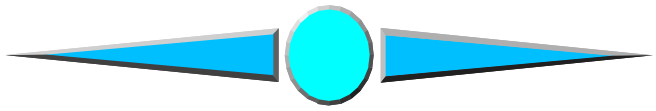
Office Of the State Coroner



Annual Report

2010-2011

State Coroner Western Australia

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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, 2011.

The Coroners Act 1996 was proclaimed on 7 April, 1997 and this is the fifteenth 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 year 2010-2011 commenced on a reasonably structured basis for the WA Coroner's Court. Temporary funding commenced by government on 14 August 2009 was continued during the financial year in the sum of $622,000 for an additional six temporary staff. While the one-off payment of $200,000 provided in 2009 was not duplicated during this year, the additional funding resulted in significant improvements, particularly during the first half of the year.

Provision of the dedicated receptionist enabled most calls to the office to be responded to and the Senior Coronial Counsellor position enabled some degree of direct counselling to be provided in the metropolitan area. The additional resourcing of counsel assisting enabled work to be done and prioritization to commence in respect of the outstanding backlog of 117 inquests.

Importantly the additional counsel assisting resources enabled the complex Operation Lantana investigation to go ahead and the associated inquest to commence before the Deputy State Coroner. That matter involved the deaths of five cancer patients in 2005 and was particularly complex, involving Australian registered doctors and nurses who appeared to have assisted an overseas doctor to run a non science based cancer clinic where patients were given large amounts of oral and intravenous unorthodox treatments.

Over the year, however, a number of significant events took place which together resulted in extreme problems for the Coroner's Court and great stress and excessive workloads for staff. In brief a number of the significant events which impacted on the court were as follows –

- One of the persons appointed as counsel assisting on a temporary contact using the non-recurrent funding left the office on completion of his contract in July 2010 and for practical reasons considerable delays were experienced in filling the position with the new counsel assisting not starting with the office until January 2011.
- The investigation relating to the Operation Lantana deaths continued in 2010 and a 23 volume brief was prepared which contained many documents seized across Australia and Internationally. The inquest commenced in November 2010, but was then adjourned until 2011.
- Dr Kemp, Senior Counsel Assisting, who had spent months preparing the brief became unwell and was unable to work for the period 10 March -22 July 2011.

- On 15 December 2010 a suspected illegal entry vessel (SIEV) crashed on the rocky shoreline of Christmas Island as a result of which 50 passengers died. Subsequently the bodies of 30 of those persons were recovered, in respect of 20 persons who died their bodies were never recovered. The Coroner's Court was required to respond to this disaster immediately and continuously for the remainder of the year and beyond. The disaster attracted attention on the world stage and there was a requirement to deal with aspects of the incident expeditiously (aspects of this matter will be discussed later in this Overview).
- The Office Manager and the Administrator of the Coroner's Court became focal points of communication in respect of the disaster for both state and commonwealth authorities. As part of the Disaster Victim Identification (DVI) process which followed the Christmas Island tragedy DVI Identification Boards were set up and the Office Manager was a member of these.
- The State Coroner and the Deputy State Coroner were both involved in the final decisions relating to the identification of the deceased persons whose bodies were located and the State Coroner ultimately made determinations in respect of the identity of the missing persons suspected to have died.
- The inquest in respect of the Christmas Island tragedy commenced with a number of directions hearings, the first of which was held on 16 February 2011. The opening speech by counsel assisting and the first extended period of sittings commenced on 18 May 2011.
- Preparations relating to the resumption of Operation Lantana and work being completed for the Christmas Island inquest ran parallel causing enormous pressure on resources.
- Additional resources provided by the department in respect of preparation of administrative files resulted in the backlog of cases for completion moving to the two coroners and resulted in approximately 400 files coming through to the two coroners for completion within a relatively short period of time.
- In June 2011 the Law Reform Commission of Western Australia produced its Discussion Paper in respect of its review of Coronial Practice in Western Australia and an urgent response was required from, and provided by, the State Coroner and Deputy State Coroner.

The Christmas Island Disaster

Following the disaster on 15 December 2010 it was necessary for the deceased persons to be identified. 30 separate identification files were prepared, one in respect of each deceased person whose body was recovered. Evidence comprised accounts of witnesses including survivors of the disaster, family members in Australia and overseas and other

witnesses. DNA evidence was used in many cases as proof of identity. In a number of cases dental evidence was obtained from the countries of origin and dental comparisons provided conclusive evidence as to identity. All 30 deceased persons were identified to the satisfaction of the State Coroner or Deputy State Coroner.

In respect of the deceased persons whose bodies were not recovered, the process was much more complicated. Again in each case a separate file was created, largely as a result of investigations conducted by the Australian Federal Police (AFP). Unfortunately in some of these cases the evidence initially presented was not sufficient to provide proof of identity and further investigations were conducted by WA Police.

None of these cases was reviewed by a DVI Identification Board.

In respect of these suspected deaths difficulty was encountered in establishing whether or not some of the persons in question were on the vessel. In many cases there was evidence that the persons suspected of being deceased had left Iran or Iraq, but evidence as to their being on the boat in question was lacking. This situation was further complicated by the fact that many of the witness statements obtained had been obtained for other purposes and only dealt with the identity of missing persons in an indirect and inconclusive way. A further problem related to the fact that many of those on the vessel were known by a number of different names and those names did not translate easily from the language of origin into English and spellings were inconsistent.

WA Police officers were required to obtain a number of additional statements from family members, some of whom were able to identify those missing using photographs of passengers on the vessel taken by those on shore shortly before it sank.

The investigation into the circumstances surrounding the incident was extremely extensive and a large number of issues were raised by a range of different individuals and parties. The ultimate brief prepared by WA Police contained 25 annexures, each annexure comprising multiple lever arch files. Annexure 2, for example, comprised 9 lever arch files. The total brief comprised well over 100 lever arch files.

At the time of writing the brief includes 729 witness statements as well as a very large number of reports, records, emails and other documents.

The fact that a brief was prepared in time for the inquest to start and continue during the year, although a very large number of additional statements were obtained subsequently, is a great credit to all concerned. The AFP obtained a large number of statements shortly after the incident,

but ultimately much of the investigation fell to WA Police officers whose performance was outstanding.

My thanks go to Detective Superintendent Graham Castlehow of WA Police and his staff for their dedication and willingness to explore issues in a professional and competent manner.

As a result of arrangements in place relating to the Territory of Christmas Island, funding for the inquest was borne by the Commonwealth Government. This enabled the appointment of Counsel Assisting from the independent bar, namely Mr Malcolm McCusker QC, and Mr Marco Tedeschi. During the year Mr McCusker QC was appointed Governor and was no longer able to continue working on the inquest. At a later date Mr Paul Yovich was retained as counsel assisting.

Although the Commonwealth funding enabled some replacement resourcing to take place, the impact of this "mega" inquest on the Coroner's Court cannot be overstated.

Operation Lantana

The Operation Lantana case referred to above similarly comprised a "mega" inquest which involved a huge drain on the office's limited resources. This inquest into the deaths of five cancer patients in 2005 involved review of a clinic which had originally operated in Darwin and after the Perth deaths was involved with continued treatment in South Australia. In addition to the Western Australian investigation, Northern Territory and South Australian coroners passed information on to this office.

The overseas doctor concerned was based in Austria and had convictions in the USA and Thailand and a death relevant to the inquest had occurred in Thailand, consequently considerable international information had to be collected.

Determining the cause of death was a difficult matter in this case in the context of the medical condition of the deceased persons prior to treatment and involved obtaining evidence from multiple experts. Ultimately the court obtained oral evidence from 5 experts who had provided 12 statements between them.

To assist the experts to comment on the effect and risks of the treatment, court staff compiled information relating to over twenty patients who had received the treatment in question.

Dr Kemp, Senior Counsel Assisting, spent months preparing the brief and it was necessary for her to visit Darwin to obtain copies of relevant exhibits held there. She was assisted by Detectives involved in the investigation, Detective Sergeants Rakich and Bethell, and in the office was provided assistance by Sergeant Housiaux.

Assistance Provided by the Department

During the year the Department of the Attorney General provided support to the office in a number of significant ways. The department provided a Findings Clerk, Kathryn Thomas, to assist with file closures. In addition during June 2011 the department made arrangements for three regional managers to assist with preparation of files for closure and arranged for funding for overtime work by Coroner's Court staff with a view to endeavouring to reduce the backlog of cases in the registry.

During the period when the Deputy State Coroner was on leave from 4 May 2001 to 30 June 2011 arrangements were put in place for retired magistrate, Mr Jerry Packington, to work as a coroner. During this period Mr Packington assisted by finalising a number of matters and his availability as a coroner enabled listing of inquests to continue during the period. This was a significant benefit because when one of the two full time coroners is on leave, the demands of the office relating to immediate responses to ordering of post mortem examinations, release of bodies, dealing with objections and finalisation of matters usually makes it impracticable to list inquests of significant length.

In addition the department put in place arrangements to enable the temporary appointment of Mr Dominic Mulligan as a coroner for part of the 2011/2012 financial year.

The Work of the Office

In the year 2010-2011 the number of cases referred for investigation and the number of reportable deaths increased generally as it had in previous years.

2,743 deaths were referred to the Coroner's Court, this comprised an increase of 163 deaths over the previous financial year (2009-2010).

The number of deaths ultimately determined to be reportable also increased significantly, from 1,860 to 1,994. This number is particularly significant as in respect of each reportable death it is necessary for the coroner investigating the death to make findings pursuant to section 25 of the *Coroners Act 1996*.

Unfortunately during the year the number of cases completed was substantially less than the number of deaths reported and only 1,364 cases were completed for the reasons outlined above

At the conclusion of the final financial year cases referred to a coroner which had not been completed amounted to 2,316 of which 845 were over 12 months old.

It was in this context that urgent arrangements were made with the assistance of the department for Mr Dominic Mulligan to be appointed as a temporary coroner for part of the year 2011-2012 pursuant to section 11(2) of the *Coroners Act 1996*.

Dr Karin Margolius

On 1 September 2010 Dr Karin Margolius OAM passed away.

Dr Margolius was the first female forensic pathologist in Western Australia, she worked with PathWest as a pathologist for 20 years until her death.

In 2010 she was awarded a Medal of the Order of Australia (OAM) for services to "clinical forensic medicine, to education, and through support for people with cancer".

Dr Margolius fought ovarian cancer for six years and in spite of her illness and ongoing chemotherapy treatment, continued to work and to provide answers for grieving families to the end.

Dr Margolius held a total of seven tertiary degrees including a law degree and wrote more than thirty papers, touching on cervical cancer, hidden homicides and disaster medicine.

All staff at the Coroner's Court worked very closely with Dr Margolius for many years and she will be missed by all of us.

From a personal perspective I recall fondly Dr Margolius giving evidence in a number of murder trials which I prosecuted prior to being appointed State Coroner. Her assistance to the Coroner's Court was always of the very highest level. Her evidence was always balanced, carefully thought through and reliable.

In her efforts to determine the causes of death in coronial cases, she approached every case mindful of the dignity of the deceased and was always respectful of religious and cultural diversity.

It was a privilege to work with Dr Margolius.

Involvement of Relatives

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

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

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

During the year 1 July 2010 - 30 June 2011 a total of 2,743 deaths were referred to the Coroners Court. In 749 cases a death certificate was ultimately issued. Of the remaining 1,994 cases a total of 184 objections were made to the conducting of a post mortem examination.

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

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

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

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 have not been included.

Deaths Referred to the Coroner's Court

Reported deaths

Immediate post mortem	24
No objection to post mortem	1733
Objection to post mortem	184
No post mortem conducted (missing persons etc)	77
Number of Reported Deaths	1994

Developments in cases where an Objection was initially received

Objections to Post Mortems

Objection accepted	118
Objection withdrawn	65
Objection over-ruled	1
Total Objections to Post Mortems	184

Objection withdrawn after coroner over-ruled	0
Applications to Supreme Court	0

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

In the majority of cases where an objection was received the decision which was ultimately made was in accordance with the wishes of the family. There were a total of 184 objections of which 65 were withdrawn prior to a ruling being given by a coroner and 118 were accepted by a Coroner and no post mortem examinations were ordered. In only 1 case 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

REFERRALS – CORONIAL COUNSELLING SERVICE
1 July, 2010 – 30 June, 2011

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)
6,019	4,204	919	896

Coronial Ethics Committee

The Coronial Ethics Committee was set up under the auspices of the *Coroners Act 1996* and runs in compliance with the National Health and Medical Research Counsel's guidelines in relation to Ethics Committees.

The Committee requires a detailed written submission in relation to requests for Coronial data. It meets quarterly to consider each request and attempts to strike a balance between family concerns (including privacy, confidentiality and consent issues), and the benefits of research to the community at large. The Committee then makes recommendations to the State Coroner about whether the information should be released and with what conditions.

The Coroner's Court is very grateful for the considerable work done by Ethics Committee members both in reading a large amount of material in preparation for meetings and in giving up their time for the meetings. They are people with many commitments elsewhere and they generously do this on a voluntary basis.

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 / Melanie Smith	*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

The Committee met 3 times this financial year and has addressed the following new projects as indicated in the table below.

Number of Projects Considered	Number of projects approved	Number of projects not approved
10	9	1

The Committee also considered annual reports and amendment requests from existing projects.

A significant amount of Committee time, especially for the Chair and Secretary, was consumed by the unexpected withdrawal of funding from the Telethon Institute of Child Health Research (TICHR) as the result of a change in approach by the Ministerial Council for the Prevention of Suicide. This resulted in the cessation of the collection of coronial suicide data which had been collected by TICHR for 20 years. The Committee was most anxious for the research continue. Eventually an application was received from a new group of researchers, the Sellenger Centre for Research in Law, Justice and Social Change, School of Law and Justice, Edith Cowan University, to access this essential data.

The Committee had lengthy discussions and communication with those new researchers applying to access Coronial data to inform their project entitled Suicide in WA- Informing Prevention and Intervention Strategies. The Committee was particularly concerned to ensure the use of such sensitive information would be properly monitored and that the appropriate linkages would be established as they had been for the previous 20 years.

Mr Neville Collard is no longer on the Committee and the Committee thanked him for his service and is now recruiting to replace him.

The Committee requires significant secretarial support which is provided by a counsel assisting the State Coroner with administrative assistance from Court officers. This necessarily takes time away from inquest work as these staff members would otherwise be working on the preparation of files for inquests and appearing at inquests.

For a large part of the year Ms Melanie Smith replaced Dr Celia Kemp as secretary and spent considerable time each week on work for the Committee.

Counsel to Assist Coroners

Mr Scott Schaudin, who was employed as counsel assisting on a temporary contract, finished his contract in July 2010 and returned to resume his substantive position at the Legal Aid Services in New South Wales.

Ms Melanie Smith accepted a temporary twelve month contract as counsel assisting in January 2011. Ms Smith came from the WA Office of the Director of Public Prosecutions.

Dr Celia Kemp, Senior Counsel Assisting, was forced to take a considerable period of sick leave from March to July 2011. During her absence Mr Dominic Mulligan replaced her for some of that period.

Currently the in-house-counsel assisting comprise–

- Dr Celia Kemp
- Mr Jeremy Johnston
- Ms Melanie Smith

WA Police Assistance

WA Police continued to provide support to the Coroner's Court in the form of two officers who worked in the office and provided an extremely important service in monitoring the quality of police investigative briefs and liaising with WA Police as well as on occasions assisting in inquest hearings.

Sergeant Geoff Sorrell transferred back to other police duties after approximately 6 years service at the Coroner's Court.

Sergeant Housiaux worked in the court during the year and he was assisted for part of the year by Senior Constable Jock Rankin who was seconded from the Coronial Investigation Unit until a replacement can be found for Sergeant Sorrell.

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, 2010 - 30 JUNE, 2011

Name Of Deceased	Date Of Death	Date Of Inquest	Number Of Sitting Days	Coroner	Court Sitting	Finding	Date Of Finding
GIBBS Kenneth William	8/2/2008	6/7/2010	1	State	Perth	Suicide	6/7/2010
MARRIETTE Graham Johnno	27/2/2008	8/8/2010	1	State	Perth	Natural Causes	2/8/2010
~ HANSEN Colin Lloyd	8/9/2006	13-15/7/2010	3	State	Kalgoorlie	Suicide	16/7/2010
SCADDAN Bailey George	8/9/2007	21/7/2010	1	Deputy	Perth	Accident	30/7/2010
BOGAR Valentine Albert	5/8/2007	19-20/8/2010	2	State	Bunbury	Accident	13/9/2010
BLACKSHAW Dorothy Lilian	13/11/2007	26-28/7/2010	3	Deputy	Perth	Accident	24/9/2010
~ HERBERT Troy Matthew ~ JONES Darryl ~ MILLER Matthew James ~ HIGGINS Jarrod Scott	13/12/2009 29/10/2007 7/11/2008 27/11/2008	23-27/8/2010 13-15/10/2010	8	State	Perth	Accident	21/4/2011
* NJAMME Dennis	21/6/2008	24-25/8/2010 30/8/2010 2/9/2010	4	Deputy	Perth	Natural Causes	29/3/2011
~ NJANA Hendrick	30/12/2008	30/8-3/9/2010	5	State	Broome	Open Finding	21/12/2010
HERCEG Vedrana	15/9/2007	31/8/2010-2/9/2010	3	Deputy	Perth	Accident	4/1/2011
BARNES Donna Lillian	19/9/2007		1	State	Perth	Natural Causes	21/4/2011
ARMSTRONG Jeremy Graham	15/12/2008	14-15/9/2010 11-13/1/2011	5	State	Bunbury	Open Finding	17/1/2011
NORMAN Cassius Lenny Jack	5/9/2009	20-24/9/2010	5	State	Karratha & Roebourne	Accident	28/2/2011
SWEENY Annemarie Evelyn	8/11/2008	20-22/10/2010	3	State	Northam	Accident	20/12/2010
*GREEN Hector Cedric	16/11/2007	6-7/12/2010	2	State	Perth	Natural Causes	20/12/2010
THORNE Gabrielle Shonae	29/3/2008	6/12/2010	1	Deputy	Perth	Accident	18/1/2011

Name Of Deceased	Date Of Death	Date Of Inquest	Number Of Sitting Days	Coroner	Court Sitting	Finding	Date Of Finding
KELLY-GROSSER Natasha Gladys	14/12/2010	14-15/12/2010	2	Deputy	Perth	Natural Causes	18/1/2010
OPERATION LANTANA Sandra McCARTY Pia BOSSO Deborah GRUBER Sandra KOKALIS Carmelo VINCIULLO Sandra KOKALIS		1-19/11/2010	15	Deputy	Perth	Adj until August 2011	
PETERKIN Doreen Alice	2/1/2007	12-13/1/2011	2	Deputy	Perth	Accident	15/2/2011
WHITEHOUSE Bradley	10/2/2008	24-31/1/2011 8-11/3/2011 6/4/2011	13	State	Perth	Open Finding	21/4/2011
WALDEN Athenia Hana	11/5/2008	7/2/2011 23-28/3/2011	6	State (1 day) Packington	Perth		Not completed
XMAS ISLAND TRAGEDY	15/12/2010	31/1/2011 16/2/2011 30/3/2011 17/5-3/6/2011	17	State	Perth	Adj to July and September sittings	
MARRA Marino	30/11/2007	22-25/2/2011	3	Deputy	Busselton	Accident	1/6/2011
COLLINS Edward Thomas	14/1/2007	22-25/2/2011	3	State	Perth	Natural Causes	28/2/2011
~ ARNOLD Luke David	28/12/2008	1/3/2011	1	Deputy	Perth	Accident	3/10/2011
GRONERT Leyanei	10/5/2004	2-4/3/2011	3	Deputy	Perth	Misadventure	7/7/2011
ZAITU Azmie Bin	22/8/2010	2-3/3/2011	2	State	Cocos Island	Accident	4/3/2011
BUNGLE BUNGLES Christian CATARGIU Jessica COUSINS Whitney PINNEY Sarah THOMAS	14/9/2008	12-14/4/2011	3	Deputy	Kununurra		Not completed

Name Of Deceased	Date Of Death	Date Of Inquest	Number Of Sitting Days	Coroner	Court Sitting	Finding	Date Of Finding
FRYER Mark Anthony	20/10/2008	3-5/5/2011	3	Deputy	Perth		Not completed
PRICE Shaun Michael Ian	7/6/2008	3-6/5/2011	4	Packington	Albany	13/9/2011	Homicide
KUCHEL Boyd Timothy	13/6/2007	15/4/2011 23-26/5/2011	1 4	State Packington	Perth (D/H) Perth (Inquest)		Not completed
* NEBRO Daniel Rowley	3/7/2009	2/6/2011	1	Packington	Bunbury		Not completed
* MORATO Henrique Gregory	9/10/2008	7-8/6/2011	2	Packington	Perth		Not completed
* DOYLE Blake Michael	25/11/2009	9-10/6/2011	2	Packington	Perth		Not completed
* NEUMANN Karl	24/9/2009	11/6/2011	1	Packington	Perth		Not completed
* TUCKER Allan Murray	19-20/9/2008	28-29/6/2011	2	State	Perth	Natural Causes	20/7/2011
* SHEEHY Andrew Michael Brian	14/8/2009	30/6/2011	1	State	Perth	Suicide	20/7/2011

Mr Hope heard 19 Inquests 76 sitting days Ms Vicker heard 13 Inquests 44 sitting days Mr Packington heard 7 Inquests 19 sitting days	Total Inquests heard 40 Number of Sitting Days 139 7 Prison Deaths In Custody conducted 8 Police Deaths in Custody or actions of police officers 11 Country deaths conducted
* Death In Custody (DIC)	** Country death

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

Dorothy Lilian BLACKSHAW

Dorothy Lilian Blackshaw (the deceased) died on 13 November 2007 at the Fremantle Hospital as a result of Aspiration Pneumonia following Hemiarthroplasty for a Fractured Left Neck of Femur. The Deputy State Coroner conducted an inquest hearing into the circumstances surrounding the death at the Perth Coroner's Court on 26-28 July 2010. The Deputy State Coroner's findings were delivered on 24 September 2010.

The Deputy State Coroner found that the deceased an 85 year old great-grandmother well loved by an extended family.

In November 2005, due to her deteriorating ability to care for herself and the inability of her extended family to care for her as they wished her to be cared for, she was transferred to Bethanie Waters Aged Care Facility.

The Deputy State Coroner accepted the deceased was extremely unhappy although understanding of her need to be in an aged care facility. The Deputy State Coroner observed that she had no doubt her distress at this move severely exacerbated feelings of guilt (un-necessarily) in her daughters. The deceased was eventually moved to a single room which made her quality of life much better, however, her daughters still visited her everyday. They were very involved with her care.

The Deputy State Coroner accepted where a resident is being closely monitored by family members carers may spend less time with that resident and more time with those residents not so lucky to have a caring family. This is a good use of resources. However, in those circumstances it is very important carers and nurses accept input from a family more readily than appears to have been the case in this particular matter.

The Deputy state Coroner was satisfied the deceased had been becoming more wheel-chair bound but her life improved from late September 2007 when she was given a goal to achieve, the visit of her granddaughter and great granddaughter. The Deputy State Coroner was further satisfied she did improve in her attitude to life in her expectation she would soon meet her previously unseen great granddaughter. The fact of the deceased's improvement was noted by carers but not really appreciated as being a significant event.

Consequently, when she again become less mobile and more wheel-chair bound, virtually overnight, it was accepted as deterioration in her general wellbeing due to age and immobility by all but her family, who were aware of her enthusiasm as to the pending visit.

In the nights before the 31 October 2007 the deceased had been found wandering the facility without her walker. It is quite likely some event occurred which resulted in a fracture of her neck of femur which at that stage was not displaced. While in pain, the deceased would still have been able to mobilise to some extent. The Deputy State Coroner accepted the deceased was not located following a fall and if that had occurred it would have been recorded. The evidence supports falls were recorded and Bethanie Waters monitored residents for neurological signs following a fall of which they were aware.

The Deputy State Coroner accepted however, some trauma to the deceased occurred and as a result she experienced pain which she was not able to communicate effectively. The family were very aware of her pain but reluctant at first to insist there must have been a significant event.

The Deputy State Coroner was satisfied from the above the deceased was in pain from 1 November onwards. This does not appear to have been noted by her carers as over and above a complaint of pain to do with arthritis. There does seem to have been a situation where the family were able to interpret the deceased's pain levels but her regular carers were not as adept as interpreting her moods.

The Deputy State Coroner was satisfied Mrs Mills requested her mother be seen by a doctor on Monday 5 November 2007, and after input from Mrs Barker on 5 November 2007, that occurred.

The Deputy State Coroner accepted Dr Hilton was not given an adequate history of the deceased's recent circumstances in view of the fact he believed she had consistently been wheel-chair bound since his last review of the deceased. The Deputy State Coroner also accepted Dr Hilton was looking for an explanation for the deceased's pain but was unable to detect a localised area of pain and consequently prescribed regular analgesia in an attempt to alleviate her symptoms.

The Deputy State Coroner was satisfied Dr Hilton did examine the deceased for a fracture, however, accepts rotation and shortening of the deceased's leg as seen on 7 November 2007, was not significant on 5 November 2007.

The Deputy State Coroner was satisfied regular analgesia had not controlled the deceased's pain by 7 November 2007 and it appears to have increased, on the evidence heard in court of the numerous attempts to mobilise and transfer the deceased. Each transfer potentially increased any dis-placement of the fracture.

The Deputy State Coroner was satisfied by midday of 7 November 2007 the deceased was in extreme pain in her terms. This was understood by

her family who were now prepared to take control of events and demand an ambulance.

The Deputy State Coroner was satisfied the deceased's family were unhappy with the deceased's care and did not contrive to make the *"evidence fit the fracture"* after the event.

There is little notation in the progress notes but the little there is indicates the deceased's family were very concerned about her pain levels and it was due to their input she was finally diagnosed. It is not clear the deceased would have been reviewed by the registered nurse, or her rotated leg accepted on 7 November 2007, if Mrs Barker had not insisted on the calling of an ambulance.

By the time the ambulance arrived all parties were in agreement the deceased had suffered a fractured femur.

The Deputy State Coroner was satisfied the fracture occurred at the time of the deceased's perceived deterioration by the family on or about 1 November 2007 and was exacerbated thereafter by mobilisation.

The Deputy State Coroner found that there was a difficulty with the evidence in that the EN the subject of some of the discussions with the deceased's family members could not be located for the purposes of providing a statement or giving evidence at the inquest.

The deceased was taken to Fremantle Hospital where the difficulties of surgery and prognosis for the deceased were explained to the family. There was a "not for resuscitation agreement" if the quality of the deceased's life was observed to be deteriorating. While the surgery was successful the deceased did not recover successfully. She developed aspiration pneumonia and died.

The Deputy State Coroner was satisfied the deceased would not have died at that precise point in time had she not experienced a fracture of her left femur.

The Deputy State Coroner also accepted the deceased had been noted as a high falls risk patient in December 2006 and measures were implemented to protect her as far as possible from the risk of a fall. Once a fracture occurred by whatever means, the prognosis for someone in the deceased's circumstances are unpredictable.

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

The Deputy State Coroner made comments on the care of the deceased while she was in Bethanie Waters Aged Care Facility as follows -

The Deputy State Coroner was satisfied Bethanie Waters Aged Care Facility did appropriately assess the deceased on admission as being a low falls risk. As time progressed and her condition deteriorated she was reassessed and a high risk falls plan implemented. This involved the use of two assistants when transferring from different stages of mobility, with increased use of her wheel-chair.

The deceased was in an extremely enviable position in that she received regular visits from her family. The Deputy State Coroner commented that she appreciated this may promote a situation whereby carers do not observe the individual circumstances of a resident as closely as they would where a resident was more dependent on carer input.

The Deputy State Coroner, however, was of the view, that not enough attention was paid to the concerns of the deceased's family as to their observations of their mother's condition.

While the Deputy State Coroner understood the *"events based progress noting"* she was concerned it leads to omissions where carers or nurses are particularly busy and perceive a resident as not being wholly dependent on their input.

An investigation of the Blackshaw family's complaint was undertaken by the Office of Aged Care Quality and Compliance (OACQC) of the Commonwealth Department of Health and Aging. This is a separate body from the Accreditation Agency which ensures accreditation compliance of aged care facilities. The two agencies work in co-operation with one another to ensure an appropriate level of care in aged care facilities.

Evidence was given by Ms Vivian Burnham of OACQC that in the course of the investigation the investigators spoke with some of the carers from whom evidence was heard at the inquest. Unfortunately, neither those investigators nor the inquest were able to hear from the EN dealing with Mrs Barker and her mother in November 2007.

By the time of the inquest Ms King (a carer) could not recall some of the information she had given the investigators, however, conceded it would have been the truth at the time she gave that information.

Of significance to a discussion about 'event based progress notes' is Ms King's recall at the time of the investigation she had witnessed an event on Tuesday (6 November 2007) when the deceased's daughter, Mrs Barker, expressed concern about her mother's pain levels. She had

asked the EN if an ambulance should be called but the EN concerned advised Mrs Barker *"to wait and see"*. The 'wait and see' was taken to refer to whether or not the analgesia prescribed by the doctor on 5 November 2007 would become effective.

The Manager for Bethanie Waters, Ms Carpenter, indicated it was her view that response from an EN to a concerned family member was inappropriate and that the RN should have been involved.

The Deputy State Coroner was concerned there was no entry in the deceased's progress notes on 6 November 2007 of the deceased's pain being commented on to the extent the deceased's daughter had requested an ambulance on 6 November 2007.

Further on Wednesday 7 November 2007, prior to Mrs Barker insisting on an ambulance for her mother, Ms King had given the deceased a bed sponge and although she could see no injury to the deceased she did note the deceased had complained of a *"sore knee"* afterwards. Again there is no record of this in the progress notes and Ms King had advised the investigators it was the responsibility of all staff to update care plans.

This lack of appropriate events based recording in the progress notes led to the Office of Aged Care Quality and Compliance indicating Mrs Barker's concern had *"not been substantiated"* because there was no record of the incident she complained of in the progress notes.

As pointed out to Ms Burnham in evidence, it is misleading to say a family's complaints have not been substantiated simply because the progress notes do not record something which was later proved to have occurred. Their own investigators had supported Mrs Barker's claims there was a lack of notice taken of the deceadsed's pain by staff and yet there was no entry in the progress notes.

Ms Burnham stated as a result of the investigation into Bethanie Waters and the accreditation process undertaken by the Accreditation Agency there were improvements made in a very timely manner which resulted in the facility being re-accredited.

The Deputy State Coroner had observed that Bethanie Waters is an appropriately accredited facility, provided they remain responsive to continuous improvement requests on behalf of the Accreditation Agency. The Deputy State Coroner also reviewed the areas questioned by the Agency, and Bethanie Waters responses, and they seemed to be appropriate.

Carers and nurses are now trained with a pain management education competency tool. The fact it was delivered as quickly as November 2007, immediately following the death of the deceased, indicates Bethanie

Waters were sensitive to the difficulties once appreciated. A new handover sheet has been implemented which, having seen the handover sheets for 6 November 2007 which do not reflect the conversation witnessed by Ms King, is a benefit.

The Deputy State Coroner, however, was still of the view there should be more provision for families to have input into their observations of a resident, especially where a resident is not recorded as being a complainer and her family are clearly attentive and supportive of the resident.

It is of some concern the input of the deceased's family was not more readily accepted by her carers. Even on 7 November 2007 there was a suggestion the concern of the family was not warranted. On examination she clearly had a fractured femur. The reluctance to accept the family's concern was reflected by the repeated transfers which appear to have increased the fracture and consequently the deceased's pain.

The Deputy State Coroner made the following recommendations -

- The implementation of a diary system for families of residents.

  The Deputy State Coroner observed that a document which family members and visitors to a resident could complete as a separate entity from the progress notes.

  It would provide a comprehensive history to attending doctors as to individual circumstances and reasons for requests for doctors' appointments. Had the deceased's fracture been diagnosed prior to displacement, it is possible her prognosis could have been improved, although the Deputy State Coroner was unable to say definitively the outcome would have been different.

The Department of Health responded to the Deputy State Coroner's recommendations in a report dated February 2011 in the following terms –

> Inquest findings received by DoH.
>
> Findings noted.
>
> Status: CLOSED

Jeremy Graham ARMSTRONG

Jeremy Graham Armstrong (the deceased) died on 15 December 2008 at the Royal Perth Hospital, Wellington Street, Perth as a result of pneumonia complicating head and neck injuries. The State Coroner conducted an inquest hearing into the circumstances surrounding the death at the Bunbury Court House on 14-15 September and 11-13 January 2011. The State Coroner's findings were delivered on 13 January 2011.

The State Coroner found that the deceased was an 18 year old student who in the early hours of the morning of Sunday 14 December 2008 was on Ocean Drive, Bunbury, presumably either crossing the road from beach towards the city or attempting to flag down the taxi driven by Mr Brennan, when he was struck by that taxi.

It is possible that he wished to flag down the taxi as he had earlier waited for a taxi at the taxi rank at the Lord Forrest Hotel.

Although the area was particularly clear of vegetation and lighting was good. Mr Brennan claimed that he failed to see the deceased at all until his vehicle struck him. The deceased must have been on the road directly in front of Mr Brennan's vehicle as the vehicle approached and he must have been within Mr Brennan's line of vision for a significant period prior to the collision.

In a context where police did not question Mr Brennan's account during the initial investigation, limited evidence was obtained from any scene examination and there were no eye witnesses it was not possible to determine whether the death arose by way of unlawful homicide or as a result of an accident.

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

The State Coroner made the following recommendation in relation to the police investigating officers who attended the scene but failed to comply with the Commissioner's Orders to preserve the scene.

Recommendation No. 1
That the Commissioner of Police take steps to ensure that orders and directions relating to evidence capture at scenes of serious and fatal traffic collisions are complied with by attending police.

The State Coroner made comments in the following terms ·

In this case a decision was made by police to the effect that the evidence available would not support a charge of dangerous driving causing death. It is unfortunate in such a circumstance that there is no alternative charge which would recognise that the standard of driving was below that which should be expected of a reasonably prudent driver and that as a result a person died from injuries sustained in a motor vehicle collision.

In the United Kingdom and New South Wales there are charges which are less grave than dangerous driving causing death, but which still involve a prosecution for causing death.

In the United Kingdom the *Road Traffic Act 1988* contains a provision –

> A person who causes the death of another person by driving a mechanically propelled vehicle on a road or other public place without due care and attention, or without reasonable consideration for other persons using the road or place is guilty of an offence.

The court has been advised that police officers from the Major Crash Investigation Section and State Traffic Operations support the development of changes to the *Road Traffic Act 1974* which would create an offence along similar lines.

Recommendation No. 2
That consideration be given to amending the Road Traffic Act 1974 to create an offence similar to that provided for by section 2B of the Road Traffic Act 1988 (UK).

The State Coroner made comments in respect to the police investigation -

The Police Investigation

The quality of any investigation into a traffic death is very much reliant on early evidence capture, preservation of the scene and evidence from police who attend the scene. In this case there were no independent eye witnesses, evidence capture was sub-standard, the scene was not preserved so that it could be examined by at least officers from South West Traffic Section and evidence could not be obtained from the officers who attended the scene at a stage when that evidence could assist with the enquiry process. The statements which were finally produced by them were of an unsatisfactory standard and contained reference to statements made by the driver of the involved vehicle which were not recorded at the time and were manifestly inaccurately recorded.

From that early stage the investigation was certainly never going to reach basic standards of competency.

Charge of the Investigation

Following the fatal collision there was ongoing communication between the South West Traffic Office and the Major Crash Investigation Unit as to how the investigation would be progressed and who would have conduct of the investigation.

It appeared that from the time of the collision on 14 December 2008 until early April 2009 there was some confusion as to who would be responsible for conducting a comprehensive investigation into the circumstances surrounding the death and that for that period limited investigations were conducted.

This confusion was clearly detrimental to the ultimate investigation and explained how it was that the investigation was not more coherent and important evidence was not obtained at an early stage.

Evidence at the inquest revealed that action has since been taken to ensure that when a case is reviewed by the Major Crash Investigation Section and a decision is made that that section will not have carriage of the investigation, that decision will be recorded and will be clearly communicated to other police involved.

Recommendation No. 3
That WA Police continue to monitor the interaction between the Major Crash Investigation Section and other police units to ensure that the recent changes are both effective and that there is certainty as to who has ownership and carriage of the investigation of all serious traffic crashes.

The State Coroner expressed concern as to the wording of the Major Crash Investigation Section's Charter of Responsibility and made the following recommendations -

Recommendation No. 4
That the Major Crash Investigation Section's Charter of Responsibility be reviewed and the criteria which indicate when the section is to investigate be amended to provide greater certainty for police involved and to better reflect in which cases and at what stage of investigations the specialist expertise of the section can be best used.

Cassius Lenny Jack NORMAN

Cassius Lenny Jack Norman (the deceased) died on 5 September 2009 at the Roebourne District Hospitall as a result of electrocution. The State Coroner conducted an inquest hearing into the circumstances surrounding the death at the Karratha Court House on 20-21 September 2010 and then at the Roebourne Court House on 22-24 September 2010. The State Coroner's findings were delivered on 24 February 2011.

The State Coroner found that the deceased was a 2 year old child who died as a result of being electrocuted at 409A Harding Street, Roebourne, a domestic residence, on 5 September 2009.

The deceased died when he entered a hole in the wall of the house and put his right hand on the earthed metallic exposed wall frame of the house and at the same time grasped a flexible extension cord. The flexible extension cord had a pin sized hole which penetrated the cord's sheath and the primary installation of the active conductor. There was conductive water penetrating the hole in the cord and the deceased received an electrical shock of up to 240 volts AC.

Although arrangements had been put in place by the Department of Housing to ensure that RCDs would be fitted to all houses in Roebourne in 2006, lot 409A Harding Street was not fitted with RCDs. If an RCD had been fitted it would have prevented this electrocution.

The house in question was in a very poor condition and although efforts had been made to repair the hole in question by the Department of Housing in 2008, the hole was again exposed at the time of the death and the occupants had not taken basic steps to cover it.

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

The State Coroner made the following comments on safety issues -

While Regulation 52(3) of the Electricity (Licensing) Regulations 1991 provide that an electrical contractor who sends a notice of completion in respect of notifiable work which has not been completed commits an offence, a prosecution must be commenced within 2 years after the offence is alleged to have been committed.

In this case the notice of completion had been received on 13 September 2006 and the death occurred on 5 September 2009 so the limitation period had expired.

The State Coroner made the following recommendation in respect to this –

Recommendation No. 1
That the limitation period for offences contrary to regulation 52(3) of the Electricity (Licensing) Regulations 1991 be amended so that the period of limitation commences to run from the time when the regulator becomes aware of a suspected breach rather than from the date on which the offence is alleged to have been committed.

In respect of Mr Dowding, he failed to perform important work (the installation of RCDs in 409A Harding Street) which he was expected to have completed and he signed a misleading notice of completion. It was important to ensure that similar problems do not occur in the future.

In that context the State Coroner made he following recommendation –

Recommendation No. 2
That consideration be given as to whether there is proper cause for disciplinary action in respect of Mr Dowding in accordance with Regulation 30 of the Electricity (Licensing) Regulations 1991.

Mr Peter Harris signed the notice of completion in respect of work at 409A Harding Street, Roebourne, which was submitted to Horizon Power and the Department of Housing. He certified that the work had been done as the nominee of Sinewave. That work was not done and it appeared clear that Mr Harris did not take appropriate steps to ensure that before he signed the document the work had been completed.

The testing and checking sheets, therefore, contained fabricated information and were not genuine recordings of tests done.

In that context the State Coroner made the following recommendation –

Recommendation No. 3
That consideration be given as to whether there is proper cause for disciplinary action in respect of Mr Harris in accordance with Regulation 30 of the Electricity (Licensing) Regulations 1991.

It appeared that the Department of Housing did not have in place a system which would have identified that the RCDs had not been installed and to ensure that action was taken to correct the situation.

The Department of Housing engaged electrical contractors to carry out electrical work on the property on a number of occasions between 2006 and 2009 but it did not appear that those contractors drew the fact that RCDs had not been installed to the attention of any officer in the Department of Housing, able to correct the situation.

In addition although a number of inspections were carried out on the property by Departmental staff, those staff members were not advised how to identify whether or not an RCD had been installed. The Department of Housing did not take adequate steps to ensure that the electrical work which it had paid millions of dollars to have done had been completed correctly or at all.

That State Coroner made recommendations in the following terms –

Recommendation No. 4
That the Department of Housing complete regular electrical audits of its properties to ensure that electrical safety is being provided to its tenants.

Recommendation No. 5
That the Department of Housing ensure that its officers inspecting properties are able to identify RCDs and can ensure that RCDs are in place and appear to be in operating condition. Those officers should also be able to identify obviously unsafe electrical fixtures or fittings.

Recommendation No. 6
That in future when the Department of Housing engages electrical contractors to carry out electrical works on its tenanted properties the terms of engagement require those electrical contractors to report any absences of RCDs or other issues bearing on electrical safety which come to their attention.

The State Coroner has not received a response to the recommendations.

Annemarie Evelyn SWEENY

Annemarie Evelyn Sweeny (the deceased) died on 8 November 2008 at Soldiers Road, Narembeen, as a result of multiple injuries. The State Coroner conducted an inquest into the circumstances surrounding the death at the Northam Court House on 20-22 October 2010. The State Coroner's findings were delivered on 20 December 2010.

The State Coroner found that the deceased was a 20 year old female who died as a result of a single motor vehicle collision which occurred at about 7:20am on 8 November 2008.

Evidence at the inquest revealed that prior to her death the deceased had worked a number of night shifts and for an extended period had experienced disrupted sleep cycles. On the evening of 7 November 2008 she was so fatigued that the registered nurse with whom she was working suggested that she go to an available room and sleep, leaving the registered nurse to complete the shift on her own.

On the day before her last night shift the deceased had taken a number of Doxylamine (Restovit) tablets to help her sleep, apparently with little success, and these tablets are likely to have contributed to her drowsiness.

Shortly after the deceased left the Narembeen Hospital to drive to the farm where she was living the deceased lost control of the motor vehicle she was driving, which collided with a tree causing her death.

The State Coroner was satisfied that fatigue was a major contributor to the fatal collision and that the Doxylamine taken by the deceased earlier contributed to her drowsiness.

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

The State Coroner made comments on safety issues in the following terms –

1. Concerns contained in the Main Roads WA Commissioned Crash Location Report

Main Roads WA commissioned a Crash Location Report in respect of this motor vehicle crash. David Moyses, Road Safety Investigator, gave evidence at the inquest in respect of issues raised by that report.

Essentially two issues were raised in the report, namely:

(1) That the gravel warning sign installed immediately west of the crash prior to the end of the sealed section of road was not the correct size for its application and did not comply with the Australian Standards. The sign was also faded and not made of the correct material.
(2) The vehicle struck a tree located 3 metres from the edge of the road, while the clear zone for this section of road was calculated as 6 metres placing the tree within the effective clear zone.

Frank Peczka, Chief Executive Officer with the Shire of Narembeen, gave evidence in response to the concerns raised by Main Roads WA.

According to Mr Peczka he was not the Chief Executive Officer at the time of the fatal crash and prior to being contacted by Sergeant Housiaux in respect of the matter in May 2010, claimed that the Council was not aware of the concerns of Main Roads WA and had not received a copy of the Crash Location Report.

In respect of this contention it was noted that the Crash Location Report was dated 10 December 2008 and according to the evidence of Mr Moyses, it was forwarded to the Shire on 23 December 2008.

According to Mr Peczka, the sign in question had been installed 5-10 years prior to the crash and had not been upgraded. He stated that he believed that the sign had been compliant with the relevant requirements at the time. He stated that the council's own assessment in 2008 after the fatality was that the road had been appropriately signed.

In a letter to Sergeant Housiaux dated 9 June 2010 Mr Peczka wrote that, "Council will now undertake further assessment as to the suitability of the identified "cautionary road sign" ". At the inquest Mr Peczka did not dispute the assertion contained in the Main Roads WA report that the sign did not comply with Australian Standard 1742.21 in that it was too small and not constructed of the correct material.

While the deceased was familiar with the road in question it was not possible to determine whether the defective sign played a part in the collision which occurred approximately 300 metres after the change in road surface from bitumen to gravel.

In the State Coroner's view it was most unsatisfactory that the Shire of Narembeen did not take immediate action to ensure that the sign in question was replaced by a sign which complied with Australian Standards when this matter was first raised and though this issue was drawn to the Council's attention by Sergeant Housiaux in May 2010, at the time of Mr Peczka's evidence to the inquest on 22 October 2010 a compliant sign was still not in place.

The State Coroner made the following recommendation –

Recommendation No. 1
That the Shire of Narembeen replace the existing warning sign on Soldiers Road advising of the end of the sealed section of road with a sign that is compliant with Australian Standards and is of the specified minimum size and constructed of the specified material.

2. Fatigue caused traffic crashes involving health staff

Professor Laurence Hartley, an expert in transportation fatigue, gave evidence at the inquest that health staff who work shifts are particularly vulnerable to fatigue caused traffic crashes when returning home from night shifts.

He stated that in addition to the fact that difficulties associated with attempting to sleep during the day and lack of good sleep quality may contribute to fatigue for night shift workers, in the case of health staff risks associated with sleep deprivation may be exacerbated by the fact that sleepiness may be masked by the work environment. He said that nurses and other health workers usually work in bright lights, on their feet, in circumstances antagonistic to awareness of fatigue. He stated that these health workers face a very changed environment when they go to drive home in a car where they sit hardly moving, relaxed and comfortable and subject to gentle motion within the vehicle. These factors, together, contribute to increased risk of fatigue caused motor vehicle crashes.

In that context, while it was noted that the Narembeen Regional Hospital administration had put in place a number of measures to address employee fatigue, it was concerning to note that according to Carol Hawkins, Executive Director of Nursing for the WA Country Health Service, that service does not have in place any policies addressing fatigue as a potential contribution to accidents going to and from work although a "review" of the service's policies was currently being undertaken and information about the subject was available on the service's website.

In addition, according to Ms Hawkins, it was "not clear" to her that the WA Country Health Service had in place any training or education for staff directed towards addressing fatigue issues or how to manage shift work.

She also stated that while Narembeen Regional Hospital does have accommodation available for staff working shift work who need to sleep prior to journeying home, similar facilities are not available at all hospitals and there is a need for the WA Country Health Service to address availability of accommodation for nursing staff after the completion of night shifts.

The State Coroner made the following recommendation –

Recommendation No. 2
That WA Country Health Service take the following action –

1. Put in place appropriate policies to address the safety of staff who work shift work;
2. Monitor fatigue related crashes involving staff working shift work;
3. Put in place training and education to address fatigue related issues; and
4. Review accommodation throughout the state for staff working shifts with a view to ensuring, where possible, accommodation is available for staff who need to sleep prior to driving home.

The State Coroner received a letter dated 28 February 2011 from the Chief Executive Officer, Shire of Narembeen, in respect to Recommendation No. 1 in the followings terms –

> "COUNCIL ACTION : Council replaced the identified Warning Sign on 29th October 2010 with a new sign in accordance with current standards and specifications for a new Warning Sign".

The State Coroner received advice from the Department of Health in a report dated February 2011 in the following terms –

> "Status: PENDING RESPONSE"

Gabrielle Shonae THORNE

Gabrielle Shonae Thorne (the deceased) died on 29 March 2008 at the Lady Lawley Cottage, 8 Gibney Street, Cottesloe and her death was consistent with asphyxia complicated by aspiration following dislodgement of a tracheotomy tube in a young girl with cerebral palsy and a seizure disorder. The Deputy State Coroner conducted an inquest hearing into the circumstances surrounding the death of the deceased at the Perth Coroner's Court on 6 December 2010. The Deputy State Coroner's findings were delivered on 18 January 2011.

The Deputy State Coroner found that the deceased was was a nine year old Ward of the State cared for at Banksia House, Lady Lawley Cottage.

The deceased was quite severely disabled as a result of her original premature birth and grade 2 intraventricular haemorrhage (IVH) and bronchopulmonary dysplasia. Her condition was exacerbated in November 2000 when while in hospital, she suffered hypoxic brain injury as a result of the dislodgement of her tracheostomy tube. As a result, in addition to her previous problems she developed a dyskinetic cerebral palsy, cognitive impairment and a chronic seizure disorder.

The deceased became a Ward of the State in 2002 due to great difficulty with being able to be cared for in a normal environment. She required consistent observation. She became a resident at LLC and was brought up and stabilised in as near to a home environment, with appropriate complex medical care, as was possible.

The deceased was loved and cared for well by her carers and believe this is reflected by the fact that since 2006 she had appeared relatively stable, suffered no seizures, and was able to attend a special school on a daily basis.

On 29 March 2008 there was some excitement in the group home circumstances with the prospect of the open day and the deceased being dressed in new clothes for the event.

She was sponged and dressed in the morning and taken into the main living area for her feed. Sometime earlier she had been observed awake and alert by one of the carers. A short while later another carer noted she appeared to be asleep. This alerted the carer who had dressed her that morning to the fact all may not be well.

On examination it was found she had decannulated. Immediate steps were put into place to revive the deceased, however, on this occasion those steps were unsuccessful and she could not be revived and unfortunately died. This was not the first time she had decannulated and

it was not the first time there had been a serious outcome from that decannulation.

The deceased had a seizure resulting in dislodgement of her tracheostomy tube, however, she may have either regurgitated her food and aspirated causing dislodgment, or she simply caused dislodgement of the tube by her normal movements. Unfortunately, she did not appear to have coughed or spluttered at the time which would have attracted attention.

The situation was not immediately noted although the Deputy State Coroner was satisfied there were three carers in her immediate vicinity who were performing duties connected to the care of the children with whom they were involved.

While not understanding precisely what happened it was clear the deceased's death at this time was as the result of an accidental dislodgement of her tracheostomy tube.

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

The Deputy State Coroner made comments on the supervision, treatment and care of the deceased in the following terms ·

The deceased was a significantly disabled child and it was as a result of her disabilities she was a Ward of the State.

Following the deceased's death a review of the procedures and policies in place at LLC was undertaken by an independent specialist, Sue Peters from PMH. While the Deputy State Coroner noted a number of recommendations were suggested and presented to LLC, most of which were acted upon, she did not believe there was any deficiency in the care provided to the deceased, despite the tragedy of her death.

There was certain tension involved in caring for a child as disabled as the deceased which weights quality versus quantity of life. Where possible the staff minimised her discomfort, while trying to ensure her safety, as was apparent with the cessation of the use of Velcro straps for the cotton ties, and then the movement back to Velcro straps, when it was found the ties caused Gabby more discomfort.

Where her carers were able to make deceased's life more pleasant they did so. If there was some risk associated with this option, the Deputy State Coroner believed the preference would have been for the deceased to be involved in the daily functioning of the unit, by sitting in the living area where she could be stimulated by her surroundings rather than being immobilised or cocooned away from daily living activities.

A review undertaken with a view to the realistic implementation of those recommendations which will benefit children such as the deceased, rather than making their life even more restricted, will occur where it has not already been done.

The Deputy State Coroner's view as to the deceased's supervision, treatment and care was that it was adequate despite the circumstances of her death.

Natasha Gladys KELLY-GROSSER

Natasha Gladys Kelly-Grosser (the deceased) died on 2 January 2009 at the 1 Cypress Road, Forrestfield and her death was consistent with chronic thydroiditis (Hashimoto's Disease). The Deputy State Coroner conducted an inquest hearing into the circumstances surrounding the death of the deceased at the Perth Coroner's Court on 14 December 2010 The Deputy State Coroner's findings were delivered on 18 January 2011.

The Deputy State Coroner found that the deceased was a 16 year-old aboriginal girl who had suffered a comparatively dysfunctional upbringing due to the dislocation of her parents from a normal family environment.

It was clear her paternal grandmother attempted to compensate for her grand children's difficult adolescence by caring for them and trying to provide them with a stable environment. She was certainly protective of the children in their early lives.

Unfortunately, as the deceased grew up she experienced both some intra familiar conflicts, as well as difficulties in her living circumstances and schooling. It was possible the difficulties experienced in dealing with these situations masked the deceased's ailing health symptoms from deeper scrutiny. Everything of which she complained could be explained by crises within her personal life.

The deceased was able to move from household-to-household when she felt the need for a change of environment. It is possible this necessary lack of continuity, also prevented the adults who were clearly caring of her, from observing ongoing changes in her health, other than a real concern she was "not eating properly and looking after herself". She was resistant to, and non-compliant with continued medical input for any difficulties with her anaemia and depression on the occasions she experienced it.

Unusually, the deceased did not respond to her difficult circumstances by becoming antagonistic or indulging in substance abuse. To all appearances she was a beautiful girl with excellent potential to develop into a contributing member of her community.

It was a tragedy her prospect of some form of independence and control over her circumstances did not have an opportunity to eventuate.

At the time of her death she had, to some extent, engaged with a youth worker at her new school and was being assisted with her future living arrangements.

By late 2008 the deceased was about to commence a new school year and was staying in a supportive environment.

On 1 January 2009 she complained of feeling unwell and the following day did not visit relatives with the people with whom she was staying.

On their return to their home in the evening of 2 January 2009 they located the deceased in bed and were unable to rouse her. They immediately commenced CPR and called for the attendance of an ambulance. Unfortunately she could not be resuscitated and died.

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

The Deputy State Coroner made comments on the care of the deceased in the following terms -

The deceased was in an unusual situation in that while assisted by the then Department for Community Development (DCD), she was never made a formal Ward of the State. She was cared for by her paternal grandmother who in her early years, was very protective of the deceased and her siblings. Because the family arrangements appeared to suit the deceased's parents, and her grandmother was willing to care for the children, the Departmental situation remained one of a non-formal placement. Mrs Grosser was assisted financially with her care of the children but their case management was not as intrusive as it would have been had the children been Wards of the State.

When the child welfare legislation changed in 2007 the deceased was well into her teens and developing her own way of dealing with her personal relationship difficulties. While she was in a transitional placement pending the introduction of the new legislation that status was never changed because she did seem to be able to access support when she felt she needed it.

The Deputy State Coroner found that the death to be particularly tragic in view of the fact her condition was treatable, and believed it would have been doubtful that her situation would have been significantly different had she been a true Ward of the State. She was clearly in the care of adults who were interested in her progress and she was striving towards a useful future for herself.

By the time of the deceased's death she was being assisted with her life-style problems by a DCP case worker in conjunction with a youth support worker with whom she was prepared to engage.

No one, including the deceased, realised she was suffering a treatable physical illness.

The Deputy State Coroner commented that the death of this 16 year-old girl from Hashimoto's disease was a tragedy for her family and the community.

Doreen Alice PETERKIN

Doreen Alice Peterkin (the deceased) died on 2 January 2007 at the Trover House, Brightwater Aged Care Facility, Madeley as a result of head injury in an elderly lady following a fall. The Deputy State Coroner conducted an inquest hearing into the circumstances surrounding the death at the Perth Coroner's Court on 12-13 January 2011. The Deputy State Coroner's findings were delivered on 15 February 2011.

The Deputy State Coroner found that the deceased was a frail 82 year-old woman requiring high care in an aged care facility. She required assistance with all aspects of daily living which meant she required lifting from her bed to her wheelchair and from her wheelchair to a commode for personal hygiene issues.

Both the safety of the deceased and the carers needing to transfer her required the use of a lifting device in the form of a hoist be used.

The Deputy State Coroner was satisfied the ceiling "trolley" devise and portable lifting hoist used were appropriate for the tasks for which they were utilised.

The Deputy State Coroner accepted the carers involved with the deceased on the day of her death had been trained, both by way of orientation and the buddy system utilised by Brightwater in the training of its carers. There was no evidence the carers were anything other than attentative to the deceased's needs.

On 2 January 2007 the deceased was in the dining room after lunch in her wheelchair and was due for her daily shower at the commencement of the afternoon shift for carers. She was wheeled from the dining room into her bedroom and her wheel chair placed alongside her bed.

The portable hoist on its wheeled trolley was brought into the room and used to lift the deceased from her wheelchair to over her bed. She was undressed by the carers and then transferred to her commode chair to allow Mr Mangar to shower her.

The deceased was taken into her ensuite where she was washed by Mr Mangar after he had helped Ms Blatchley transfer another resident using the same hoist. Once Mr Mangar had completed washing the deceased he placed her in her nightie and went to the room of the other resident to see how Ms Blatchley was progressing. Mr Manger and Ms Blatchley decided they had time to transfer the deceased from her commode chair into bed and took the hoist from the other resident's room back into the deceased's room.

The deceased was placed in the slings which were attached to the hoist and the extension arm was used to attach the hoist to the overhead "trolley".

The Deputy State Coroner was satisfied the carabiner was appropriately through the closed hole under the shepherd's crook. During the movement from one room to another or during attachment to the overhead "trolley" the webbing strap attached to the carabiner was inadvertently twisted over the extension arm, possibly by the crook moving through the carabiner, rather than hanging freely from the closed loop underneath the shepherd's crook. As a result once the lift commenced and the overhead "trolley" took the weight of the deceased the centre of gravity moved through the strap pulling the extension arm vertically. This allowed the crook to be pulled out of the "trolley".
There would have been no indication this was occurring unless the carers were watching the ceiling attachments.

They were not. Ms Blatchley turned to obtain a towel to dry the deceased as the lift commenced. Mr Mangar was operating the handset for the lift. Neither carer registered the centre of gravity as the strap moved vertically and pulled the extension arm into a vertical position and thus, out of the overhead "trolley". With the use of a swivel attachment and closed hook, that could not occur.

The whole device fell, with the deceased, and she landed on the floor with her bottom and then upper body.

The Deputy State Coroner was satisfied that as a result of the fall the deceased sustained a fractured neck of femur and a head injury although it was impossible to say whether or not this resulted from her head striking the floor or the bed as she fell onto the floor.

While conscious initially it was clear the deceased's very frail physiological condition did not allow her to compensate for the head injury she sustained and she deteriorated very rapidly. She passed away before she could be transferred to hospital.

The Deputy State Coroner was satisfied the extension arm design improvements required by Worksafe of both Brightwater and the hoist suppliers were effective in introducing a modification to the extension arm design which would have prevented this type of accident, rare as it had proved to be.

The Deputy State was satisfied Worksafe and the suppliers of the hoist had actively promoted the safer system of extension arm attachment for overhead ceiling mounted hoist use.

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

Bradley Frederick WHITEHOUSE

Bradley Frederick Whitehouse (the deceased) died on 10 February 2008 at 2 Princess Road, Westminster, the cause of death was unascertainable. The State Coroner conducted an inquest into the circumstances surrounding the death at the Perth Coroner's Court on 24-31 January 2011 and 8-11 March 2011 and 6 April 2011. The State Coroner's findings were delivered on 21 April 2011.

The State Coroner found that the deceased was a baby who had been dead for several hours before police and St John Ambulance were contacted at 3:11 and 3:15pm respectively.

The deceased had last been seen by a medical professional on 9 January 2008 when he was taken by his mother, Deborah Hughes, to the Immunisation Clinic at Mirrabooka.

When found the deceased was clearly severely malnourished. That was not the result of a few days of illness, but an extended period of malnourishment

The deceased had been malnourished from the time when he was first taken home from hospital, but the severity of the malnourishment significantly increased over the last month of his life, leaving him severely emaciated at death.

At post mortem examination the deceased was found to be malnourished and dehydrated with intussusception of the small bowel and very small adrenal glands. His emaciated condition left him vulnerable to sudden death though the precise mechanism of the ultimate cause of death was unclear.

Unfortunately the investigation conducted by police into the circumstances of the death was inadequate and efforts were not made at an early stage to identify the events which took place during the last weeks or month of the deceased's life which contributed to or resulted in his death.

In the second month of his life the deceased gained 600grams which demonstrated that at that stage at least he had the ability to absorb nutrients. The evidence of witnesses who saw the deceased feeding were to the effect that he was able to attach well and there were no obvious problems with his feeding. There was no history of severe diahorrea or vomiting.

In the above circumstances it was likely that inadequate nutrient provision was responsible for the deceased's failure to thrive. In other words he was simply not given enough food.

While the precise mechanism of death was unclear, the State Coroner found that malnourishment was a significant factor in the death. In the absence of clear, reliable evidence as to how that malnourishment developed to the extent it did, the State Coroner made an Open Finding as to how the death arose.

The State Coroner made comments on matters connected with the death including public health and safety or the administration of justice in the following terms -

The Police Investigation into the circumstances surrounding the death

Police investigation into the circumstances of the death was of very low quality and very little evidence was obtained by police investigators as to how it was that the baby came to be so emaciated.

This was an obvious question and should have been a matter of concern to police.

The Western Australia Police Service Investigative Checklist for Child Fatalities includes the following –

> Criminality or negligence should not be assumed, but the possibility should not be overlooked.

In circumstances where the deceased was extremely thin and had died at home, the possibility of negligence certainly required prompt and adequate investigation.

The State Coroner made the following recommendations –

Recommendation No. 1
That if it is the intention of Western Australia Police to leave investigation for hidden homicide with the Coronial Investigation Unit, that Unit be adequately resourced to conduct extensive investigations when these are required.

Recommendation No. 2
That Western Australia Police ensure that in cases where deceased babies or infants are malnourished, neglected, or have injuries which are unexplained, a comprehensive investigation is conducted.

Death of a Toddler

The toddler died on 8 September 2007 in a town in the South West of the State. The inquest was held at the Perth Coroner's Court on 21 July 2010. The Deputy State Coroner's findings were delivered on 30 July 2010.

The Deputy State Coroner made a Suppression Order in the following terms –

SUPPRESSION ORDER

There is an order suppressing the name or any other identifying feature of the deceased child from publication.

The Deputy State Coroner was satisfied the toddler was a well loved, happy, normally developing child. All the post mortem indications are he was fit and healthy and would have been perfectly capable of enjoying life. He had only recently been allowed to sleep in the top bunk of the bunk bed in his room and had been known on occasion to sleep off the edge of his sleep surface.

On the night of 7 September 2007 the toddler was put to bed in his clothes to enable him to be woken quickly in the morning and taken with the rest of the family for a trip to Perth.

During the night it would appear the toddler slipped between the mattress and the guard rail of the top bunk. His head became wedged in that space. From the position described by his parents he appears to have had his hands up in the vicinity of the mattress and became suspended by his head with his neck pressed into either the mattress or the mattress support base.

When his mother came to wake the toddler in the morning she discovered him in that position. She did not immediately realise all was not well. When the toddler's father saw the toddler he realised there was a problem. He immediately lifted the toddler who slipped easily from the gap.

Unfortunately, it was too late to be effective in saving the toddler.

The toddler was rushed to hospital but could not be revived and would appear to have been deceased for at least an hour or two prior to 5:00am.

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

The Deputy State Coroner made the following recommendation –

> Brochures and media releases outlining risk factors and safety features for bunk beds include pictorial guidelines on safe construction for the easy guidance of carers of young children. Pictures and diagrams often catch the eye and may more readily alert people to relevant safety concerns.

Marino MARRA

Marino Marra (the deceased) died on 30 November 2007 at the Bunbury Regional Hospital as a result of multiple injuries. The Deputy State Coroner conducted an inquest into the circumstances surrounding the death at the Busselton Court House on 21-24 February 2011. The Deputy State Coroner's findings were delivered on 1 June 2011.

The Deputy State Coroner found that the deceased was part of a line marking crew working on the Eelup Roundabout and Australind Bypass exit from that Roundabout and entry to the Bypass in the early hours of 30 November 2007.

At approximately 2.55am the deceased was walking in the closed (right hand) lane of the Bypass towards the Moonlight Bridge, when the line marking truck pulled up behind him in the same lane.

At the time the line marking truck pulled up and manoeuvred to a stop, the utility, BY 71537, driven slowly by Mr Brain, was behind the line marking truck, but to its left on the roundabout, intending to pull into the closed lane in front of the line marking truck once the line marking truck had parked.

At that time a sedan was driven onto the roundabout from Sandridge Drive, it passed the Koombana Drive exit onto the Roundabout, and needed to drive from the open lane on the Roundabout (inner right) to enter the open lane (outer left) of the Australind Bypass. In order to do that the driver of the sedan had to move from the right to the left and go around the cones closing off the closed (inner right) lane. As he did so he encountered the utility, he swerved to pass the utility driven by Mr Brain, and his vehicle's left front fender came into contact with the right rear tail light of the utility. His direction of travel as he swerved around the utility threw him into the closed lane behind the deceased, but in front of the line marking truck driven by Mr Pratt.

As the driver was attempting to correct out of the closed lane, back into the open lane the sedan impacted with the deceased who landed on the bonnet before being thrown off the sedan to the left and onto the left-hand road edge. The vehicle then "fish tailed" as the driver attempted to straighten the sedan to proceed down the open lane towards the bridge. The vehicle knocked over cones delineating the lanes in the process.

The Deputy State Coroner found that on the evidence of Snr Constable Magorian with respect to the damage to the sedan, it was likely that at the time of striking the utility the sedan was not travelling at a speed which on initial impact would have caused the death of the deceased. Had the driver stopped as a result of the collision with the utility he may well not have struck the deceased at all or only impacted with the deceased enough to place him on the bonnet.

The Deputy State Coroner found that it would appear the majority of the injury to the deceased was as a result of his impact with the road when he was thrown from the bonnet of the sedan, as it changed movement and momentum to exit the closed lane, after the initial collision with the utility.

The ability to investigate the relevant circumstances of the crash had been compromised by the perceived need to accommodate transport movement prior to the closing of the scene by forensic police later in the morning.

There was no doubt the driver's capacity to drive at the time of the two collisions was severely impaired by a number of factors affecting his judgement and reaction times; especially taking into account his young age and therefore driving experience; and the power of the sedan.

- These included his level of intoxication with a number of contributing substances, red bull, alcohol and ecstasy.
- His failure to wear appropriate visual aids, as conditioned on his licence.
- His failure to appreciate the road and weather conditions, as well as his individual state, prevented him from driving in a manner appropriate to the circumstances of the road at the time.

There is no doubt the deceased died as a result of the injuries he received in the crash in the early morning of 30 November 2007.

The Deputy State Coroner made the following recommendations –

Main Roads amend the Code of Practice to require TMPs to provide provision for total road closure, with alternative routes, where there has been serious injury or a fatality.

The Road Traffic Act 1974 be altered to require a driver to provide a blood sample for the purposes of drug analysis where there has been a fatality or serious injury, regardless of the timelines.

Edward Thomas COLLINS

Edward Thomas Collins (the deceased) died on 14 January 2007 at the Mullewa Hospital, Mullewa, as a result of cardiac arrhythmia associated with surgically corrected congenital heart disease. The State Coroner conducted an inquest into the circumstances surrounding the death at the Perth Coroner's Court on 22-25 February 2011. The State Coroner's findings were delivered on 25 February 2011.

The State Coroner found that the deceased was a 3 month old baby who died on 14 January 2007.

At the time of his death the deceased was an extremely vulnerable baby who had undergone cardiac surgery and was underweight for his age.

On 13 January 2007, the day before his death, the deceased was taken to Mullewa Hospital Emergency Department by his concerned parents.

Although observations taken at the hospital revealed that the deceased's condition constituted a medical emergency and immediate action should have been taken to contact a doctor, to give him appropriate medications and to ensure that he would be adequately monitored and treated, the deceased was returned to his parents by Registered Nurse Gail Griffin who advised his mother that, "The baby looks well and is bright and alert and shows no signs of being listless or unwell".

While it cannot now be ascertained whether the tragic outcome for the deceased would have been different had efforts been made to treat him on the afternoon of 13 January 2007, the fact that appropriate steps were not taken reduced the possibility that he could have been saved.

The State Coroner found that the deceased died as result of Natural Causes in circumstances where it is not known whether with medical intervention a different outcome would have resulted.

The State Coroner made comments to the following effect -

While there was considerable evidence at the inquest in respect of policies, guidelines and procedures in place and available to staff at Mullewa Hospital, a document which was certainly available in laminated form was a document headed "Patients to be notified to the doctor by A&E Triage Nursing staff". That document contained a simple and clear numbered list. The list contained at number 2, "All neonates and infants up to the age of 6 months" and at number 3, "All children up to the age of 5 years with pyrexia".

As the deceased was 3 months of age and had pyrexia he clearly satisfied both conditions, so it was clear that the triaging nurse, Nurse Griffin, should have notified a doctor of the presentation.

The State Coroner noted that the list was attached to an Operational Circular dated 11 October 2001 drafted by the then Acting Commissioner of Health, Professor Byrant Stokes.

It was the evidence of Christine Cream, Acting Regional Nurse Director for the WA Country Health Service Midwest, that this policy is presently undergoing review. The State Coroner expressed the view that if the policy is to be altered in any way it is important that the criteria be kept simple and clear and easily understandable by nursing staff. This is particularly important for relatively remote country hospitals serviced by Visiting Medical Officers.

It was the State Coroner's view the list, which could be and was laminated and made available to staff, was very helpful and in the relevant context reflected the importance of a doctor being contacted in all cases of unwell babies.

The State Coroner made the following recommendation –

Recommendation No. 1
That if operation circular 1485/01 is altered, the guidelines contain a similar attached list which, like the existing list, is very clear and easy to understand. I further recommend that any list of patients to be notified to a doctor by Accident and Emergency triage nursing staff continue to include infants up to the age of 6 months and children up to the age of 5 years with pyrexia.

Deaths in Care

Involuntary patients within the meaning of the *Mental Health Act 1996*.

Donna Lillian BARNES

Donna Lillian Barnes (the deceased) died on 19 September 2007 at the Murchison Ward, Graylands Hospital, Brockway Road, Mt Claremont as a result of acute heart failure in association with acute on chronic obstructive airways disease (recent influenza "A" infection), focal coronary atherosclerosis and morbid obesity. The State Coroner conducted an inquest hearing into the circumstances surrounding the death at the Perth Coroner's Court on 8 September 2010. The State Coroner's findings were delivered on 13 January 2011.

The State Coroner found that the deceased was a 50 year old involuntary patient housed at the Murchison Ward, Graylands Hospital, who appeared to have died in the early morning of 19 September 2007.

The deceased had suffered from severe mental illness for many years and her principle diagnosis had been either Chronic Schizoaffective Disorder or Paranoid Schizophrenia. At the time of her death she was suffering from a severe mental illness.

In addition the deceased had developed numerous physical illnesses and disabilities. She was a person at significant risk of sudden death through heart disease or as a result of her chronic airways disease.

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

The State Coroner made comments on the quality of the supervision, treatment and care of the deceased while in care as follows –

While an inpatient at Graylands Hospital the quality of the deceased's supervision, treatment and care appears to have been generally good.

The deceased appears to have received high quality treatment for her psychiatric illness from her psychiatric team, headed by Dr Georgina Dell, and Dr Dell together with Dr Krishnan monitored her numerous physical problems.

While the Graylands Hospital records for the period immediately prior to her death were lacking or, in a number of respects, deficient, it appears that throughout the deceased received medications and treatment as required.

From the time when she developed a flu-like illness which later proved to be due to influenza, there were no further medical assessments of her after Dr Krishnan saw her on 12 September 2007 until her death a week later. Although she was seen on a number of occasions by nursing staff and twice by Dr Krishnan, during this period she was not further assessed in spite of her history of immobility, heavy smoking and asthma. While this is somewhat surprising, it would appear that the deceased was not showing any obvious signs of deterioration in her condition and it seems to have been assumed that following her being given antibiotics her condition would have improved.

While poor record keeping and a failure to record observations in the Integrated Progress Notes, during this period was unfortunate, in a context where the deceased was a long term patient with chronic problems, the State Coroner considered that generally the standard of her physical care was reasonable, if in the above respects sub-optimal.

The State Coroner further observed that it was a worrying feature of the case that the deceased's medication chart recorded her as having received medications at 8am on the morning of her death, when she had been found with no vital signs at 7:45am.

The State Coroner made the following recommendation

Recommendation No. 1
That Graylands Hospital take steps to ensure that medication charts accurately reveal the giving of medications and that the charts not be written up in advance or at a time when medications have not been provided to patients.

There has been no response to the recommendation at the time of the preparation of this annual report.

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.

The following inquests were conducted.

Colin Lloyd HANSEN

Colin Lloyd Hansen (the deceased) died on 8 September 2006 on Turich Way, Victory Heights, Boulder. The inquest hearing was held at the Kalgoorlie Court House on 13-15 July 2010 and the findings were delivered by the State Coroner on 16 July 2010.

The State Coroner found that the deceased was a 40 year old Aboriginal male who died after setting his own caravan on fire.

Prior to setting his caravan on fire the deceased had contacted police using the emergency 000 number and had indicated in an unclear and non-specific way that he proposed to take his own life.

Although the deceased's telephone calls were received at 3:44 and 3:45am, there was a substantial delay until there was any active police response. Between the time of the call received at the Kalgoorlie Police Station at about 3:55am until the time any police officers left the station to respond a period of about 30 minutes lapsed, during which two officers were having a crib break and other officers were available for tasking. In the period between the generation of the job task at 4:06am and police officers leaving the station a period of about 27 minutes lapsed.

In the period between the emergency call by the deceased at 3:55am and some minutes before FESA were alerted to the fire at about 4:20am it appears that the deceased set alight petrol which he had poured around in his caravan and caused his own death.

The Sate Coroner found that it was not possible to determine precisely when the deceased lit the fire or whether an immediate urgent response by police after 3:55am would have been in time to save his life. The distance from the police station to the deceased's residence was less than 6kms and could have been covered in a matter of minutes. The deceased appears to have still been alive when his mother and sister first went to his caravan some time after the fire had been started, so it is not possible to exclude the possibility that he could have been saved.

The State Corner found that the deceased's own actions in pouring the petrol and setting it alight resulted in his death.

The Sate Coroner found that the death arose by way of Suicide, but observed that it was possible that prompt action taken by police might have prevented the death.

The Sate Coroner made several comments as follows –

1. The Police Computer System

In this case if the name Colin Hansen had been searched at the time when the emergency calls were received (it appears the name Colin Hanson was searched) the first screen would have identified an address in Mandurah used by the deceased some years earlier. It appeared the police computer system had not been updated to record the deceased's recent address even though the events of an earlier suicide attempt at his current address had been entered on the same system.

The State Coroner found that this case highlighted the importance of updating addresses on the police IMS system particularly when there are alerts in place.

Consideration should be given to software improvements which automatically update the screen address for a person when details of a fresh incident are recorded which include a new address for that person.

2. Emergency Response

Emergency 000 calls put through to Kalgoorlie Police Station were not recorded once put through and no records were made of those calls at the station as a matter of course.

In this case the emergency call made by the deceased at 2:14am was not recorded by Constable Brownlie and the other officers were not aware of it. Had some record been made of it it is possible that it could have been identified as being relevant and its contents taken into account in later decision making.

The State Coroner made the following recommendation.

Recommendation No. 1
That all 000 emergency calls should be recorded and if it is not possible to immediately make sound recordings a written record of each call should be made by the officer receiving that call.

3. Prioritisation of Emergency Calls

The State Coroner observed that at the Kalgoorlie Police Station on occasions Probationary Constables received, coded and prioritised emergency calls under supervision, though the supervisor was not always present or able to monitor the allocation of priority to jobs tasked. In addition evidence at the inquest revealed that the Probationary Constables received no formal training as to how to prioritise the response to emergency calls or as to how to identify calls which were not genuine emergency calls.

The State Coroner also noted that it appeared that although junior staff were expected to enter a job code for each task entered on the computer system they were not provided with a list of the relevant job codes.

The State Coroner made the following recommendation –

Recommendation No. 2
That WA Police provide formal training and guidance to officers receiving emergency calls as to how to prioritise tasks. I further recommend that a list of job codes be placed near to dedicated emergency telephones, preferably in laminated or similar form, for ready use by officers.

4. Police Interviews of Police

The State Coroner observed that in most of the interviews of police officers following the death a senior officer stationed at Kalgoorlie Police Station sat in as an "interview friend". In three of the interviews this officer was Acting Senior Sergeant Craig Parkin, the acting officer in charge of the police station. Five Sergeants all attached to Kalgoorlie Police Station sat in on the interviews.

In most cases the officer being interviewed and the senior officer sitting in at the interview were not friends or even acquaintenances and at the inquest it was difficult to obtain clear answers as to how the "interview friends" were "selected" by the officers.

This use of "interview friends" creates an unfortunate impression and is not likely to encourage junior officers being questioned to be forthcoming about systemic failures.

A probationary constable being questioned in the presence of the officer in charge of the police station, for example, is not likely to feel free to be critical of management or to volunteer concerns as to safety practices.

The presence of the senior hierarchy of the police station at most interviews of staff also creates an unfortunate impression of lack of impartiality in the process. The benefits in involving independent officers in an investigation are largely negated by the presence of senior staff of the involved station during important interviews.

That State Coroner made the following recommendation –

Recommendation No. 3
That following future deaths in police presence if junior officers feel a need for a "friend" to be present at interviews either a union official or an actual friend be used where available and every effort be taken to ensure that any "friend" present is not in a position of authority over the person being interviewed, to the extent that this can be achieved without delaying the conducting of the interviews.

In a letter dated 25 August 2010 the Hon Rob Johnson, Minister for Police; Emergency Services and Road Safety responded to the inquest findings[1] .

In respect to the advice provided in relation to the inquest, a copy of the letter to the Commissioner of Police dated 10 June 2010 is enclosed[2]. It is noted that at the inquest five police officers were legally represented.

It is a matter for the parties not for the court to decide whether they should be legally represented. The reference to being advised whether there is a "need" to be legally represented presumably relates to the situation where the possibility of an adverse finding is identified.

It should be assumed that at every inquest hearing coroners will be striving to identify recommendation which, if implemented, might result in reducing the likelihood of future deaths occurring in similar circumstances.

[1] See p.55
[2] See p.57

Minister for Police; Emergency Services; Road Safety
Leader of the House in the Legislative Assembly

Our Ref: 31-09512

PERTH CORONERS COURT
27 AUG 2010
RECEIVED

Ms Dawn Wright
Administrator
Office of the State Coroner
10th Floor, Central Law Courts
501 Hay Street
PERTH WA 6000

Dear Ms Wright

Thank you for your letter of 21 July 2010 concerning the State Coroner's recommendations contained in the findings from the inquest into the circumstances surrounding the death of Colin Lloyd Hansen.

The Western Australia Police have advised that since September 2006 the agency has undertaken significant reforms in the processes involved in the receival and despatch of calls from the community, including all 000 Emergency Calls made from Western Australia.

I am advised that the issues raised in each of the recommendations indicated in your correspondence were addressed by WA Police prior to the Inquest by the State Coroner. This information would have been made available at the time of the Inquest had it been requested by the Coroner's Office.

WA Police have also advised that at the time of the Inquest the agency was advised by the Coroner's Office that WA Police did not need to be represented at the hearings.

In relation to the specific recommendations which you have indicated WA Police have advised the following:

Consideration should be given to software improvements which automatically update the screen address for a person when details of a fresh incident are recorded which include a new address for that person.

WA Police update the residential address for persons recorded on the agency's data base, as a matter of course, when it is confirmed that a person has changed address.

20th Floor,197 St Georges Terrace, Perth Western Australia 6000
Telephone: +61 8 9222 9211 Facsimile: +61 8 9321 6003 Email: Minister.Johnson@dpc.wa.gov.au

Recommendation 1: I recommend that all 000 Emergency Calls should be recorded and if it is not possible to immediately make sound recordings a written record of each call should be made by the officer receiving that call.

The Police Communication Centre (PCC) in Midland receive and manage all 000 Emergency Calls which are recorded electronically and searchable via phone number, date and time. The transfer of 000 Emergency Calls from regional areas to the PCC commenced in June 2008 and was completed by July 2009.

Management of all 000 Emergency Calls from the Goldfields-Esperance Police District was transferred to the PCC on 30 June 2008.

Recommendation 2: I recommend that WA Police provide formal training and guidance to officers receiving emergency calls as to how to prioritise tasks. I further recommend that a list of job codes be placed near to dedicated emergency telephones, preferably in laminated or similar form, for ready use by officers.

All employees staffing the Police Communication Centre are thoroughly trained and qualified in call taking procedures which includes the prioritising of tasking.

Recommendation 3: I recommend that following future deaths in police presence if junior officers feel a need for a "friend" to be present at interviews either a union official or an actual friend be used where available and every effort be taken to ensure that any "friend" present is not in a position of authority over the person being interviewed, to the extent that this can be achieved without delaying the conducting of the interviews.

Police Officers have the right to bring to a formal interview a "friend" and that friend can be any person nominated by the police officer in question.

I trust the above information is of assistance.

Yours sincerely

ROB JOHNSON MLA
MINISTER FOR POLICE; EMERGENCY SERVICES; ROAD SAFETY

25 AUG 2010

CORONER'S COURT OF WESTERN AUSTRALIA

Our ref : 8034/06
Your ref :

10 June 2010

Mr Karl O'Callaghan
Commissioner of Police
WA Police Service
Police Headquarters
Adelaide Terrace
EAST PERTH WA 6000

Dear Commissioner

COLIN LLOYD HANSEN

Please be advised that the State Coroner shall hold an Inquest into the death of the abovenamed at the Coroner's Court, Kalgoolie Court House, Brookman Street, Kalgoorlie on 13-15 July 2010 at 10.00am.

Yours sincerely

Dawn Wright
Administrator
Office of the State Coroner

Cc **INSPECTOR STINGEMORE**
INTERNAL AFFAIRS, 16TH FLOOR, 256 ADELAIDE TERRACE PERTH

10th floor Central Law Courts 501 Hay Street, PERTH WA 6000
TELEPHONE : 08 9425 2900 FACSIMILE : 08 9425 2901 COUNTRY CALLERS : 1800 671 994

Darryl James JONES (aka Yarran) and Matthew James MILLER and Jarrod Scott HIGGINS and Troy Matthew HERBERT

Darryl James Jones (the deceased) died on 29 October 2007 at Royal Perth Hospital, Wellington Street. The State Coroner found that the deceased died as a result of head injury.

Matthew James Miller (the deceased) died on 7 November 2008 at Fremantle Hospital, Alma Street, Fremantle. The State Coroner found that the deceased died as a result of chest and abdominal injuries.

Jarrod Scott Higgins (the deceased) died on 20 November 2008 at Albany Highway, Beckenham. The State Coroner found that the deceased died as a result of neck injury with fracture dislocation of cervical spine.

Troy Matthew Herbert (the deceased) died on 13 December 2009 at Welshpool Road East, Lesmurdie. The State Coroner found that the deceased died as a result of multiple injuries.

The inquest hearing into these four deaths was held at the Perth Coroner's Court on 23-27 August 2010 and 13-15 October 2010. The State Coroner delivered his findings on 21 April 2011.

The four deaths were inquested in one inquest pursuant to section 40 of the *Coroners Act 1996*. A common feature of the four deaths was that in each case the deceased died as a result of a motor vehicle collision which occurred during the course of, or shortly following the termination of, a police pursuit.

In each case there was an issue as to whether police were compliant with the WA Police Manual and particularly with policy TR-7.4 which provided that even when a police driver was suitably qualified, that driver should not exceed 140kph in other than extraordinary circumstances, when the permission to exceed 140kph could be obtained from a Commissioned Officer or Acting Commissioned Officer.

Another common feature in every case was the fact that the deceased driver was found to have had methylamphetamine in his blood. Expert reports provided to the inquest revealed that use of methylamphetamine would have played a significant role in the decision making of the drivers concerned.

The State Coroner concluded in each case as follows –

Darryl James Jones (aka Yarran)

The deceased was thrown from the car he was driving on Ranford Road, Forrestdale, and suffered head injuries from which he later died at Royal Perth Hospital.

Shortly before he was thrown from the vehicle the deceased had been attempting to evade pursuing police officers.

The deceased was under the influence of drugs, particularly methylamphetamine, at the time of the pursuit, which undoubtedly played a part in his poor decision making.

The deceased drove in a very dangerous manner and the vehicle he was driving had been stolen the day before.

The pursuit took place at grossly excessive speeds and during the course of the pursuit pursuing police officers drove at speeds considerably in excess of the maximum speed specified in WA Police Policy TR-7.4 without authorisation.

At the time of the fatal incident, however, police officers had abandoned the pursuit and so their driving did not directly contribute to the death.

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

Matthew James Miller

The deceased died at Fremantle Hospital as a result of chest and abdominal injuries he suffered when he lost control of the Harley Davidson motorcycle which he had been driving at speed on Hamilton Road, Hamilton Hill.

At the time when he lost control of the motorcycle the deceased was attempting to evade pursuing police officers who had lost sight of him momentarily before the crash.

During the course of the pursuit the police vehicle reached speeds in excess of 140kph, the maximum speed specified by WA Police Policy TR-7.4, without permission being obtained from a Commissioned Officer or Acting Commissioned Officer for the driver of the police vehicle to do so.

At the time of the crash the deceased had consumed methylamphetamine and a subsequent toxicology analysis revealed that his blood concentration was below the level which would materially compromise his ability to control a vehicle travelling at a safe speed. Methylamphetamine

could, however, have contributed to poor judgment and inappropriate behaviour.

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

Jarrod Scott Higgins

The deceased died after crashing the vehicle in which he was the driver on Albany Highway, Beckenham.

The deceased died as a result of neck injury with fracture dislocation of the cervical spine as found by forensic pathologist Dr G A Cadden after a post mortem examination conducted on 24 November 2008.

At the time of the crash the deceased was attempting to evade pursuing police officers. In his vehicle at the time he had a number of suspicious items including a sawn-off rifle, a dagger, a quantity of tablets and some cash.

At the time of his driving the deceased was under the influence of methylamphetamine which would have substantially impaired his capacity for safe driving, through the effects on his behaviour and performance.

Immediately before the collision the deceased was travelling at a speed grossly in excess of the speed limit and was being pursued by a police vehicle which was being driven at a speed considerably in excess of the 140kph maximum permitted by WA Police Policy TR-7.4. The driver of the police vehicle did not have permission to exceed the 140kph limit from a Commissioned Officer or an Acting Commissioned Officer and was, therefore, driving in breach of the policy.

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

Troy Matthew Herbert

The deceased died when the motorcycle which he was riding crashed on Welshpool Road, Lesmurdie. The deceased died as a result of multiple injuries which he sustained as a result of the crash and he died at the scene.

The crash occurred very shortly after police officers aborted a pursuit at the direction of the Police Operations Centre.

During the pursuit the police vehicle was driven at a speed in the vicinity of 200kph without the authorisation of a Commissioned Officer or Acting Commissioned Officer. The police vehicle was, therefore, driven in contravention of WA Police Policy TR-7.4.

At the time of the crash the deceased was riding the motorcycle at an excessive speed in order to evade police who had been pursuing him at speed moments before.

The judgment of the deceased was seriously affected by methylamphetamine he had taken and there was no good reason for him to attempt to evade police when the pursuit commenced.

The deceased found that the death arose by way of Accident.

The State Coroner made comments on safety issues as follows –

The fact that each of the deceased drivers had consumed Methylamphetamine

All four of the drivers whose deaths have been the subject of this inquest were affected by methylamphetamine.

There can be no doubt that the use of methylamphetamine in recent years has increased and that increase has created considerable problems for our society. Methylamphetamine abuse in the case of drivers of motor vehicles is particularly dangerous as tragically evidenced by these cases.

The fact that drivers of motor vehicles may be influenced by methylamphetamine adds a further level of difficulty for police officers performing a difficult risk appraisal and making a decision whether or not to continue with a pursuit. It is also clear that methylamphetamine use can result in drivers resorting to flight from police in a context where uninfluenced by drugs such a decision would never be made.

In all of these cases the State Coroner considered it likely that methylamphetamine use was a factor in the decision to attempt to evade police. In at least the cases of Mr Miller and Mr Herbert, prior to the pursuit commencing, there was no good reason for attempting to flee from police.

In this context the State Coroner made the following comment –

That increased methylamphetamine use is posing a serious safety issue for our community, particularly in the context of affected drivers of motor vehicles driving in a dangerous manner. Police need to be alert to the possibility that drivers who they pursue could be methylamphetamine or amphetamine affected and need to factor that additional hazard into their risk assessment process.

The Decision to attempt to evade the Police

The State Coroner observed that pursuits would obviously not be an issue if all motorists stopped when directed to do so. In each of these cases the motorist concerned made a decision to attempt to evade police officers by driving in a very fast and unsafe manner.

In each case the likely consequences to the driver of being apprehended by police would pale into insignificance compared to the horrific consequences which resulted from the pursuit. In every case the motorist who made the decision to attempt to evade police died unnecessarily.

The tragedy was particularly poignant in the cases of Mr Miller and Mr Herbert, who prior to attempting to evade police had only committed offences of the most trivial nature.

In each case a relatively young life had ended tragically and the family had been left to grieve an unnecessary death.

The State Coroner made a comment in this context.

These cases have highlighted the stupidity of motorists attempting to evade police and not stopping when directed to do so. The terrible consequences which can be associated with crashes following high speed pursuits usually bear no relationship to the likely consequences associated with stopping when directed to do so and accepting any possible punishments which our justice system might subsequently impose.

The Police Pursuits

In Western Australia the *Road Traffic Code 2000* by regulation 280 provides for exemption for drivers of emergency vehicles (in this context police officers) in respect of otherwise possible breaches of those regulations in circumstances where the driver is taking reasonable care and it is reasonable that the provision should not apply. It is also necessary that the vehicle display a blue or red flashing light or is sounding an alarm unless it is reasonable not to do so.

WA Police Officers are, however, otherwise not exempted from the rules of the road and particularly from the provisions of the *Road Traffic Act 1974*.

At the time WA Police had in place a policy intended to deal with this issue, TR-7.4 Urgent Duty Driving/Riding.

The State Coroner observed from the evidence at the inquest hearing that in every case police officers did not comply with the maximum speed of 140kph and did not seek permission to exceed that speed from a Commissioned Officer or Acting Commissioned Officer.

The State Coroner made the observation that it was a matter of concern that as a result of the police investigations into the circumstances of these deaths it should have been apparent to WA Police that there were regular breaches occurring of the police pursuit policies.

He further went on to comment that it should also have been a matter of great concern that the Police Operations Centre had not been able to exercise effective supervision and control as a result of having received inadequate information as to the speed of the vehicles concerned.

It was the view of the State Coroner that WA Police owed a duty to its officers to protect them from accepting excessive risks while on duty – both drivers and passengers, and also owed a duty to the community to place effective controls on police pursuits. Once the evidence of these failures became known immediately action should have been taken to ensure the available technology was used to prevent further breaches. The possibility of prosecutions or serious disciplinary action was a far less important issue.

The Monitoring of Speed by the Police Operations Centre

The State Coroner observed that these cases had revealed that the 140kph cap was routinely breached, not only by drivers directly involved in pursuits, but in the case of the death of Mr Jones, by other police drivers.

It has only been as a result of availability of new technology that it has become apparent that these breaches have been taking place. It is now possible to monitor the speed of police vehicles using AVL data.

At the time of these pursuits Police Operations Centre officers were not monitoring the speed of vehicles using the available data, but were reliant on information provided by police officers in the police vehicles, usually the passengers, by radio. Clearly that was not a reliable method of communicating the relevant information.

Information provided to the inquest revealed that procedures have recently changed at the Police Operations Centre and that the current position is that a radio supervisor monitors the current speed of the primary vehicle involved in a pursuit on the AVL and advises the controller as often as required. That is an important improvement in procedures.

The State Coroner made the following recommendation in respect to this issue –

Recommendation No. 1
That in the case of all pursuits the practice of monitoring the current speed of vehicles involved on the AVL system continue and in the event of future changes to the available technology, steps are taken to ensure that it is possible for the speed of police vehicles to be easily monitored on the same computer screen which shows the location of the vehicles.

Video Cameras on Police Vehicles

The only available independent data providing information as to the reliability or otherwise of information conveyed by radio to the Police Operations Centre has been the AVL data. In respect of other matters bearing on the safety of pursuits such as other vehicles on the road, road conditions etc. no similar objective evidence has been available. The factors which would tend to pose problems in conveying accurately speeds would apply at least equally in respect of all other factors and the State Coroner had no reason to suppose that these are being more accurately conveyed from pursuit vehicles to the Police Operations Centre than are speeds. In that context that State Coroner concluded that it would be very helpful if video cameras were fitted to vehicles which would be likely to be involved in such pursuits which could provide important information as to whether or not adequate consideration is being taken of other risk factors by drivers of police pursuit vehicles.

Video cameras fitted to police vehicles would also provide very helpful reliable evidence in any subsequent prosecutions.

Information provided to the inquest was to the effect that video cameras could be fitted to police vehicles at a relatively reasonable cost.

The State Coroner made the following recommendation –

Recommendation No. 2
That WA Police review the possibility of fitting video cameras within police vehicles which are likely to be used in pursuits and give consideration in future to purchasing vehicles with video cameras fitted.

Speed Alarms

While the State Coroner accepted that the police drivers in this case should have been aware of the speed of their vehicles, there are obvious benefits in having a car alarm set at the maximum speed provided for by the policy.

The State Coroner made the following recommendation –

Recommendation No. 3
That car alarms, when available on police vehicles, not be disabled but be set at 140kph.

The 140kph Limit

Speed is clearly only one factor to take into account in determining risk associated with driving and in that context the State Coroner gave consideration to the usefulness or otherwise of having a basic 140kph cap to apply to all circumstances of driving across the state which can only be breached in "exceptional circumstances".

In the State Coroner's view the context in which a motor vehicle is driven, the nature of roads, the extent of housing or other buildings, likely other vehicles or pedestrian traffic, weather conditions and other factors comprising the circumstances of the driving all need to be factored in.

The State Coroner observed that it was important to ensure that decisions to exceed the 140kph cap are monitored by a Police Operations Centre Communications Controller and that cases of unauthorised exceeding of this cap are kept to an absolute minimum. If expanding the circumstances in which approval can be given to exceed this cap will encourage officers to communicate with the Police Operations Centre more often before making a decision to exceed the cap, then that would be a good reason for slightly expanding the relevant criteria.

The State Coroner made the following recommendation –

Recommendation No. 4
That consideration be given to amending the Emergency Driving Policy to enable the Police Operations Centre Communications Controller to authorise the driver of a pursuit vehicle to exceed 140kph in cases where the 110kph open road speed limit applies or there is a 100kph speed limit applicable and the circumstances otherwise are such that it is considered reasonably safe to do so, in addition to where exceptional circumstances exist.

The Risk Assessment

The State Coroner observed that it was unclear whether the current WA Police Emergency Driving Policy, which in its criteria for commencing a pursuit includes "the seriousness of the incident giving rise to the necessity to engage in a pursuit", permits a pursuit to be commenced in respect of minor traffic matters such as those in at least two of the present cases.

The State Coroner observed that if it is the intent of the policy that pursuits may be commenced for minor traffic matters, then it is difficult to understand how this risk factor is to be applied by police officers.

It was accepted by Mr Lachore, on behalf of the Commissioner of Police, that this is an aspect of the policy which is currently unclear and that police officers require more training in order to apply the policy.

The State Coroner made the following recommendation –

Recommendation No. 5
That WA Police review policies in respect of risk assessment with a view to providing clarity for police officers potentially involved in pursuits particularly as to how and in what circumstances the factor, the seriousness of the incident giving rise to the necessity to engage in a pursuit, is to be applied.

Hendrick NJANA

Hendrick Njana (the deceased) died on 30 December 2008 at Royal Perth Hospital, Wellington Street, Perth. The inquest hearing was held at the Broome Court House on 30 August – 3 September 2010 and the findings were delivered by the State Coroner on 21 December 2010.

The State Coroner found that the deceased was a 24 year old Aboriginal male who was the innocent victim of a savage attack perpetrated on him by Mr Midd on the night of 27 December 2008. CCTV footage covering the period before and immediately after the attack appeard to show that the deceased did nothing to provoke that attack on him.

Although the deceased was innocent of any offence, CCTV footage was not available to police who attended the scene and he was arrested for the relatively minor offence of disorderly conduct by fighting.

The deceased was then taken by ambulance to Broome District Hospital where police officers left him to be treated.

The deceased and his brother discharged themselves from the hospital against medical advice and were almost immediately arrested again by Constable Croy and Constable Simpson, officers who had been involved in the original arrest and believed that both were still under arrest.

The deceased was then taken to Broome Police Station where he was lodged in a cell. No adequate inquiries were made by police as to the circumstances which had resulted in the deceased leaving the hospital, the extent of his injuries, of the identity of his treating medical practitioners, whether there were any particular concerns about his ongoing welfare or whether any particular observations of his welfare were required.

Regular cell checks appear to have been conducted through much of the early morning but after about 4:30am, at a time when police officers were proposing to release the deceased on bail, it was discovered that he was unconscious.

The deceased was taken by ambulance to Broome District Hospital where his situation was assessed as being very grave. He was flown by the Royal Flying Doctor Service to Perth where on 30 December 2008 he died.

Mr Midd, the man responsible for the attack on the deceased and his injuries was not charged with murder or manslaughter.

The State Coroner found that the deceased died as a result of head injuries and consequential bleeding in the brain caused by his being struck by Mr Midd, his falling to the ground and his subsequently being kicked by Mr Midd.

The State Coroner made a number of comments on the quality of the supervision, treatment and care of the deceased while in custody to the following effect –

It was most unfortunate that the deceased was an innocent man who died in police custody.

While it was understandable that police officers who attended the Coles Express Check Point Service Station shortly after 8pm on 27 December 2008 encountered difficulty discovering precisely what had happened, at the time of their arrival, the deceased was unconscious on the floor and it was clear that to a large extent at least he was the victim of any assaults which had taken place.

The actions of police in organising for an ambulance to attend and for the deceased and his brother to be taken to the Broome District Hospital were reasonable and appropriate.

Unfortunately at the hospital a misunderstanding developed as to when it was that the deceased was injured. If police advised nurses on duty at the time of their initial attendance that the deceased had been assaulted immediately prior to their attendance at the hospital, this was not noted. The only reference to the timing of the injuries was that recorded by Dr Kriek who believed that the incident had occurred at 6 pm.

The deceased and his brother were under the influence of alcohol and it was likely that their accounts as to timing would be unreliable. While the deceased's partner appears to have been relatively sober and coherent, it would have been helpful if nursing staff had ensured that a reliable history

had been taken and recorded in the notes while police were still in attendance.

The State Coroner made the following recommendation –

Recommendation No. 1
That in cases where police arrange for an injured victim of a crime of violence or an injured person in custody to be taken to a hospital, police and nursing staff ensure that a reliable history is taken prior to departure of police, particularly if the injured person is under the influence of alcohol.

Unfortunately the Custody Handover Summary in this case did not record the fact that the deceased had been unconscious and did not prompt officers involved to make any further inquiries of staff at the Broome District Hospital as to medical treatment given to the deceased or any medical assessment which had been made of his condition.

In the State Coroner's view the present police computerised documentation is deficient in that it does not require officers to make appropriate enquiries to ensure the health and welfare of prisoners in police custody is adequately monitored.

The State Coroner made the following recommendation –

Recommendation No. 2
That the Custody Handover Summary require entry of a summary of any medical treatment or medical assessment made in respect of any prisoner who has been seen by a medical practitioner shortly before being taken into custody or while in custody.

The State Coroner found that it was most unfortunate that although the cell was subject to CCTV monitoring and evidence at the inquest revealed that there were monitors at a number of locations within the police station, it appears that at the time the CCTV was not recorded and there appeared to be no ability to record those CCTV images, although there was an ability to record CCTV elsewhere within the police station.

There was, therefore, no independent verification of when cell checks were conducted or of their nature and no recording of the appearance of the deceased while in the cell.

The State Coroner made the following recommendation –

Recommendation No. 3
That WA Police ensure that CCTV coverage of cells in police stations is recorded so that in the event of a death in custody or serious incident within the cells that recording will be available.

The State Coroner observed that while the quality of the supervision, treatment and care of the deceased was sub-optimal and police policies and procedures designed to ensure that the medical status of injured prisoners is adequately monitored were not complied with in a number of significant respects, medical evidence at the inquest revealed that the deceased would have been very unlikely to have survived his injuries even if their gravity had been detected earlier. It was the view of the State Coroner that the tragic outcome in this case did not result from these failures.

The State Coroner received a letter dated 12 April 2011 from Detective Superintendent Tony Flack, Internal Affairs Unit, who advised –

The WA Police have reviewed and given due consideration to the recommendations arising from your inquest into the death of Mr Hendrick Njana and commissioned the project to review and examine "Custody and Duty of care" processes for persons detained in Police facilities.

It is anticipate the Project will be completed in three months and examine and provide appropriate recommendations on the following aspects –

Custody processes, applications and tools; and
The use and recording of CCTV

An essential component of the Project will be an examination of all recommendations arising from the inquest.

The State Coroner received from the Department of Health a response in a report dated February 2011 the following –

Status: PENDING RESPONSE

Luke David ARNOLD

Luke David Arnold (the deceased) died on 28 December 2008 at the verge of 115 Strawberry Drive, Seville Grove, Armadale. The inquest hearing was held at the Perth Coroner's Court on 1 March 2011. The Deputy State Coroner's findings were delivered on 3 October 2011.

The Deputy State Coroner found that the deceased was was riding a stolen motorcycle, with a stolen registration plate, while under the influence of a number of illicit drugs, and in possession of methylamphetamine and ecstasy.

It was likely that whatever he had been doing, he was on his way home. This would entail turning left off Strawberry Drive and right into Lisbon Way. The police officers in JA403 attempted to stop him prior to his turning. They were unaware of his identity or home address.

The police officers observed the deceased on his motorcycle, which appeared to be registered, however, there was an issue as to whether or not he was indicating appropriately in view of the fact there was another vehicle on the road, theirs. After keeping him in view for a short distance Constable Whitney, as the senior officer and driver, decided to stop the deceased and clarify his movements at that time of a Sunday morning.

As a result of making that decision Constable Whitney activated the police emergency lights just as they entered Strawberry Drive from the roundabout. The deceased looked over his shoulder and it would have been clear the police wished him to stop. He did not.

He quite deliberately accelerated away down Strawberry Drive and, as a result, Constable Whitney also accelerated to keep him in view, while Constable Partyka commenced the appropriate procedures to obtain authorisation for a pursuit. This was never completed.

Before the process could be finalised the deceased crossed the on-coming traffic lane, which was completely clear of traffic, and mounted the opposite verge by way of a drive way. The fact he did this, in the view the Deputy State Coroner, verified it was a deliberate act done in an attempt to evade the police. The kerbing in the area was high impact kerbing designed to deflect tyres and make it difficult to access the verges.

The Major Crash Investigation Unit's examination of the scene located scuff marks along the verge and drive-way traversed by the motorcycle. The tyre marks indicated the motorcycle was deviating from a consistent trajectory due to the different surfaces being traversed, or the rider being out of control.

The motorcycle appeared to have crossed the intersection of Silverhill Loop with Strawberry Drive without making contact with the surface of the intersection and then scuffed the opposite kerb, before hitting a wooden power pole.

The motorcycle received relatively little damage in the collision. There was rim damage consistent with kerb strikes and impact damage on the right handlebar assembly consistent with the motorcycle leaning to the right when striking a wooden object. Damage to the wooden power pole was also consistent with a strike from both the motorcycle, and the helmet of the deceased, who became separated from the motorcycle. The

motorcycle continued to the front door of 115 Strawberry Drive, which faces onto Silverhill Loop.

The deceased was thrown in a different direction and landed at the base of a brick letter box, without his helmet, which was located nearby. He died at the scene before the following police officers could assist him.

The forensic evidence was consistent with the police officers' account of what happened and that of the independent residents who observed some of the events.

The VKI recording supported Constable Whitney's assertion that from the time the deceased accessed the verge, in response to the police action of giving chase when he failed to stop; to the loss of control of the motorcycle; there was not enough time for a decision to abort the chase to have made a difference to the outcome for the deceased. He had chosen his path in a deliberate attempt to evade the police.

In the particular circumstances of this case the Deputy State Coroner was not of the view the speed of the chase prior to the authorisation of a formal pursuit was relevant to the outcome. Consequently she did not intend to enter into any discussion about the accuracy, or not, of AVL data, or the ambiguity, or not, of Urgent Duty Driving/Riding Policy at the time.

The most recent amendment of the Urgent Duty Driving/Riding Policy (6.7.11) has attempted to clarify any ambiguities. It was not clear to the Deputy State Coroner whether or not the current policy would warrant an intercept in the circumstances of the current case, where on the surface there appeared to be a very minor traffic breach, but there was an over-riding concern with local criminal activity. Leaving that issue aside the Deputy State Coroner was satisfied relevant risk factors were appropriately considered at the relevant time.

It was the action of the police in attempting to stop him which caused the deceased to behave as he did. It was as a direct result of his behaviour in attempting to evade the police, and the manner in which he did so, which resulted in his death.

The fact his behaviour may have been partially explained by his circumstances was clear, but in the Deputy State Coroner's view emphasised the likelihood driving or riding under the influence of amphetamine based drugs impaired driving judgement and ability.

Constables Whitney and Partyka did not know of the circumstances relevant to the deceased which made it likely he would fail to stop on realising police were interested in his actions. As far as they were concerned the road conditions were safe, there was no other traffic on the

roads and the deceased, until he crossed the road and accessed the verge, was not a danger to other road users or himself.

The police, in attempting to stop the deceased, were responding to a community issue with respect to the number of burglaries committed in that area. It was considered to be in the community interest in 2008 they did so, and while there was no apparent or obvious danger in giving chase while seeking authorisation to pursue, it was reasonable they did so.

The Deputy State Coroner was satisfied that Constable Whitney appropriately considered relevant risk factors when activating JA403's emergency lights to stop the deceased.

When the deceased failed to stop and accelerated away those risk factors had not altered and the police officers gave chase. At the time it became apparent the deceased may endanger pedestrians by his actions there was a valid argument the police emergency lights would have served as a warning there was a problem in association with road access. However, regardless of that fact, the deceased lost control and crashed before a decision to pull back from the chase could have altered the outcome.

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

Inquests – Deaths In Care – Department for Corrective Services

During the year 2 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
26/7/2007		**McDONALD** Charles Edward	Prison	Hakea Prison	
14/8/2007	9-12/3/2010	**CONWAY** Mark Lewis	Police	Sally Port Fremantle Police Station	Misadventure
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
29/10/2007	23-27/8/2010 14-16/10/2010	**JONES** Darryel James	Police	Armadale	Multiple Injuries
16/11/2007	6-7/12/2010	**GREEN** Hector Cedric	Prison	Kalgoorlie Prison	Natural Causes
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	19/2/2010	**GARDINER** Terrence Sydney Graham	Prison	RPH	Natural Causes
1/6/2008	24-25 & 30/8/2010 & 2/9/2010	**NJAMME** Dennis	Prison	Greenough Regional Prison	Natural Causes
22/8/2008	27-30/4/2010	**WINMAR** Ian Frank	Prison	Albany Regional Prison	Misadventure
18/9/2008	23-26/3/2010	**REX** Justin	Prison	RPH	Natural Causes
20/9/2008	19-20/9/2008	**TUCKER** Alan Murray	Prison	Casuarina Prison	
9/10/2008	7-8/6/2011	**MORATO** Henrique Gregory	Prison	Hakea Prison	
7/11/2008	23-27/8/2010 14-16/10/2010	**MILLER** Matthew James	Police	Chase at Munster	Accident
16/11/2008	23-27/8/2010 14-16/10/2010	**DALY** Benjamin David	Police	Chase Baldivis	Accident
20/11/2008	23-27/8/2010 14-16/10/2010	**HIGGINS** Jarrod	Police	Chase at Koondoola	Accident
14/8/2008	30/6/2011	**SHEEHY** Andrew Michael Brian	Prison	Casuarina Prison	Accident
30/12/08	30/8-3/9/2010	**NJANA** Hendrik (a)	Police	Broome Lockup	Open Finding
3/7/2009	2/6/2011	**NEBRO** Daniel Rowley	Prison	Bunbury Prison	
14/8/2009	30/6/2011	**SHEEHY** Andrew Michael Brian	Prison	Casuarina Prison	Suicide
24/9/2009	11/6/2011	**NEUMANN** Karl	Prison	Hakea Prison	
2/11/2009		**TJOE** Matthew	Police	Victoria Park	
25/11/2009	23-27/8/2010 14-16/10/2010	**DOYLE** Blake Michael	Prison	Hakea Prison	Accident
13/12/2009	23-27/8/2010 14-16/10/2010	**HERBERT** Troy	Police	Lesmurdie	Accident
19/1/2010		**JAMIESON** Sandy	Prison	Albany Regional Prison	
8/2/2010		**SAMSON** Keannita	Police	Port Hedland	
14/2/2010		**WILLIAMS** Brian William	Prison	Albany Regional Prison	

Date of Death	Date of Inquest	Name of Deceased	Custody	Place of Death	Finding
14/3/2010		**WOODS** Deon David	Police	Perth Watch House	
21/3/2010		**KIMOTO** Ayumi	Prison	Hakea Prison	
22/3/2010		**WINMAR** Grantley Ross	Prison	Acacia Prison	
15/9/2010		**TINKER Amy**	Prison	Greenough Regional	
2/10/2010		**GARRETT** Jason Bruce	Prison	Casuarina Prison	
24/11/2010		**HUMES** Peter Phillips	Prison	Hakea Prison	
27/11/2010		**NGUYEN** Tien Chung	Prison	Wooroloo	
8/1/2011		**PHILLIPS Dennis John**	Police	Kalgoorlie Lock Up	
14/4/2011		**WARE** Benjamin Alfred	Police	Ellenbrook Chase	
23/4/2011		**POOLE** Raymond Thomas	Police	Shooting	
10/6/2011		**ROBINSON** Shane John	Prison	Casuarina Prison	

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

Hector Cedric GREEN

Hector Cedric Green (the deceased) died on 16 November 2007 at Kalgoorlie Regional Hospital as a result of ischaemic heart disease and coronary arteriosclerosis with thrombosis. The inquest hearing was held at the Perth Coroners Court on 6-7 December 2010 and the findings were delivered by the State Coroner on 20 December 2010.

The State Coroner was satisfied that the deceased was a 49 year old Aboriginal man who died while in custody as a result of ischaemic heart disease and coronary arteriosclerosis with thrombosis.

On 16 November 2007 the deceased was transferred to the Kalgoorlie Regional Hospital from the Eastern Goldfields Regional Prison.

Upon arrival at the hospital staff attempted to resuscitate the deceased without success and he was declared life extinct at 7:20pm.

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

The State Coroner made comments to the following effect –

The Department of Corrective Services Medical files reveal that the deceased had suffered from Type 2 diabetes from 14 December 1997.

During his more recent periods of incarceration until his last period of incarceration the deceased's diabetes appeared to have been reasonably treated although he had not received an HBA1C test after 4 February 2004.

The HBA1C is the single most important test required to follow the biochemical progress of diabetes.

The deceased was not given an HBA1C test or a urinary microalbumin test until these tests were requested on 14 November 2007 and finally conducted on 16 November 2007. In addition, although on his previous periods of incarceration the deceased had been prescribed medications which were appropriate for his diabetes, on his most recent period of incarceration it appears that he was only prescribed Diamicron and through inadvertence or error he received none of the Simvastatin, Aspirin or Coversyl Plus which he had previously been prescribed.

The State Coroner found in these circumstances it must be stated that the deceased's quality of treatment and care while in custody was not satisfactory.

The State Coroner noted that the deceased's diabetes was not adequately addressed and it was particularly disappointing that this was in a context where the highest rates in the world for diabetes are in Western Australia's Central and Western Desert regions.

Evidence at the inquest revealed that the majority of prisoners at the Eastern Goldfields Regional Prison are indigenous Western Australians and that a significant number of those prisoners suffer from Type 2 diabetes.

In that context it should be expected of the prison that Type 2 diabetes would be well monitored and adequately treated.

The Department of Corrective Services had available at the prison a document which was intended to be used to ensure that adequate testing would take place and that diabetes sufferers would be adequately cared for. Unfortunately this document was not used for the deceased until he had been in custody for two months and when it was commenced the "investigations required" section of the document was not completed and those investigations were not conducted.

The State Coroner recognised that the Department of Corrective Services experiences serious difficulties in attracting suitable medical professionals to work at the Eastern Goldfields Regional Prison and that lack of staff probably contributed to a number of the problems identified in respect of the deceased's care.

At the inquest, however, it appeared to be accepted by all parties that action could be taken by the Department to address a number of the deficiencies and positive suggestions were made with a view to improving both the quality of the investigation in this case and the care of diabetic Aboriginal prisoners in custody in WA.

Investigation Deficiencies

An obvious deficiency in both the police investigation and the investigation conducted by the Department of Corrective Services Internal Investigation Unit (IIU) was the fact that no statement or report was obtained from the treating doctor for the purposes of either investigation.

The State Coroner found that it was not until 10 February 2010 that Dr Haripersad was first contacted and a medical report requested from him and one was not supplied until 2 December 2010.

Neither the police investigation nor the IIU investigation identified the fact that the deceased was not receiving his routine medications during the period of his last incarceration.

It was clear from the medical records that the deceased only ever received the Diamicron.

It appears that both police and Internal Investigations officers were misled by Nurse Chan who in a statement dated 26 March 2008 claimed that the deceased had received all of the above medications in blister packs.

The deceased's last blister pack was located by police and it showed the deceased was not receiving the medications apart from the Diamicron.

In evidence Nurse Chan stated that he believed that the deceased had been receiving all of the medications at the time when he made the statement and claimed that he did not have access to the medical records at the time and was reliant on his memory.

The State Coroner observed that this case has highlighted the importance of ensuring that when nursing and medical staff are interviewed medical records are available and can be referred to.

The State Coroner made a recommendation in the following terms –

Recommendation No. 1
That in the case of deaths in custody when a prisoner has died from natural causes a detailed statement or report should be taken from the treating medical practitioner. I further recommend that when statements are taken from treating doctors or nurses the notes (or copies) are available for reference.

Routine Medical Tests for Diabetes

The State Coroner observed in this case the deceased did not receive either the HBA1C test or a urinary microalbumin test although it was conceded that both tests should have been conducted.

While the Department of Corrective Services has put in place a number of measures with a view to ensuring that appropriate investigations are conducted routinely for diabetes sufferers, it is important to ensure that these investigations do in fact take place.

The State Coroner made a number of recommendations as follows –

Recommendation No. 2
That the Department of Corrective Services put in place measures to ensure that appropriate investigations for diabetes monitoring take place shortly after reception of diabetic prisoners in accordance with the Diabetes Careplan document.

Recommendation No. 3
That all Indigenous prisoners over the age of 35 years be given an ECG shortly after being received into custody.

Recommendation No. 4
That the Department of Corrective Services put in place procedures which would assist medical practitioners and nurses in their communication with Aboriginal persons. In that context I suggest that consideration be given to involving Aboriginal Health Workers or at least Aboriginal persons coming from the relevant areas and familiar with the language and culture of Aboriginal prisoners to assist with the practicalities of asking questions necessary to complete a Diabetes Careplan documentation, obtaining comprehensive medical histories and conducting other similar tasks.

And

That consideration should be given to ensuring that doctors unfamiliar with obtaining histories from Aboriginal prisoners, as part of their induction, work with a doctor experienced at obtaining medical information from such prisoners.

Recommendation No. 5
That the Department of Corrective Services communicate with representatives of Bega Garnbirringu with a view to determining whether any of its resources could be accessed by prisoners housed at the Eastern Goldfields Regional Prison.

Recommendation No. 6
That the Department of Corrective Services liaise with appropriate Aboriginal organisations and Aboriginal Health Care Workers with a view to designing diets which, while compliant with the requirements of a diabetes diet, would be reasonably appealing to Aboriginal prisoners.

Recommendation No. 7
That the Department of Corrective Services closely monitor prisoners in minimum security prisons who are permitted to self medicate to ensure that the medications are being taken as prescribed.

The State Coroner received a letter dated 17 March 2011 from the Department of Corrective Services who advised the following –

DEPARTMENT OF CORRECTIVE SERVICES' RESPONSE TO THE FINDINGS OF THE CORONER INTO THE MANNER AND CAUSE OF DEATH OF MR HECTOR CEDRIC GREEN

Background

The State Coroner held an inquest in the Perth Coroner's Court on 6 and 7 December 2010 into the death in custody of Mr Hector Cedric Green.

Mr Green died in Kalgoorlie Regional Hospital (KRH) on 16 November 2007, having been transferred to the hospital from Eastern Goldfields Regional Prison (EGRP). Upon arrival at the hospital, staff commenced Cardio Pulmonary Resuscitation (CPR). Attempts to resuscitate Mr Green were unsuccessful and life was declared extinct at 1920hrs.

Finding

The Coroner found that Mr Green died as a result of Ischaemic Heart Disease and Coronary Arteriosclerosis with Thrombosis and that death arose by way of Natural Causes (Pages 19 and 20 of the Coroner's Report refers).

Comments on the Supervision, Treatment and Care of the Deceased

The Coroner noted that "it appeared that prison officers responded to the deceased's deteriorating condition in a reasonable manner and that when ambulance officers attended, immediate action was taken to address his deteriorating condition" (page 6 refers).

The Coroner stated that "during the deceased's last period of incarceration, it appeared clear from the medical records that the deceased did not receive appropriate medications and his treatment fell short of the quality of treatment expected from medical practitioners treating patients within the community outside prison" (page 7 refers).

In specifically considering the failure to prescribe the required medications, the Coroner stated, "I did not accept the evidence of Dr Haripersad as being credible. In particular, I do not accept Dr Haripersad's claim that the deceased somehow had access to substantial amounts of Simvastatin, Aspirin and Coversyl" (page 11 refers). However, the Coroner went on to say that "while it was clearly a suboptimal situation that the deceased did not receive these medications, it could not be positively established that the failure to provide these medications contributed to his death occurring when it did" (page 17 refers).

The Coroner also commented on the failure to order the required tests, including glycated haemoglobin, lipid profile, urinary microalbumin and an ECG, until two days prior to his death, despite this being a requirement of the Department's Diabetic Care Plan. The Coroner stated, "in my view these tests should have been ordered at the time when Dr Haripersad first examined the deceased on 15 August 2007…Dr Haripersad has the qualifications MBBS DCH and FRACGP and should be competent to practice medicine independently in Australia. This failure to order standard blood tests for a diabetes sufferer is very concerning in that context" (pages 14 and 15 refer).

With regards to the nursing care provided to Mr Green, the Coroner stated, "while Nurse Chan did make significant efforts to encourage the deceased to control his diet, the overall nursing care provided for the deceased was disorganised and substandard" (page 17 refers).

With regards to the investigations undertaken by WA Police and the Department's Internal Investigation Unit (IIU), the Coroner noted the failure to seek a report or statement from Dr Haripersad and the inaccurate reporting of the medications Mr Green received before his death. The Coroner stated, "this case has highlighted the importance of ensuring that when nursing and medical staff are interviewed, medical records are available and can be referred to" (page 24 refers).

The Coroner further stated that, "this case highlighted the potential for communication problems" and went on to say, that "the potential for miscommunication was particularly evident in a context where complex medical issues had to be discussed by three persons" (pages 26 and 27 refer).

With regards to 'on-person medication', the Coroner indicated that "while it was the Department's position that leaving the taking of [some] medications up to the individual prisoner encouraged responsible self-treatment, it is a matter of concern that for some prisoners problems could arise which could result in their not taking medications required for the treatment of serious illness" (page 30 refers).

In concluding his findings, the Coroner stated, "in these circumstances it must be stated that the deceased's quality of treatment and care while in custody was not satisfactory" (page 21 refers). The Coroner therefore made the following seven recommendations:

Recommendation 1: I recommend that in the case of deaths in custody when a prisoner has died from natural causes, a detailed statement or report should be taken from the treating medical practitioner. I further recommend that when statements are taken from treating doctors or nurses, the notes (or copies) are available for reference.

DCS Response: The Department of Corrective Services supports this recommendation. The Health Services' Directorate will instruct treating medical practitioners to write a detailed report upon their patient's death. The Health Services' Directorate will also ensure that prior to any members of clinical staff providing statements on deceased prisoners, they will have access to all medical information. The Health Services' Death in Custody policy will be updated to reflect this change in process.

Recommendation 2: I recommend that the Department of Corrective Services put in place measures to ensure that appropriate investigations for diabetes monitoring take place shortly after reception of diabetic prisoners in accordance with the Diabetes Care Plan document.

DCS Response: The Department of Corrective Services supports this recommendation. The current process requires that during initial health screening, if a prisoner is identified as diabetic, a care plan is commenced within 28 days, which specifically includes HBA1C and Albumin Creatinine ratio tests. As a further improvement measure, the care plan is currently being developed into an electronic document which will automatically trigger a reminder to commence a care plan as soon as a clinician enters a diagnosis of diabetes into the medical record. The Health Services' Directorate is also looking at the implementation of continual training and thorough follow up of staff performance if the care planning process does not occur.

Recommendation 3: I recommend that all indigenous prisoners over the age of 35 years be given an ECG shortly after being received into custody.

DCS Response: The Department of Corrective Services supports this recommendation. This requirement will be included in the initial electronic screening tool conducted on admission. If an ECG is required, a further appointment will be made within 28 days, dependent on the

presence of other clinical indicators. For example, a prisoner with a history of cardiac problems will be given a priority appointment. Any abnormalities identified in tracing will be referred for review by a Senior Medical Officer. This new process will be reflected in Health Services' policy.

Recommendation 4: I recommend that the Department of Corrective Services put in place procedures which would assist medical practitioners and nurses in their communication with Aboriginal persons. In that context, I suggest that consideration be given to involving Aboriginal Health Workers or at least Aboriginal persons coming from the relevant areas and familiar with the language and culture of Aboriginal prisoners, to assist with the practicalities of asking questions necessary to complete the Diabetes Care Plan documentation, obtaining comprehensive medical histories and conducting other similar tasks. I also recommend that consideration should be given to ensuring that doctors unfamiliar with obtaining histories from Aboriginal prisoners, as part of their induction, work with a doctor experienced at obtaining medical information from such prisoners.

DCS Response: The Department of Corrective Services supports this recommendation in principle and notes that cultural awareness training is available to all Department of Corrective Services' staff via the Training Academy. The Health Services' Directorate also endeavour to engage local AMS (Aboriginal Medical Services) where available to provide in-reach medical services. To date, the Directorate has had limited success due to the unavailability of AMS staff in regional areas. Due to recent submissions from Bega Garnbirringu (local Kalgoorlie AMS) for COAG (Council for Australian Government) funding, which is provided for a 12 month period, it is anticipated that more structured service provision can be delivered from that provider. COAG funding has been provided to the Department of Health and the Department of Corrective Services is currently liaising with Bega Garnbirringu and other regional AMS regarding service provision requirements.

Recommendation 5: I recommend that the Department of Corrective Services communicate with representatives from Bega Garnbirringu with a view to determining whether any of its resources could be accessed by prisoners housed at Eastern Goldfields Regional Prison.

DCS Response: The Department of Corrective Services supports this recommendation. It has been the Health Services Directorates' policy to collaborate with the local AMS and invite them to enter into formal agreements with the Department to provide services, as and when required. The Directorate has had limited success in engaging with them to commit to an ongoing regular service. The Department will continue to communicate with local AMS, including Bega Garnbirringu, on an ongoing basis to endeavour to enhance our service.

Recommendation 6: I recommend that the Department of Corrective Services liaise with appropriate Aboriginal organisations and Aboriginal Health Care Workers with a view to designing diets which, while compliant with the requirements of a diabetes diet, would be reasonably appealing to Aboriginal prisoners.

DCS Response: The Department of Corrective Services does not support this recommendation. Whilst the Department acknowledges the comments of the Coroner, it is deemed that we are already providing a low fat healthy diet across the board for all prisoners. A dietary review of custodial facilities in Western Australia was undertaken in conjunction with the Department of Health in 2003 and the current prison diet was adapted from the outcome of that review. All prisoners however, have a choice to purchase snacks whether healthy or unhealthy from the prison canteens, and have the unrestricted option to consume snacks deemed unhealthy. These are available in the prison unit throughout the day. However, the Health Services' Directorate will continue to educate all prisoners with diabetes about healthy

eating as part of their ongoing health education. No further action is proposed in respect of this recommendation.

prisoners in minimum security prisons who are permitted to self medicate to ensure that the medications are being taken as prescribed.

DCS Response: The Department of Corrective Services does not support this recommendation. The Health Services' Directorate has a policy and process in place regarding the selection process (including a risk assessment rating tool) to determine those prisoners who are suitable and deemed competent to have medications on person. The Health Services' Directorate is unable to monitor compliance outside of the prison's health centre. No further action is proposed in respect of this recommendation.

Preparation of this Report

This report was prepared by Mrs Shana Eusebio with input from the Health Services Directorate (Offender Management and Professional Development Division).

Shana Eusebio
Coordinator Coronial Inquests

10 February 2011

Endorsed: _____
Deputy Commissioner
Adult Custodial

Endorsed: _____
Deputy Commissioner
Offender Management & Professional Development
14.3.11

Endorsed: _____
Assistant Commissioner
Professional Standards

Dennis NJAMME

Dennis Njamme (the deceased) died on 21 June 2008 at Greenough Regional Prison (GRP) as a result of ischaemic heart disease in a man with known diabetes and hypertension. The inquest hearing was held at the Perth Coroners Court on 24-25 and 30 August 2010 and 2 September 2010 and the findings were delivered by the Deputy State Coroner on 17 March 2011.

The Deputy State Coroner was satisfied that the deceased was a 40 year old Aboriginal male with a medical history of hypertension, diabetes mellitus and was under investigation for suspected cardiac disease at the time of his death.

He also suffered a hearing deficit which may have exacerbated a problem in hearing and absorbing medical advice. This would be in conjunction with his tendency to neglect his health while in the community and not being assisted by access to regular medical review.

It was clear he was non-compliant with medications when not in a custodial environment.

On Mr Njamme's most recent period of imprisonment, commencing in May 2007, investigations commenced at Casuarina Prison with respect to Mr Njamme's general state of health as a result of some of his blood test results. By early 2008 he had reported an episode of central chest tightness on exertion which Dr Patterson queried as ischaemic heart disease. He instructed Mr Njamme to speak to nurses immediately he had any similar repeat symptoms.

Dr Patterson was concerned enough about Mr Njamme's presentation to refer him to Fremantle Hospital cardiology. This resulted in an appointment booked for 19 May 2008. He was also prescribed a glyceryl trinitrate nasal spray (GTN).

Prior to Mr Njamme's cardiology appointment in May he was transferred to GRP in February 2008. His medical status on TOMS was not updated other than the fact of the appointment at Fremantle Cardiology on 19 May 2008.

Once at GRP there was more concern with Mr Njamme's diabetes than his potential cardiac issues. Dr Gilles was very focused on attempting to improve his general health and thereby assist his diabetes. She did not focus on cardiology issues despite the referral on TOMS of which she remained unaware.

Dr Gilles was most anxious Mr Njamme reduced his weight and commenced gentle exercise. She reviewed full blood and urine tests for him and was concerned he be regularly reviewed. She did not note the blank CVD care plan in his medical file.

In evidence Dr Gilles stated the care plan for diabetes and cardiovascular diseases are very similar. However, she was concerned her failure to register the blank CVD care plan on his file resulted in a lack of focus in her mind on his potential for cardiovascular disease, such as angina, or alerts her to ask about the cardiologist's appointment. She was aware he was a poor historian and was not convinced he would have been able to answer her questions. Dr Gilles did believe a combined cardiovascular and diabetes care plan would be beneficial.

On 15 April 2008 Mr Njamme followed the earlier advice from Dr Patterson and attended at the GRP medical centre reporting chest pains. The nurse reviewing him performed an ECG and the result was sent to GRH Emergency Department, together with his TOMS medical status report outlining the cardiology appointment in May. He was sent to GRH for investigation. GRH recorded no abnormal results for Mr Njamme and it was believed his chest pain was not cardiac in origin. The fact the test results were negative does not exclude cardiac disease.

On 18 April 2008 Dr Gilles noted the deceased needed an exercise ECG. She believed this would be performed in Geraldton and remained completely unaware of the cardiologist's review at Fremantle Hospital in May. There is no evidence arrangements were ever made for Mr Njamme's exercise ECG.

Mr Njamme was transferred to Casuarina on 15 May 2008 in preparation for his examination at Fremantle Hospital Cardiology on 19 May 2008. There is no reference to this in Mr Njamme's medical file progress notes.

Dr Lee, Cardiology Registrar at Fremantle Hospital examined Mr Njamme but had very little history with which to work. He was only aware of the one episode of chest pain, the basis of the referral in January. He could only observe the other obvious risk factors for coronary artery disease. Dr Lee wished to perform an exercise ECG but the issue of restraints was a problem. Dr Lee believed an angiogram to be more diagnostic and one was booked for 2 July 2008.

Mr Njamme was transferred back to GRP on 26 May 2008. Dr Lee's report would have been sent to Dr Patterson at Casuarina Prison prior to being forwarded to GRP for his medical file. The difficulty with this process was that Mr Njamme's medical file had no reference to the fact of his

attendance at the cardiology review on 19 May 2008. As such the doctors at GRP remained oblivious of that issue.

The Deputy State Coroner noted that this was a very unsatisfactory systems problem.

When Dr Gilles next saw Mr Njamme the report from Dr Lee, we assume, was not on the deceased's medical file. She was only aware of the results of testing she had ordered and which was now on file. There was no reference to her request for a stress ECG and the fact it had not been done.

Dr Gilles was very happy Mr Njamme appeared to have lost weight and he informed her he was "training". Dr Gilles did not for one moment imagine the deceased meant he was training for the footy competition.

It was in the setting of Mr Njamme's cardiac issues being investigated, but not by his current medical practitioner, that he came to be involved, we assume, in the football competition. It appears to have consisted of a couple of hours a week quite intense exercise, in sustained bursts. This would have put considerable stress on a system, already indicating it was compromised by his intermittent chest pain.

Added to the exercise was the fact Mr Njamme had bad news on the morning of the football game which may have contributed to a heightened level of stress.

At approximately 11:00am on 21 June 2008 Mr Njamme collapsed while playing football at the GRP. The game was stopped and he was placed in the recovery position. It was unclear to those around him as to the reason for his collapse. It was confusing for those seeking medical attention for him as to whether he had fallen as the result of play or as the result of a medical condition. The Deputy State Coroner found that this contributed to a failure to immediately call a code red.

The Deputy State Coroner further observed there was an initial belief by those in proximity to Mr Njamme he was breathing. CPR was not commenced immediately which may have been his only chance for a positive outcome. It was emphasised the "may" as the post mortem medical evidence would seem to indicate Mr Njamme's cardiovascular system was so compromised he may have had a malignant myocardial infarction without exertion, without stress, and have been irretrievability compromised even if CPR had commenced immediately. Mortality rates for myocardial infarctions are high, even in a hospital setting.

A radio call was made to the prison medical centre requesting the attendance of the nurse with the stretcher. When the stretcher arrived the nurse could not find any pulse or signs of life. Mr Njamme was lifted onto the stretcher and taken to the prison medical centre. A call was made for the attendance of St John Ambulance Officers.

By the time Mr Njamme had been transported to the medical centre where CPR was instituted he could not be resuscitated. He had suffered a malignant myocardial infarction resulting in complete heart failure.

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

The Deputy State Coroner made comments on the supervision, treatment and care of the deceased in the following terms –

a) <u>Medical records and continuity of care</u>

The biggest concern with Mr Njamme's medical history for his 2007/2008 term of imprisonment revolved around the lack of cohesion between the various medical practitioners reviewing Mr Njamme. This was not assisted by his difficulty with narration of his medical history, however, that is common in indigenous prisoners. There should have been enough information on his medical file to give any doctor a comprehensive understanding of his issues despite his inability to consistently narrate appropriately.

There is no doubt the doctors involved with Mr Njamme were concerned to give him good medical treatment but the accessibility of documentation did not allow for that advice to be comprehensive and consistent.

Dr Gilles, as his most recent medical adviser, although suspecting a cardiac issue may need investigating, never really focused upon that issue satisfactorily. If she had been aware of his referral for cardiology review, due to prior chest pain, it is probable her concern with his cardiac health would have been more proactive.

The Deputy State Coroner found there was no reference in Mr Njamme's medical progress notes to the fact he had actually attended a cardiologist at Fremantle Hospital on 19 May 2008.

The negative effect of this was two-fold:

Had Dr Gilles been aware of the imminent referral, she would have been able to provide Dr Lee with a better history than was provided by a copy of his TOMS entries.

Further, on Mr Njamme's return, and her next review, she would have understood there had been active investigation of his cardiac problems which were continuing. This may have triggered a renewal of her belief there was an issue she needed to take into account when discussing his medical health with him.

The issue of what was appropriate exercise for someone in Mr Njamme's situation was never considered due to none of his medical advisors being in possession of all the relevant information. Essentially, until he had an exercise stress test or the angiogram, his exercise should not have been as demanding as the football training and playing he apparently took upon himself.

The difficulty in maintaining a cohesive and comprehensive medical history where prisoners receive input from a number of practitioners in different locations has been recognised by Prison Services Health Directorate.

On 2 September 2010, Dr Fitzclarence attended court to demonstrate a pilot project which is being trialled in the Department of Corrective Services (DCS). It commenced in April 2008, and since March 2009, has been used throughout the prison system. It is still being refined. It is called EcHO and is a patient management information system for clinicians in the prison system.

It is whilst EcHO is still being developed, issues such as the overall continuity of care can be addressed, so they may be overcome. The Deputy State Coroner understood the content of Dr Lee's report would now have been transferred to EcHO on receipt and therefore become available on Mr Njamme's medical record in a timely manner. Hopefully, there is also an alert new data is available to be accessed by the next reviewing practitioner.

The Deputy State Coroner received submissions from Aboriginal Legal Service (ALS) with respect to the use of indigenous health workers to accompany indigenous prisoners on outpatient appointments and the availability of funding through the Mar Mooditj Foundation.

Geraldton Regional Aboriginal Medical Service (GRAMS) currently provides doctors to GRP and supports the use of indigenous health workers at GRP. One would assume an accompanying health worker would be familiar with a prisoner's medical file and so be in a position to provide a full and proper history.

These initiatives should be encouraged in an attempt to involve aboriginal prisoners with their health care and educate them for return into the community. It could be an invaluable tool in the provision of improved medical services to the indigenous community.

b) Leadership in a medical emergency

The Deputy State Coroner accepted Prison Officer Ellis realised very quickly he should have called a Code Red with respect to the incident on the football oval when Mr Njamme collapsed.

The Deputy State Coroner also accepted it was initially thought he collapsed as the result of play, rather than a medical event. Possibly that was even more of a reason to call a "Code Red". The Deputy State Coroner was satisfied this was an entirely innocent omission on the part of the prison officers in attendance. It appears everybody was confused as to what had occurred and the obvious and appropriate course of action was overlooked.

The Deputy State Coroner emphasised training is designed to take over where confusion abounds. Where one is unsure of the nature of the medical emergency then it is imperative it is called in at the most serious level.

The second aspect of concern as to the occurrence on the football oval was the attending nurse seemed to suffer some confusion as to her appropriate role. The Deputy State Coroner accepted there is a tension in prisons, whether in the recreational setting or not, between welfare and security. The nurse's issue is welfare, and that is paramount. It is up to prison officers to be concerned about security.

There should have been no confusion in any attending health practitioner's mind as to their role, and no confusion that once having stated what should happen, it was up to the prison officers to facilitate that as they saw fit.

While on the subject of leadership in a medical emergency, the Deputy State Coroner touched on the issue of prisoner restraints in a situation where prisoners are attending specialists appointments for medical investigations. The Deputy State Coroner appreciated the security personnel attending hospital reviews with a prisoner have very specific orders with respect to restraints, but there must be some recognition of the fact use of restraints may not be ideal. If a medical practitioner requires restraints be removed for the purposes of any procedure then there should be an ability to respond to the issue in a timely manner

The Deputy State Coroner understood that this issue has already been addressed. The Deputy State Coroner commented that if it has not it needs to be done. The Deputy State Coroner further observed that she would have thought the suggestion indigenous health workers attend outpatient visits with indigenous prisoners could be very beneficial in these sorts of circumstances.

c) Cardiopulmonary Resuscitation (CPR)

The Deputy State Coroner observed that she was concerned the issue of the appropriateness of conducting CPR as soon as possible arose in this case. It is many years since the Deputy State Coroner felt the need to comment on the adequate resuscitation of a collapsed prisoner. Usually prison officers implement appropriate resuscitation techniques very quickly as a result of their training.

The Deputy State Coroner observed that she was concerned that more prison officers appeared to be allowing their first aid training to lapse and as a result are not confident in implementing resuscitation techniques. The Deputy State Coroner was aware CPR guidelines have changed over time which is all the more reason to ensure adequate numbers of officers attend refresher courses.

The Deputy State Coroner noted that recommendations before now have referred to prisoners also being trained in CPR and that issue has been covered in some prisons. The Deputy State Coroner believed that would also alleviate the safety issue referred to by the nurse in the case of the deceased. Prisoners who feel they can contribute to an emergency are less likely to become fraught and anxious if they perceive appropriate measures are being taken or that they can positively assist in some constructive way.

The Deputy State Coroner commented that it was very important prison officers remain up-to-date with their CPR and first aid training, if only to give them confidence to assess and implement relevant CPR very rapidly. The Deputy State Coroner was sure part of that training these days covers the difference between agonal and spontaneous 'breathing' and the benefits of cardiac compressions.

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

1. At this early stage in the implementation of EcHO the progress notes aspect of the system ensures recording of contemporaneous medical investigations in an obvious manner. This will allow a proper updated and relevant history to be provided to external consultants and advise in-house doctors of the investigations which are currently being conducted with respect to individual prisoners.

2. The initiative by GRAMS to use indigenous health workers in GRP be supported while accepting prison security is an issue which will always provide some tension with welfare issues. These need to be addressed.

3. Funding available for indigenous health workers via the Mar Mooditj Foundation. This is based on submissions from ALS on behalf of Mr Njamme's family. Unfortunately I did not have the opportunity to hear from the Foundation in person. If a mechanism can be developed whereby security concerns are protected, the Deputy State Coroner strongly urge prison authorities to work cooperatively with external sources of funding where possible. The use of indigenous health workers where prisoners need to attend consultant reviews and ongoing investigations could be invaluable. This will ultimately contribute to the community as a whole by using the window of opportunity provided for input to indigenous health issues while indigenous prisoners are in custody.

4. Training with respect to calling a Code Red where there is a medical emergency which has not yet been defined be impressed upon prison officers.

5. Appropriate, adequate and ongoing CPR training be provided to prison officers and appropriate prisoners.

6. There be a clear direction to nurses attending medical emergencies they are to provide leadership in the welfare arena, which will allow attending prison officers to appropriately concern themselves with security issues.

The State Coroner received a letter dated 21 July 2011 from the Department of Corrective Services advising of the following –

DEPARTMENT OF CORRECTIVE SERVICES' RESPONSE TO THE FINDINGS OF THE CORONER INTO THE MANNER AND CAUSE OF DEATH OF MR DENNIS NJAMME

Background

The Deputy State Coroner held an inquest at Perth Coroner's Court on 24, 25 and 30 August and 2 September 2010 into the death in custody of Mr Dennis Njamme.

Mr Njamme was a 40 year old traditional Indigenous sentenced prisoner from the Balgo Community. He was serving a three and a half year sentence at the time of his death resulting from a breach of parole on a previous seven year sentence for robbery whilst armed and grievous bodily harm and new convictions of unlawful wounding offence.

Mr Njamme had a sporadic offending history dating back to 1985 when he was approximately 17 years of age. He incurred numerous convictions for driving offences and offences including unlawful wounding, disorderly, hinder police and damage. Mr Njamme's most recent convictions show a strong correlation between alcohol use and violent offending behaviour.

At 1100 hours on 21 June 2008, at Greenough Prison Mr Njamme collapsed and died whilst playing in a structured game of Australian Rules Football.

Finding

The Deputy State Coroner found that Mr Njamme's death arose by way of natural causes; he had suffered a malignant myocardial infarction resulting in complete heart failure (page 38 of the Deputy State Coroner's Report refers). The post mortem examination concluded death was as the result of ischaemic heart disease in a man with known diabetes mellitus and systemic hypertension (page 32 of the Coroner's Report refers).

Comments on the Supervision, Treatment and Care of the Deceased

The Deputy State Coroner noted, "the biggest concern with Mr Njamme's medical history for his 2007/2008 term of imprisonment revolves around the lack of cohesion between the various medical practitioners reviewing Mr Njamme. This was further compounded by his difficulty with narration of his medical history. There should have been enough information on his medical file to give any doctor a comprehensive understanding of his issues despite his inability to consistently narrate appropriately (page 39 of the Deputy State Coroner's Report refers).

The Deputy State Coroner acknowledged that "There is no doubt the doctors involved with Mr Njamme were concerned to give him good medical treatment but the accessibility of documentation did not allow for that advice to be comprehensive and consistent" (page 39 of the Coroner's Report refers).

The Deputy State Coroner found that it was "quite astounding there was no reference in Mr Njamme's medical progress notes to the fact he had actually attended a cardiologist at Fremantle Hospital on 19 May 2008" (pages 39 and 40 of the Coroner's Report refers).

The Deputy State Coroner noted the commencement of a pilot project [EcHO] "in April 2008, and since March 2009, has been used throughout the prison system. It is still being refined. It is called EcHO and is a patient management information system for clinicians in the prison system."

However the Deputy State Coroner expressed concern that, "the issue of the failure to note Mr Njamme was due for cardiology review, had had a cardiology review, and was awaiting a report with a plan, including an angiogram, would have been omitted in the same way it was in the progress notes. It was on TOMS, but not easily located on the medical file unless Dr Gilles had referred back to the progress notes of January 2008" (page 41 of the Coroner's Report refers).

In noting a submission from Aboriginal Legal Service (ALS) regarding the availability of funding through the Mar Mooditj Foundation the Deputy State went on to say "Geraldton Regional Aboriginal Medical Service (GRAMS) currently provides doctors to GRP and supports the use of indigenous health workers at GRP. One would assume an accompanying health worker would be familiar with a prisoner's medical file and so be in a position to provide a full and proper history.

These initiatives should be encouraged in an attempt to involve aboriginal prisoners with their health care and educate them for return into the community. It could be an invaluable tool in the provision of improved medical services to the indigenous community" (page 42 of the Coroner's Report refers).

The Deputy State Coroner accepted one Officer's realisation that he should have called a Code Red and that he thought Mr Njamme's collapse was considered to be a result of play rather than a medical event. She went on to say, "It appears everybody was confused as to what had occurred and the obvious and appropriate course of action was overlooked. I can only emphasise training is designed to take over where confusion abounds. Where one is unsure of the nature of the medical emergency then it is imperative it is called in at the most serious level" (page 43 of the Coroner's Report refers).

The Deputy State Coroner noted that "the attending nurse seemed to suffer some confusion as to her appropriate role". The Deputy State Coroner acknowledged that "there is a tension in prisons, whether in the recreational setting or not, between welfare and security. The nurse's issue is welfare, and that is paramount. It is up to prison officers to be concerned about security. "There should have been no confusion in any attending health practitioner's mind as to their role, and no confusion that once having stated what should happen, it was up to the prison officers to facilitate that as they saw fit." (page 43 of the Coroner's Report refers).

The Deputy State Coroner expressed concern that "prison officers appear to be lapsing in their first aid training and as a result are not confident in implementing resuscitation techniques. I am aware CPR guidelines have changed over time which is all the more reason to ensure adequate numbers of officers attend refresher courses".

The Deputy State Coroner made the following recommendations in relation to this inquest:

Recommendation: *At this early stage in the implementation of EcHO I am anxious the progress notes aspect of the system ensures recording of contemporaneous medical investigations in an obvious manner. This will allow a proper updated and relevant history to be provided to external consultants and advise in-house doctors of the investigations which are currently being conducted with respect to individual prisoners.*

DCS Response: The Department of Corrective Services HSD process is for paper reports from external providers, including investigations, to be sent to Central Medical Records for scanning into the TRIM database, which interfaces with ECHO. HSD has recently clarified the date, nature and content of documents scanned into TRIM to ensure easier recognition and access by clinicians. Health Service Policy requires that all documents and results are signed as actioned before scanning into TRIM or the medical record.

Recommendation: The initiative by GRAMS to use indigenous health workers in GRP be supported while accepting prison security is an issue which will always provide some tension with welfare issues. These need to be addressed.

DCS Response: The Health Service Directorate accepts that Aboriginal Health Workers are nominated by their local communities for training and return there to work once their training is complete. Therefore, efforts by the Health Service Directorate to secure Aboriginal Health Workers for GRP have been unsuccessful to date. Aboriginal Prisoner Health Re Entry Program funded by COAG, through the Department of Health is now being implemented in collaboration with Aboriginal Medical Services and other community providers, to ensure continuum of care for Aboriginal Prisoners on discharge.

Recommendation: I understand there is funding available for indigenous health workers via the Mar Mooditj Foundation. This is based on submissions from ALS on behalf of Mr Njamme's family. Unfortunately I did not have the opportunity to hear from the Foundation in person. If a mechanism can be developed whereby security concerns are protected, I strongly urge prison authorities to work cooperatively with external sources of funding where possible. The use of indigenous health workers where prisoners need to attend consultant reviews and ongoing investigations could be invaluable. This will ultimately contribute to the community as a whole by using the window of opportunity provided for input to indigenous health issues while indigenous prisoners are in custody.

DCS Response: The Health Service Directorate accepts that Aboriginal Health Workers are nominated by their local communities for training and return there to work once their training is complete. Efforts by the Health Service Directorate to secure Aboriginal Health Workers for GRP have been unsuccessful to date. Aboriginal Prisoner Health Re Entry Program funded by COAG, through the Department of Health is now being implemented in collaboration with Aboriginal Medical Services and other community providers, to ensure continuum of care for Aboriginal Prisoners on discharge.

Recommendation: Training with respect to calling a Code Red where there is a medical emergency which has not yet been defined be impressed upon prison officers.

DCS Response: Policy Directive 30 has been changed and as a result all prisons will amend their emergency procedures accordingly. This has already occurred at Greenough Regional Prison where Emergency Procedures include the following: In the event of a medical emergency within the prison, staff shall immediately initiate a Code Red Medical Emergency over the radio together with added information such as 'person non responsive'. A serious medical emergency is defined as instances where a person so observed to be apparently unconscious, to be non responsive to verbal command or to be nonresponsive to the usual checks relating to a suspected casualty.

To ensure these changes are understood by staff the Satellite Training Officers at all prisons will initiate a series of Desk Top Training sessions where staff will work through the changes to the Emergency Management Procedures. This has already commenced at Greenough Regional Prison where these sessions have been run weekly since the changed procedure was introduced in early March 2011. Approximately 50 staff have been trained in the procedure. In addition to this training, one Training Exercise has been undertaken covering an Emergency Medical Situation.

Policy Directive 72 requires that at least six Emergency Management Training exercises are undertaken per year at each prison and these exercises are reported on within Adult Custodial Division's trimester reporting schedule. This will be monitored to ensure that at least one exercise per financial year relates to an Emergency Medical Situation. Further training and exercises are scheduled in the training calendar for 2011.

Recommendation: *Appropriate, adequate and ongoing CPR training be provided to prison officers and appropriate prisoners.*

DCS Response: Currently, Greenough Prison is reporting a general compliancy of 97% of staff (excluding Health) being competent in CPR. The Satellite Trainer was trained at the end of 2009 as a CPR instructor to provide a local capability to maintain these skills. Additional staff will be trained as facilitators when required.

The Corrective Services Academy (The Academy) identified at the last Adult Custodial Divisional Training Committee (05/11/09) for the need to define 'mandatory' training requirements and identify what is required to achieve this. The Academy will work with Adult Custodial Division to develop a policy that defines the 'mandatory' training requirements. This will involve developing a policy that will include the identification and frequency of mandatory training requirements. The Academy will endeavour to draft a policy by June 2010 (the identification, determination of mandatory skills based on a risk analysis approach may see these timelines pushed out).

The Academy will work with its Satellite Trainer and local prison management to identify training requirements, including emergency responses and CPR, and implement a training plan to achieve the required level of compliancy.

Recommendation: *There be a clear direction to nurses attending medical emergencies they are to provide leadership in the welfare arena, which will allow attending prison officers to appropriately concern themselves with security issues.*

DCS Response: This recommendation has been addressed. The Health Services Directorate procedure *Medical Emergency and Resuscitation of Prisoners* states that "On notification of Code Red the RN on duty will, attend the location of the medical emergency, assess the situation and provide emergency care and necessary interventions that are within their professional scope of practise and competency". The procedure was implemented in January 2011 and the document is available for all staff on the Department's intranet.

Preparation of this Report

This report was prepared by members of the Critical Reviews Unit, Professional Standards Division with input from the Offender Management and Professional Development, and Adult Custodial Divisions.

Sue Holt
Manager Critical Reviews

July 2011

Endorsed: _____
Deputy Commissioner
Adult Custodial
7-7-11

Endorsed: _____
Deputy Commissioner
Offender Management & Professional Development
7.7.11

Endorsed: _____
Assistant Commissioner
Professional Standards
7.7.11

5

Deaths Referred to the Coroners Court
1 July 2010 – 30 June 2011

A total of 2,743 deaths were referred to the coronial system during the year.

Of these deaths, in 749 cases death certificates were ultimately issued by doctors. In many cases there were initial problems experienced in locating a treating doctor or a treating doctor had initial reservations about signing a certificate which were ultimately resolved.

In the Perth area there were 1,457 Coroner's cases and in the country regions there were 537 Coroner's cases, a total of 1,994 cases.

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

Statistics relating to the manner of deaths referred to a coroner for investigation are detailed below.

There remain 1,266 of these cases which are still under investigation and have not been completed by way of finding by a coroner.

Deaths referred to a Coroner for investigation for the Metropolitan area which have been completed and signed by a Coroner

1 July, 2010 - 30 June, 2011

Natural	381
Suicides	10
Accidents	13
Traffic	6
Homicide	0
Open	6
Misadventure	0
Determination to have no jurisdiction	1
Incompleted cases	1040
TOTAL	**1457**

Deaths referred to a Coroner for investigation for the Country area which have been completed and signed by a Coroner

1 July, 2009 - 30 June, 2010

Natural	144
Suicides	61
Accidents	43
Traffic	49
Homicide	4
Open	9
Misadventure	1
Determination to have no jurisdiction	0
Incompleted cases	226
TOTAL	**537**