be reviewed at least annually.

Any changes to policies and procedures proposed by the Contractor must first be reviewed by Contract Management, and then follow the process articulated above.

Recommendation No. 12
I recommend that the Department of Corrective Services ensure that there are sufficient contract monitors to regularly review operations in regional locations so as to ensure that the prisoner transportation fleet is maintained in a safe manner and that G4S staff are complying with the company's policies and procedures.

Response to Recommendation No. 12
The Minister for Corrective Services supports this recommendation.

Consequent upon internal restructuring DCS has already increased the number of monitors available to undertake the audit and/or review of transport and court services in regional and metropolitan areas from two to five personnel. However, it is likely that a small number of further positions will be required to allow for greater capacity to undertake additional activity where risk assessments indicate that additional monitoring is required. In preparation, DCS will develop a submission to Government for the additional resources necessary to implement the recommendation. As the implementation of this proposal would require additional resources, any accompanying business case will be considered as a part of, and subject to, the normal budgetary processes.

Recommendation No. 13
I recommend that all G4S staff should be provided with appropriately detailed practical training in respect of duty of care obligations and that such training be refreshed on a regular basis for all staff.

Recommendation No. 14
I recommend that G4S arrange training specific to the role of site supervisors in regional locations in respect of management skills and duties in respect of monitoring staff compliance with policies and procedures relating the welfare of detainees and duty of care.

Response to Recommendation No. 13 and Recommendation No. 14.
While acknowledging the non-delegable duty of care owed by the State in this case, the Minister for Corrective Services supports these recommendations

To this end, and in response to DCS' request, the Minister notes that G4S has submitted an Action Plan to address the training requirements contained in the Coroner's recommendation, including a specific duty of care module.

DCS will monitor the rollout of the Action Plan including the provision of regular refresher training to G4S staff.

Lee James Nundle

Lee James Nundle died on 27 April 2007 at Royal Perth Hospital as a result of ischaemic heart disease and coronary arteriosclerosis. The inquest hearing was held at the Perth Coroners Court on 5 June 2009 and the findings delivered by the State Coroner on 6 July 2009.

The deceased was a 50 year old male prisoner with a long history of diabetes mellitus. While he was a sentenced prisoner the deceased had been prescribed and administered medications by prison medical staff for the treatment of his diabetes and heart problems. He was twice admitted to Royal Perth Hospital for medical treatment.

His first admission from 30 March to 18 April 2007 was for the treatment of scabies. He presented on 27 March 2007 to prison medical staff complaining of itchy feet and was diagnosed with scabies on 30 March 2007 when seen by a doctor. He was transferred to Royal Perth Hospital where the scabies was treated and he was discharged back to the prison on 18 April 2007.

After his return to Wooroolloo Prison Farm on 18 April 2007 the deceased developed a diabetic ulcer on his foot which was painful. Despite treatment by prison medical staff it did not heal. The deceased was made to transfer the deceased to Royal Perth Hospital for treatment of the diabetic ulcer and this occurred on 26 April 2007.

On the evening of 27 April 2007 at 8pm a nurse at Royal Perth Hospital attended the deceased's room to give him scheduled medications. She found him unresponsive in his bed having suffered a cardiac arrest. CPR was initiated but was unsuccessful and the deceased was pronounced dead at 8:28pm hours.

The deceased had made no complaints to staff prior to his death and was last seen by a nurse at 7:30pm when he was observed to be snoring in his bed. Prior to this time he had been observed by the nurse to downstairs for a cigarette at 6:15pm.

A post mortem examination was carried out by the Chief Forensic Pathologist on the 2 May 2007 who determined that the cause of death was Ischaemic Heart Disease and Coronary Arteriosclerosis. He also noted the presence of infected ulcers on the feet and diabetes mellitus.

The State Coroner found that the deceased died as a result of Natural Causes.

The State Coroner found that the quality of the supervision, treatment and care of the deceased appeared to have been adequate and appropriate.