

The Coronial Process in Western Australia

A Handbook for Medical Practitioners and Medical Students

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Introduction

I have written this handbook in an attempt to explain to medical practitioners and students the role of the Office of the State Coroner. A medical practitioner who becomes aware of a reportable death has a duty and legal obligation to fulfil the requirements of the Coroner's Act and notify the Coroner unless the death has already been reported. This is important for several reasons as will become clearer as you peruse this booklet.

I hope that after reading this booklet the reader will have a clear understanding of the role and function of the coroner and an understanding of the basics of the Coroner's Act. It is most important for all practitioners to also have a clear understanding of what constitutes a "*reportable death*" and, therefore, what responsibilities are incumbent upon the practitioner to fulfil the requirements of the Act.

Initially, I will summarise the interesting history of the development of the office of the Coroner through the centuries and then section by section highlight the aspects of the Coroner's Act relevant to medical practitioners. I will also describe aspects of the coronial process in Western Australia.

1. History of the Office of the Coroner

The office of the Coroner is one of the oldest known to law, being exceeded in antiquity only by that of Sheriff. It originated in Norman England and dates back to 1194 during the reign of Richard the Lionheart.

In those times the Sheriffs ruled over the counties of England. The counties were divided into smaller regions called "hundreds". Sheriffs ruled over Sergeants and Bailiffs who in turn administered the "hundreds". The word sheriff has an interesting origin. It comes from the term "the reif of the shire". The word "reif" is an obsolete Scottish word meaning plunder, robbery or booty and from "Shire's reif" we get the word Sheriff. The Sheriffs had a bad reputation for extortion and the unfair gain of money from the general population by manipulation of the legal system for their own personal advantage.

In an attempt to change this system of control King Richard determined that Hubert Walter, an astute administrator who had accompanied the King on

Crusades, he was appointed Chief Justiciar. As justiciar Hubert Walter was responsible for maintaining peace and dispensing justice and he established the office of Justice of the Peace. In addition to these roles he was subsequently elected as Archbishop of Canterbury.

Archbishop Walter had to rein in the Sheriffs and did so by establishing a new body of men who travelled around England hearing legal cases. These itinerant judges were the first coroners.

The term “*Eyre*” refers to the circuit travelled by these itinerant judges in mediaeval England or the court they presided over. The “*General Eyre*” was the visitation to an area by the King’s judges who dispensed justice as they moved around the country.

The Eyre of September 1194 was held in the County of Kent and Article 20 formally established the office of the coroner. It stated:

“In every county of the King’s realm shall be elected three Knights and one Clerk, to keep the Pleas of the Crown”

Keeping the “*pleas of the crown*” meant recording the pleas on parchments known as Coroners’ Rolls. “*Holding the pleas*” meant actually trying the cases and passing sentence. The practice of sheriffs, bailiffs, coroners and constables “*holding the pleas*” was to be banned by the Magna Carta in 1215.

This group of three knights and a clerk kept the record of “*pleas of the Crown*” the General Eyre was to hear. The clerk was soon dropped and replaced by a fourth coroner. A body of coroners was formed in each county and so Hubert Walter gradually tightened up on criminal procedures and largely disempowered the Sheriffs. Under this new system the Sheriffs dealt with the lesser crimes and the General Eyre with more serious cases of felony such as rape, murder, burglary and robbery which could take years to be heard as the Eyre moved around the country very slowly. A circuit could take several years to complete. In addition to hearing cases they were also to hold inquests on dead bodies.

The keeping of the pleas of the Crown resulted in these four men initially being titled “*Crowners*”, a name which persisted for hundreds of years and is referred to in Shakespeare’s Hamlet. The Latin for “*keepers of the pleas of the Crown*” is “*custos placitorum coronae*” from where the word “*coroner*” was eventually derived.

As time went by more coroners were appointed in the Boroughs. It was a serious offence for a coroner to receive any reward for his duties. They had to be men of substance, knights and financially well off to reduce temptation and the likelihood of them following the Sheriffs’ habit of embezzlement. In 1275 the Statute of Westminster the First enacted that “*none but lawful, most*

wise and discreet, knights should be chosen." With the passage of time the qualification of knight vanished but a coroner still had to be a good law-abiding citizen and financially self-supporting. Election of the county coroners by freeholders persisted from 1194 until 1888 at which time appointment was by the city councils.

The coroner's main duty was to serve the General Eyre by collecting records of matters that needed to be dealt with by the Eyre. If a person were found dead the coroner was notified and a jury gathered from the local hundred. The body was laid out, inspected by the jury under the direction of the coroner, evidence heard and the jury's verdict pronounced. If the verdict were murder or manslaughter the accused was held for trial and on subsequent conviction his property was seized by the coroner for the King. If the offender was absent the local populace would name him and set out after him, the "hue and cry". The coroner would declare such an offender an "outlaw" and again his lands and possessions were forfeited to the Crown. Outlawry formally existed in the UK until its abolition in 1938.

The most important role was in the investigation of deaths and this is the only role of the coroner to survive in WA today. This role was particularly important for it held great potential for filling the royal coffers. There was a strict protocol that needed to be followed in the event of a sudden death and any deviation from the procedure resulted in heavy fines for the people and villages involved. These fines were paid into the royal account. The more rules there were, the more the possibility a rule would not be adhered to with the resultant application of a fine and more money for the King. In Norman times a whole village could be fined if a Norman body were found in its district, this large fine being referred to as an "amercement". The penalty could be averted if there were "presentment of Englishry", that is, if the deceased could be proven to be English and not Norman. In summary, the coroner looked for every deviation from the rules to impose more fines and raise revenue for the King.

The coroner also had to confiscate and collect the "deodands", the instruments that had caused the death of a person. These could include swords, oxen, carts and later even steam engines. The coroner would assess the value of the object and collect the value in money.

If a dead body were discovered in your village you knew you would be in for a rigid and possibly very expensive investigation. Dragging the body to the next village was a sneaky way of avoiding the arduous coronial investigative process. The first person to discover the body had to inform others and that person remained responsible for the management of the body until the coroners arrived to inspect it. Any deviation from the rules and the person who discovered the body had to pay the appropriate fine. If the village decided not to inform the coroner, or buried the body prior to the arrival of

the coroner, the whole village would receive a heavy amercement. Of course, the bailiffs could always be bribed not to call the coroner – it could just be the cheaper option!

The coroner had no help from medical doctors until recent times and it was not until 1836 that he could pay a medical witness a fee. Before this, the coroner had to inspect the body himself looking for wounds, etc, and then hold an inquest into the death. The coroner's duty to inspect the body continued up until 1980.

Coroners performed many other interesting duties down through the ages. They witnessed trials by ordeal and trials by combat. Coroners also investigated the finding of "treasure troves", the discovery of "wrecks of the sea" and the catching of royal fish "the whale and the sturgeon". They also investigated fires, including non-fatal ones. A major consideration in all of these investigations was financial, designed to boost the coffers of the King.

The first coroner to be appointed in Western Australia was Mr W.S. Sams in 1830. He served in the role for 4 months and was replaced by Mr W. Graham who served as coroner for two years. From then on the role was filled by Justices of the Peace for 115 years until the appointment of the third coroner in 1947. The current State Coroner, Mr Alastair Hope, was appointed in 1996.

Prior to proclamation of the 1996 Act the Coronial System followed the Magisterial System and there were 9 clearly defined coronial districts, 8 country districts and Perth. Stipendiary Magistrates acted as ex-officio coroners.

In Western Australia the Coroners Act 1996 was proclaimed on 7 April 1997. Until that date the previous Coroners Act 1920 had applied unchanged for 76 years. This new Act totally revolutionised the practice of coronial work in WA. The Act resulted in the creation of the Office of State Coroner which had previously nor existed.

The Act also recognises the stress and trauma experienced by relatives and friends of a loved one who died suddenly and involves them in the decision making process. The 1996 Act involves relatives of the deceased persons in the coronial process to a far greater extent than previously was the case and 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. A brochure, "When a Person Dies Suddenly", has to be served upon the relative by a police officer who also has to explain the contents of the brochure to that person, which includes their right to object to a post mortem examination.

2. The Office of the State Coroner in WA

It is the role of the Coroners Court to speak for the dead to protect the living. The Coroner has a vital role to play as an independent judicial officer serving the Crown and the public. The Coronial System is essentially a fact finding system that should reflect commitment to the deceased, the community and the family of the deceased. The system seeks to be efficient, consistent throughout the State and compassionate and ever mindful of human distress and the need to preserve human dignity.

The Office of the State Coroner of Western Australian exists within the Department of the Attorney General.

In Western Australia there is a State Coroner and a Deputy State Coroner. In addition, there are magistrates around the state who, as well as fulfilling their usual duties, contemporaneously perform the role of a coroner. The Attorney General, on the recommendation of the State Coroner, may appoint a person to be a coroner, but that person must first be qualified to be a magistrate.

The Office of the State Coroner in WA is currently situated on the 10th floor of the Central Law Courts in Hay Street and comprises:

- The State Coroner, currently Ms Rosalinda Fogliani
- The Deputy State Coroner, currently Ms Evelyn Vicker
- Counsels Assisting
- Office Manager and Administrator
- Coroner's registrars
- Police officers who are coroners' investigators
- Counsellors
- Court officers
- Secretarial and support staff
- Medical Advisors

In addition, the State Coroner is supported by several Forensic Pathologists attached to PathWest who perform post mortem examinations at the State Mortuary situated at the QE II Medical Centre.

It is a function of coroners to investigate reportable deaths and a coroner must find, if possible,

- the identity of the deceased
- how death occurred
- the cause of death
- the particulars needed to register a death.

The functions of the State Coroner over and above these are:

- to ensure that the state coronial system is administered and operates efficiently;
- to oversee and coordinate coronial services;
- to ensure that all reportable deaths reported to a coroner are investigated;
- to ensure that an inquest is held whenever there is a duty to do so under the Coroners Act or whenever it is desirable that an inquest be held;
- to issue guidelines in accordance with the Act;
- to make comments with respect to death prevention in appropriate cases and thus perform a role in education of practitioners by highlighting and recommending improvements in practice which promote death prevention;
- such other functions as are conferred or imposed under the Act.

3. The Coroners Act 1996

The current Coroners Act was proclaimed in 1997. It is important that medical practitioners understand the basic principles of the Act, in particular, their responsibility to abide by the requirements of the Act. I shall attempt to summarise the important sections and parts of the Act that are relevant to medical practitioners.

The Act lays down the role and duties of the Coroner and consists of seven parts and sixty two sections as follows:

Part One: Preliminary

This first part deals largely with the interpretation and definition of terms. The most important definition for medical practitioners is that of a “*reportable death*” and all medical practitioners in Western Australia should be familiar with what constitutes a reportable death within the meaning of the Act.

The term “*reportable death*” means a Western Australian death –

- (a) that appears to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from injury;
- (b) that occurs during an anaesthetic;
- (c) that occurs as a result of an anaesthetic and is not due to natural causes;
- (d) that occurs in prescribed circumstances (*);
- (e) of a person who immediately before death was a person held in care (**);
- (f) that appears to have been caused or contributed to while the person was held in care:

- (g) that appears to have been caused or contributed to by any action of a member of the Police Force;
- (h) of a person whose identity is unknown;
- (i) that occurs in Western Australia where the cause of death has not been certified under section 44 of the *Births, Deaths and Marriages Registration Act 1998*;
- (j) that occurred outside Western Australia where the cause of death is not certified to by a person who, under the law in force in that place, is a legally qualified medical practitioner.

(*) In Western Australia there are no prescribed circumstances. "Prescribed circumstances" in this context refers to subsidiary legislation, ie, regulations. For example, a regulation could prescribe that all deaths following a particular operation or occurring in a particular institution would be reportable, in which case it would be subject to mandatory reporting.

(**) The term "person held in care" means a person held

- under the Child Welfare Act,
- in custody under the Prisons Act,
- by the police,
- in any centre under the Alcohol and Drug Authority Act 1974,
- as an involuntary patient or apprehended or detained within the meaning of the Mental Health Act 1996
- as a detainee under the Young Offenders Act 1994.

Thus, the most important issue in *Part One* for the medical practitioner is the need to be aware of what constitutes a reportable death and the statutory obligation to report that death to the Coroner.

Part Two: Coroner and Coroner's Court

This part of the Act defines the position and function of the Coroner, his Deputy, the Registrars, investigators and the counselling service incorporated within the Coroner's office.

Part Three: Reporting of deaths

This is an important part for medical practitioners and all doctors should be familiar with this part of the Act. It refers to the reporting of a "reportable death" as defined in Part One.

Section 17 of the Act is entitled "*Obligation to report death*" and requires all persons (including doctors) to:

“report a death that is or may be a reportable death to a coroner or member of the police force immediately after he or she becomes aware of the death, unless the person has reasonable grounds to believe that the death has already been reported”.

This part goes on to emphasize that a doctor present at or soon after the death of a person *“must report the death immediately”*.

- Failure to report a “reportable death” constitutes a breach of the law and penalties may be imposed for such a breach.

Section 18 of the Act states that any person who *“reports a death must give to the coroner investigating the death any information which may help the investigation”*.

During the investigation of a reportable death the coroner needs all the information he or she can get to help ascertain the circumstances leading up to the death and thus the cause of death. This often includes a request for medical notes and records from hospital and individual medical practitioners. It is in the best interests of medical practitioners to make these records available upon such request. If the notes are not made available a coroner can issue a warrant and send a police officer to seize the records from the doctor’s establishment or hospital (Section 33 of the Act) and/or summon the doctor to give oral evidence in court (Section 46 of the Act).

- There is a common misconception in the minds of some doctors that a death must be reported to the Coroner within 48 hours of an operation. There is nothing in the Coroners Act to this effect and the 48 hour issue in fact refers to event reporting to the Anaesthetic Mortality Committee whose brief is to *“investigate deaths which occur within 48 hours of the administration of an anaesthetic OR are considered to be due to the effects of an anesthetic...”*. The Coroners Act is concerned with circumstances surrounding death and is not constrained by times or other factors such as the age of the deceased.

Part Four: Investigation of deaths

This part of the Act deals with the coroner’s authority to investigate what is or may be a reportable death and to convey to the next of kin certain information. It deals with the coroner’s duties in respect of the deceased and next of kin, his powers of investigation and the duty of the State Coroner to report to the Attorney General annually. There are sections within this part dealing with post mortem examinations including applications for and objections to post mortems and exhumation.

Coroners are required to make findings in respect of all reportable deaths whether or not an inquest is held. It is important to note that most deaths are not inquested.

Of importance and relevance to medical practitioners is Section 25 (5) which states:

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

This provision clearly differentiates the task of the coroner from the role of civil and criminal courts which make determinations as to liability or guilt. The coroner's role, by contrast, is essentially a fact finding one.

Part Five: Inquests into deaths

This fifth part of the Act deals with the coroner's powers to inquest a death and associated matters including witness statements, penalties for disobeying a coroner's directive, record of evidence and restrictions on the publication of coronial reports.

An inquest or public hearing is only held in about 3% of cases.

Of importance to medical practitioners, Section 50 of the Act states that the coroner " may refer any evidence, information or matter which comes to the coroner's notice in carrying out the coroner's duties to a body having jurisdiction over a person carrying on a trade or profession if the evidence, information or matter

- (a) touches on the conduct of that person in relation to that trade or profession; and
- (b) is, in the opinion of the coroner, of such nature as might lead to the body to inquire into or take any other step in respect of the conduct apparently disclosed by the evidence, information or matter so referred."

This section thus gives the coroner the option of referring a matter involving management by a medical practitioner to the Medical Board of WA if he so decides. Although this section is written within Part 5 of the Act, it is clearly not limited to cases which are inquested and so it is possible for such a referral to be made without a public hearing if the statements and reports obtained during an investigation raise issues of professional competence, etc.

Part Six: Miscellaneous

This part of the Act deals with such issues as organ donation, protection of the Coroner from legal proceedings and reviews of the Act.

Part Seven: Repeal of Coroners Act 1920, amendment of certain other Acts and savings provision

This final part of the Act simply notes that this Act applies to deaths which occurred before the 1996 Act came into operation.

4. Terminology used in the Coronial Process

Pursuant to section 25 of the Coroners Act a coroner investigating a death must find how the death occurred. That answer is usually provided in a narrative form of findings in the Record of Investigation into Death. There are also a number of standardised conclusions which are used to form statistical analysis of death records more meaningful and these are otherwise referred to as "verdicts". The term verdict is based on the original verdict handed down by juries in the days when juries were used in inquest hearings. Thus coroners use a number of terms or verdicts when describing their conclusions concerning the nature of deaths. The causes of death fall into two groups, "natural" or "non-natural".

Natural causes

Natural cause deaths are deaths as a result of disease or bodily infirmity which are not the result of an external source.

Non-natural causes

Non-natural causes are all causes of death which are not natural. Non-natural deaths are further subdivided as follows:

Unlawful homicide

This finding covers the offences of murder, manslaughter, infanticide and the offence of dangerous driving causing death. The Act states that a coroner is not permitted to frame a finding in such a way as to suggest that a person is guilty of an offence, so this finding can only be made when a person has already been convicted of one these offences or where the fact of the offence is known but the identity of the offender is not known.

Lawful homicide

This finding covers deaths which would be justified or otherwise excused by law. Such examples would include deaths which occurred during the suppression of a riot, preventing a crime or lawful self-defence. A coroner would only be permitted to make such a finding based on an acquittal in a criminal court and it would be unusual for such a finding to be made.

Suicide

Suicide is the act of self destruction being an intentional act by a person knowing the probable consequences of what he or she is about. In WA there are between 250 and 300 deaths by suicide each year. This is the most

common non-natural cause of death. The counselling service within the Office of the State Coroner works with the families of those who died by suicide.

Misadventure

Misadventure has been described as applying to those circumstances when the death has occurred as a result of a lawful or unlawful intentional human act unforeseeably leading to death. This finding has also been used in circumstances where a person, in doing a lawful act and without any intention to injure, causes the death of another.

An example of misadventure would be when a nurse misread a doctor's order and administered an incorrect dose of a drug which resulted in death. Another would be death from asphyxiation resulting from a police officer restraining a prisoner. Other examples would be deaths unintentionally resulting from medical procedures such as coronary stenting, pleural aspiration and elective surgery.

It is sometimes difficult to draw a distinction between the concept of misadventure and the concept of accident. Misadventure, however, is directed to a case where a deliberate human act unexpectedly (from the point of view of the person performing the act) leads to a death.

Accident

A finding of accident is appropriate where a death is caused by an occurrence which could not have been reasonably foreseen. Accident is also applied to describe an unforeseen misfortune or mishap resulting in injury or harm which has a causal connection with the death. It implies the event was unlooked for and unexpected and includes such events as motor vehicle accidents, unintentional falls, drowning and electrocutions.

Open Finding

This finding is given where the evidence does not adequately disclose the means whereby the cause of death arose. Examples include a situation where the body is so decomposed that a precise cause of death is impossible to determine. Other examples include cases where there is doubt as to whether accident or suicide may have been the cause of death such as self medication overdose deaths when there is no suicide note and the evidence is otherwise equivocal as to whether the death was intended or not.

5. Obligations on Medical Practitioners

As stated above there are obligations on medical practitioners to abide by sections of this Act.

An important point to restate here is that the Coronial process is not adversarial and does not seek to determine questions of civil liability or to determine whether any person is guilty of any offence, but rather to investigate and discover facts.

The first obligation is to report a reportable death to the coroner or the Police Coronial Investigation Unit. This requires that all doctors are aware of what constitutes a reportable death. If the death is reportable under the Act, do not complete a death certificate. If a doctor is unsure whether the death should be a coroner's case or not, then I recommend that he or she rings the coroner's delegate to discuss the matter in hand. Often the death may not need to be reported and the coroner's delegate is always only too happy to assist the doctor in this matter. There is no provision on the death certificate to indicate whether the death has been reported to the coroner. Where discussion has taken place with the coroner's delegate the appropriate box on the death certificate may be "ticked" but the death will not be a coroner's case. If you have any doubt, ring and ask.

The current numbers to ring are:

- Police Coronial Investigation Unit (CIS) - 9267 5700 - 24 hours
- Coroner's delegate - 9425 2900 - office hours

An important point for medical practitioners to understand, particularly those in hospital practice, is that once the decision has been made to report the death to the Coroner, all evidence of medical intervention in the deceased must remain untouched. This means that all tubes, drips, lines, wires and other aspects of medical intervention must be left in situ in the body as these will be examined in detail by the forensic pathologist. In the case of children, the endotracheal tube may be cut off at the lips if there is to be a viewing of the body.

The second obligation on medical practitioners is in the provision of medical records to the Coroner. When asked to provide medical records it is better to provide them on request. The coroner has the power under the Coroner's Act to issue a warrant and, if necessary, seize medical records that are not provided on request.

Stillbirths

Investigation of a baby who is born dead, a stillbirth, does not come under the jurisdiction of the State Coroner. It must first be shown that the baby was born live for the coroner to be involved.

6. What Happens after Reporting

The number which the doctor calls puts the doctor through to either the coroner's delegate, currently either Mr Gary Cooper (Office Manager) or Mr David Dent (Registry Manager), or the Police Coronial Investigation Unit. The recipient of the call will discuss the matter with the doctor and then the decision is made as to whether this is a coroner's case or not, however, this can only be decided by the coroner's delegate and not the police who will defer to the delegate for a decision. If the case is not reportable then the doctor can sign the green "Medical Certificate of Cause of Death". If the death is deemed to be a reportable death, then following that notification the doctor need not do any more other than provide further information if so requested.

The police are then informed and police officers will usually go to the scene and make arrangements for the government contractor to collect and transfer the body to the State Mortuary at the QEII Medical Centre. The police fill out a Mortuary Admission Form or P98 which accompanies the body to the mortuary. The police then have to do three things.

1. They must obtain a formal identification of the body. This is often done at the scene of death or may occur later at the mortuary.
2. They must collect a certificate stating that life is extinct and this is usually filled out by an attending doctor, or a trained nurse or a paramedic ambulance officer and on occasion if the body is severely damaged and clearly dead, by a police officer.
3. The police must then serve a brochure called "When a Person Dies Suddenly" on the senior next of kin of the deceased. This satisfies sections 20 and 37 of the Coroners Act by informing the next of kin of the procedures to be followed from here on, as well as informing them of their right to object to a post mortem examination.

Objections to post mortem examinations

The family have a minimum of 24 hours or one working day in which to lodge an objection to a post mortem examination. This time can be extended in certain circumstances, for example when deaths occur in remote regions such as in the Kimberley. While every effort will be made to respond to objections made after this time and prior to autopsy, it may be too late if an objection is made after this time. From the time the police attend, the coroner has control over that body. Under the provisions of the Act the State Coroner may overrule an objection to a post mortem if it is felt the post mortem examination is essential to ascertaining the cause of death and especially in suspicious circumstances.

There is generally a right to appeal the decision of a coroner to the Supreme Court. In very suspicious circumstances, however, a coroner may order that a

post mortem examination be conducted immediately and in these cases an objection cannot be made.

Post mortem examinations

The post mortem examinations are performed by the forensic pathologists within a day or two and an interim written result is sent to the State Coroner's office that day with the pathologist's initial findings as to the cause of death. Tissue samples are taken and organs may be retained (eg brain) at the direction of the coroner. Organ retention is, however, relatively rare. Blood, urine and tissue samples are sent to the Chemistry Centre in Bentley for toxicological analysis. Organs are only retained at the direction of the coroner (or delegate) for specified periods.

The coronial counsellor will then contact the next of kin that day if possible and let them know the interim findings and also ascertain what the family would like done with any retained organs. Usually, retained organs are returned to the body for burial at the time of the funeral. Occasionally, the organs may be returned to the funeral director for separate burial later or even cremated at the State Mortuary.

Once the post mortem examination has been performed and all necessary samples taken for tests and analysis the body is released by the coroner back to the family through their chosen Funeral Director for burial.

On receipt of the post mortem report from the forensic pathologist a letter is sent to the family with the cause of death, if known.

If there is any doubt about the medical management of the patient or any suspicious issue that may have a link to the medical management, or if the coroner has received a letter of complaint from a relative or health industry staff member pertaining to the medical management of the deceased, the coroner may decide to investigate the case and may then seek the opinion of his medical advisor on the medical management of the deceased. The advisor will then ask the coroner to obtain the medical records of the deceased and go through them and formulate an opinion about the management, particularly whether it has been reasonable or not. Most doctors and hospitals comply with the coroner's request for records knowing that under law the coroner is able to access them. If the advisor is not sure about certain aspects of the medical management of the deceased the opinion of an outside specialist in the relevant area will be sought. Sometimes a full written report is sought from that independent specialist practitioner and in those circumstances copies of the records are transferred to that specialist.

Western Australia has five full-time forensic pathologists and one forensic neuropathologist. There are others practising in the forensic area including

an odontologist, anthropologist and chemists. The forensic pathologists perform several duties, one of which is carrying out the post mortem examinations on the deceased. These are done as soon as possible allowing for the prescribed time for relatives to object to such an examination. Following the post mortem examination the coroner's office is told the cause of death straight away when such an immediate cause can be found. Sometimes the cause is undetermined and is pending, awaiting the results of further tests such as histopathology, microbiology, neuropathology and toxicology. The forensic pathologists may also recommend to the State Coroner that further clinical specialist reports are required.

The forensic pathologist may also be called by the police to attend the scene of death in suspicious circumstances and deaths in custody

7. Cause of Death Certificate

When a person dies in circumstances that do not amount to a reportable death there is a need for a medical practitioner to sign the green "Medical Certificate of Cause of Death" certificate, which means the doctor must put a cause of death on the certificate. This is later checked by the Registrar of Births, Deaths and Marriages. If the doctor is unwilling or unable to sign a "Medical Certificate of Cause of Death", or if the death satisfies the criteria necessitating notification within the Coroners Act 1996, the medical practitioner should ring the coroner or coroner's delegate and say he or she is unable to sign the death certificate and wants to report the death.

If a "Medical Certificate of Cause of Death" is filled out inappropriately by a doctor and a reportable death is not reported to the coroner this error may be detected by the officer at the Registrar of Births, Deaths and Marriages who will duly inform the coroner. The medical practitioner will be contacted and asked to explain why the certificate was filled out and why the coroner was not informed. In most instances this is a simple oversight on the part of the doctor and is often due to the fact that he or she did not know what constituted a reportable death. Again, if you are in doubt as to whether your patient's death is reportable under the Act, don't hesitate to call and ask.

Medical Referees

Medical referees are a group of medical practitioners whose role is to review Death Certificates and Cremation Forms prior to cremation of the deceased. The medical referee is contacted by the funeral director and peruses the forms to ensure there is no impediment to cremation of the body. If there is any evidence that the death is reportable under the Act the funeral director must be informed and the matter referred to the coroner. This may result in further

inquiry and investigation such as a post mortem examination which may delay the funeral and cremation.

8. Inquests and Investigations

It is the coroner's duty to investigate all reportable deaths. Upon receipt of notification of a reportable death, and following review of the material provided by the police, forensic pathologist, the medical advisor and other specialist consultants and interested parties, the coroner may choose to investigate the death further by holding a public inquest, which is a hearing in Court. The decision to publicly inquest a death is at the discretion of the coroner, apart from deaths in care and custody which must be inquested. These inquests are held at the Coroner's Court in Perth or at local courts around the state and can run from 1-2 days to 2-3 weeks or longer depending on the complexity of the case. One of the main functions of an inquest is to provide some closure for the family of the deceased.

Although there are coronial findings in every reported case it is important to note that in the case of most reportable deaths an inquest is not held. In fact, only about 3% of reportable deaths go to inquest. In other cases findings are made by the coroner based on examination of the papers, statements and reports which have been obtained by the coroner.

Most written reports from doctors relate to deaths which will never be the subject of public inquest (which is 97% of the time). These reports are treated as private and confidential but sometimes these may be viewed by family members when the family makes a request to view the deceased relative's file. Sometimes the State Coroner and Deputy State Coroner will not permit the next of kin to view aspects of the deceased relative's file if the material contained therein is considered sensitive and a breach of confidence.

In some cases comprehensive reports from doctors may provide answers which avoid the need for a public inquest to be held and in other cases, where doctors and nursing staff have been unhelpful and questions remain unanswered, this has been a factor which has resulted in a decision to hold an inquest. Discretionary inquests are rarely held when the facts surrounding a death are clearly explained in written statements and reports.

During an inquest a medical practitioner may be summonsed to appear in the Coroners Court to give evidence. He or she may have been directly involved in the management of the deceased or may be called as independent expert witness.

The object of the inquest is to establish the cause of death and the events leading up to the death. It is not designed to incriminate the medical

practitioner. However, it is true to say that during a coronial inquest evidence may be obtained that does indicate inappropriate, less than acceptable or even negligent practice by a doctor or other person.

Not all relevant witnesses are required to give oral evidence at an inquest, particularly when witnesses have provided comprehensive statements or reports and their evidence is not in dispute or otherwise controversial. Their statements or reports may be received into evidence without the need for them to attend court. In fact in most inquests the evidence of a number of witnesses is received in this way.

Usually, any doctor who gives evidence at a coronial inquest does so under oath and is liable to be charged with perjury if found to have wilfully misled the court.

Following the inquest the coroner will deliberate and eventually present the findings in a written report. In this report the coroner describes in detail the events leading up to the death, the death itself and then gives the determined cause of death. In making that finding the coroner will use one of the standard terms listed in Chapter 3.

The coroner may also make recommendations directed towards prevention of further deaths occurring in similar circumstances in the future. This is an important aspect of inquests and evidence is often led, not only as to what went wrong in a particular case, but also as to how things could be improved in the future. Medical experts can often assist a coroner in making these recommendations by suggesting how such improvements could be made.

9. The Coronial Counselling Service

The Office of the State Coroner includes qualified psychologists and social workers. These counsellors are involved in four main areas:

1. *Providing information.* The counsellor must carefully gauge what they understand to be the relatives' level of understanding of the process leading up to, and mechanism of, their loved one's death. The counsellor will keep them informed of the coronial investigation process in respect of their deceased loved one. The investigation process may be quite protracted as several reports may have to be sought from various professionals before a clear understanding of the cause of death can be determined. The counsellors spend time explaining the progression of the investigation and ultimately the cause of death to the family and this is often done face to face at the office.

2. Counsellors liaise with families about issues relating to objections to post mortems and tissue retention.
3. *Counselling.* The coronial counsellors may provide some short term counselling to grieving families. When it is appropriate the counsellors may refer the relatives to government or private agencies for medium and longer term ongoing counselling. Their counselling role may involve face-to-face interviews in the coroner's office, telephone counselling or home-visit counselling with the family.
4. *Providing support.* The counsellor must be able to, in a sense, triage the families and quickly get a feel as to how much support is going to be required for a particular family. The presence of the counsellor provides comfort to the family and provides a major opportunity for clarification and understanding of the facts relating to the death of their loved one. A counsellor will be present at the time the next of kin are given the opportunity to peruse the coronial file pertaining to their deceased relative. The support role may involve being present with the family during viewings of the deceased's body at the State Mortuary. The counsellor also attends when the family meets with medical or other experts who were involved with the management of their deceased relative.

A significant factor in grief resolution for many relatives of the deceased is in understanding just how and why their loved one died. In the midst of grief it is easy for families to draw conclusions that may not accurately reflect what actually happened to their loved one and it is in this area that empathic and informative counselling plays a major role in the whole coronial investigative process.

10. Disaster Victim Investigation (DVI)

Disaster Victim Identification is the term that describes the procedures used to positively identify deceased victims of a multiple fatality event. Such an event may be an aeroplane crash, a major fire, a bombing or a natural disaster such as a tsunami or an earthquake. All victims of such a disaster must be identified to the satisfaction of a coroner. The State Coroner is the chair of the DVI Committee.

Identification of the deceased carries both moral and legal responsibilities. Due to the complex nature of DVI procedures a multidisciplinary team is involved including coronial staff, forensic pathologists and other medical and dental experts, police, counsellors, defence personnel, transport personnel and others.

There are five phases of operation in DVI.

1. *The Scene*. The scene of the disaster is treated much like a crime scene and photographically recorded. All remains are labelled and transported to the State Mortuary or other suitable location.
2. *Ante Mortem*. The coronial counsellors are involved in this phase. Information related to the missing persons is gathered and recorded on a yellow Interpol DVI form. This information is gathered from relatives, doctors, dentists and from personal belongings of the missing person who is suspected of having been involved in the disaster in question.
3. *Post Mortem*. This involves forensic identification and recording of the remains. Forensic details are recorded on a pink Interpol DVI form.
4. *Reconciliation*. The information on the Interpol DVI yellow and pink forms is compared and presented to experts who, under the direction of the DVI Commander, determine whether adequate identification can be made for presentation to the State Coroner or other coroner.
5. *Debriefing*. Operational debriefing concludes the process.

11. The Coronial Ethics Committee

Western Australia is the only state in Australia to have a statutory Coronial Ethics Committee. Various individuals and organisations may apply to the State Coroner for information from coronial records for the purposes of education or research. Such applications in WA are examined by the Ethics Committee for suitability and appropriateness before being submitted to the Coroner for final determination. While the Act also would enable the Ethics Committee to review applications for access to tissue for research purposes, in fact this does not happen because the requirements of the Coroner's Act are very stringent.

12. The National Coronial Information System (NCIS)

The National Coronial Information System (NCIS) is a national internet based coronial data storage and retrieval system and all states and territories provide information to that system. NCIS is based at and managed by the Victorian Institute of Forensic Medicine. All reported deaths in Australia since July 2000 are recorded in the system thus providing a large database of information. Certain approved research and government agencies can access this information which aids them in research and in the formulation of health and safety strategies. Coroners may also access this information to assist them in many ways, including identifying recurrent patterns of death related

hazards. For further information see their excellent website at www.vifp.monash.edu.au/ncis/.

13. Liaison with the Health Department of WA

The Coroner's Office has developed an excellent relationship with the Health Department's Office of Safety and Quality. Regular meetings are held between the coroner, his medical advisor and a specialist medical consultant working in the Office of Safety and Quality. Some of the medical advisor's reports and coronial findings are reviewed by this consultant and salient points related to certain aspects of medical management involved in the care of the deceased are synthesised by him into small de-identified case studies and regularly published as the "From Death We Learn" booklet which is then distributed to relevant clinical areas.

This highlights one of the major roles of the coronial process, namely, education. We all have to learn from our mistakes and we can all learn better ways of doing things. We continually learn things to do and things not to do and death, although an uncompromising teacher, can probably teach us better than anything. It is of great value to doctors to be able to read publications such as "From Death We Learn" and the findings of coronial inquests, which are public documents.

I trust this booklet has been of value and has helped medical practitioners and students in their understanding of the Coroner's Act, the role of the State Coroner and has given an insight into the coronial process.

The Coroner plays an important and too often unheralded role in both the health and legal systems of Western Australia. Good coronial practice helps distressed families resolve their grief by giving clear and accurate factual knowledge in a compassionate way. In addition, the coronial process is of great assistance to medical practitioners and hospitals and can help them modify their management and improve their outcomes.

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