Office Of the State Coroner

Annual Report

2007 – 2008

State Coroner Western Australia

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

Dear Minister

In accordance with Section 27 of the Coroners Act 1996 I hereby submit for your information and presentation to each House of Parliament the report of the Office of the State Coroner for the year ending 30 June, 2008.

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

Yours sincerely

Alastair Hope
STATE CORONER

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State Coroner's Overview

As a result of significant resourcing issues identified in the annual report for the Office of the State Coroner for the year 2006-07, the achievements of the Coroners Court were relatively limited and in a number of important areas the services provided to grieving family members were reduced.

In the context of the concerns expressed in that annual report, which was itself delayed, it was considered appropriate to delay the finalization of this report until the resourcing issues were addressed.

An important development occurred on 14 August 2009 when the Attorney General announced that an additional $822,000 in funding would be provided for the court. That funding will enable significant changes to take place in respect of services provided and will enable the court to address a number of outstanding cases of considerable complexity.

Unfortunately the funding is not recurrent and is subject to the outcome of an ongoing review being conducted by the Law Reform Commission into the jurisdiction and practices of the coronial system in Western Australia. In respect of additional staff this means that it is not possible to advertise permanent positions and that new staff will be retained on a short term basis.

The decision to provide additional funding, however, has been very much welcomed by all staff of the Coroner's Court and will enable important changes to take place in the near future. Of that sum approximately $622,000 will go to salaries and will provide for the first significant increase in staffing levels for over a decade.

While at present there is only an allocation of one position as counsel assisting, the new funding will enable two additional

counsel assisting to be appointed even if only on a temporary basis. With three counsel assisting addressing outstanding matters it will be possible to conclude a number of difficult and complex cases, some of which have been delayed for a substantial period of time.

Inquest hearings conducted by the Coroner's Court can sometimes require a significant input of resources, particularly from counsel assisting. The recent inquest into the death of Mr Ward who died on 27 January 2008 as a result of heat stroke which he suffered while in custody, being transported in the rear pod of a Mazda prisoner transport van, was one such case.

The additional funding will also enable the short term appointment of a Senior Court Counsellor which will increase the court's counselling service from two to three persons. This will enable the counselling service to provide significantly more assistance to grieving families than has been the case. It will enable counsellors to conduct more home visits to families who are unable to attend the office, to assist with some families at mortuary viewings and to conduct more face to face office visits.

The additional funding will also provide for increased access to a medical adviser. Over recent years an increasing number of extremely complex medical cases have been referred to the Coroner's Court for consideration, many of which are not inquested but require considerable expert input so that answers to family questions can be provided. The increased service provided by the medical adviser will also have important ongoing health implications. Medical information which is obtained as a result of investigation of these cases is provided to representatives of the Office of Safety and Quality with the Department of Health who ensure that lessons learnt are communicated to health professionals.

Additional positions funded will include a court officer to assist with brief preparation and other tasks associated with the court's functions and provision of a dedicated receptionist.

Other funding will be directed towards improving the court's limited computer system which will not only assist with file management but will, for the first time, enable the court to monitor trends in deaths throughout Western Australia. This will enable the court to better prioritise its own activities and also provide important information to other organisations and departments etc in respect to a number of health and safety issues. It will, for example, be possible to identify trends in suicide rates and to identify particular locations where problems exist without the present need to examine hard copy files.

In summary, therefore, while the years 2007-2008 and 2008-2009 have been frustrating in a number of ways and several important cases have not been adequately addressed, provision of additional funding, especially if that funding is to be continued on a recurrent basis, will enable the court to provide an enhanced service to grieving families and to the community of Western Australia.

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 2007 - 30 June 2008 a total of 2,341 deaths were referred to the Coroners Court. In 412 cases a death certificate was issued at an early stage and the body was not taken to the mortuary. In 160 of the remaining cases a death certificate was accepted after the body was taken to the mortuary, leaving a total of 1,769 cases to be completed by inquest or a finding based on statements and reports. Of the remaining cases, a total of 122 objections were made to the conducting of a post mortem examination.

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

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

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

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

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

Deaths Referred to the Coroners Court from 1 July 2007 - 31 December, 2007

	Jul	Aug	Sept	Oct	Nov	Dec	*Total*
Death Certificate issued although the body was admitted to the Mortuary	**18**	**17**	**5**	**17**	**21**	**14**	**92**
Immediate post mortem ordered (usually these are homicide cases)	**1**	**3**	**2**	**0**	**5**	**2**	**13**
No post mortem because body missing etc.	**1**	**2**	**0**	**0**	**01**	**1**	**4**
No objection to post mortem examination	**134**	**158**	**137**	**125**	**130**	**139**	**823**
Objection received by the Coroners Court	**17**	**14**	**11**	**11**	**9**	**15**	**67**
TOTAL NUMBER OF DEATHS	**161**	**194**	**155**	**153**	**165**	**171**	**999**

Developments in Cases where an Objection was initially received

	Jul	Aug	Sept	Oct	Nov	Dec	*Total*
Objection withdrawn prior to a ruling being given by a Coroner	**5**	**4**	**2**		**4**	**5**	**24**
Objection accepted by a Coroner and no post mortem ordered	**2**	**7**	**6**	**6**	**5**	**9**	**35**
Objection over-ruled by a Coroner	**0**	**3**	**3**	**1**	**0**	**1**	**8**
TOTAL	**7**	**14**	**11**	**11**	**9**	**15**	**67**

Deaths Referred to the Coroners Court from 1 January 2008 - 30 June 2008

	Jan	Feb	Mar	Apr	May	Jun	*Total*
Death Certificate issued although the body was admitted to the Mortuary	**14**	**6**	**12**	**12**	**13**	**11**	**68**
Immediate post mortem ordered (usually these are homicide cases)	**0**	**3**	**1**	**2**	**1**	**0**	**7**
No post mortem because body missing etc.	**2**	**1**	**0**	**0**	**0**	**0**	**3**
No objection to post mortem examination	**153**	**108**	**132**	**130**	**121**	**153**	**797**
Objection received by the Coroners Court	**11**	**4**	**13**	**8**	**9**	**10**	**55**
TOTAL NUMBER OF DEATHS	**180**	**122**	**158**	**152**	**144**	**174**	**930**

Developments in Cases where an Objection was initially received

	Jan	Feb	Mar	Apr	May	Jun	*Total*
Objection withdrawn prior to a ruling being given by a Coroner	**3**	**1**	**3**	**3**	**5**	**3**	**18**
Objection accepted by a Coroner and no post mortem ordered	**8**	**3**	**9**	**5**	**4**	**6**	**35**
Objection over-ruled by a Coroner	**0**	**0**	**1**	**0**	**0**	**1**	**2**
TOTAL	**11**	**4**	**14**	**8**	**9**	**9**	**55**

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 122 objections of which 42 were withdrawn prior to a ruling being given by a Coroner and 70 were accepted by a Coroner and no post mortem examinations were ordered. In only 10 cases where an objection had been received did a Coroner order that a post mortem examination should be conducted.

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

Counselling Service

The Coronial Counselling Service continued to operate but in a diminished capacity over the year, due to resourcing and staffing issues. There were three changes in one position within the counseling service and the remaining counselor was working alone for more than three months over the year.

As a consequence severe cutbacks were instigated and service was only provided to immediate family members of the deceased. Counselling was primarily provided on the telephone with minimal capacity for office and home counseling. Other relatives and friends of the deceased were assessed by telephone and referred to community agencies. All file viewings were ceased as were all community education and training commitments including Disaster Victim Identification team training seminars. The impact of these service cutbacks resulted in –

- limited coronial information to families, potentially exacerbating their grief and trauma reactions and impacting upon their recovery process; *and*
- greater pressure on community agencies many of whom do not have specialist grief and trauma counselors and minimal understanding of the coronial procedures.

The counseling service continued to liaise with families who exercised their right to oppose a post mortem examination to inform them of the process and the time delays involved as well as the consequence of no post mortem examination being conducted. During this period families are attempting to make important decisions at a particularly difficult time and information and support throughout this period is essential.

The issue of retention of organs as part of a post mortem examination has and will always prove to be a difficult issue for grieving families to deal with. The counseling service makes every effort to ensure that open and thorough communication takes place with families in relation to important issues such as funeral arrangements and disposal of retained tissue.

Unfortunately due to this workload and the absence of a second counselor for periods throughout the past year, any networking and liaison in country areas with community resources to assist in providing a more integrated support to families following sudden death was unable to be pursued. The counseling service does have continued contact with families by virtue of an 1800 number and can arrange file viewings with the support of local court staff in those towns where a coroner is based.

REFERRALS - CORONIAL COUNSELLING SERVICE
1 July, 2007 – 30 June, 2008
(based on the work of one counsellor)

Total New Contacts (including client self referrals, police and community agency)	Letters Sent For Offers of Service	Phone & Information Service
1,850	352	25 minutes for average call

Coronial Ethics Committee

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

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

Mrs Felicity Zempilas continued in her position as the Secretary of the Committee.

The members of the Committee were as follows:

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

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

Number of Projects Considered	Number of projects approved	Number of projects not approved
8	6	2

Counsel to Assist Coroners

Mrs Felicity Zempilas continued in her position as Counsel Assisting with ongoing responsibility for all deaths in police and prison custody as well as other more complex matters.

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

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

For a brief period Ms Sarah Linton re-joined the office as Counsel Assisting and at the time of writing Ms Catherine Fitzgerald is with the office working as Counsel Assisting on secondment from the Office of the Director of Public Prosecution.

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, 2007 - 30 JUNE, 2008

NAME	DATE OF DEATH	DATE OF INQUEST	NUMBER OF SITTING DAYS	CORONER	COURT SITTING	FINDING	DATE OF FINDING
**SCHLEICHER Frances Elizabeth	11/5/2004	17-19/7/2007	3	Deputy	Geraldton	Accident	19 July 2007
**CHUBBY Patsy	4/9/2005	24-26/7/2007	3	Deputy	Carnarvon	Natural Causes	27 July 2007
**GUYT Leendert	11/11/2003	31/7/2007-3/8/2007	4	Deputy	Bunbury	Accident	3 August 2007
STONEHOUSE Adrian Peter	1/6/05	7/8/2007	1	Deputy	Perth	Accident	16 August 2007
KENNEDY Edward Phillip	16/3/2006	8-10/8/2007 4-5/9/2007	5	State	Perth	Suicide	21 February 2008
**WEBB Ross Andrew	17/7/2005	23-24/8/2007	2	State	Northam	Open Finding	26 October 2007
**JONES Dwayne Michael	13/4/2000	7/5/2007 6-7/9/2007 11-13/9/2007	6	Deputy	Kalgoorlie And Perth	Accident	14 September 2007
**WATKINS William John	31/1/2006	17-19/9/2007 26-28/9/2007	6	State	Karratha And Perth	Self-Defence	28 September 2007
**HICK Lawrence	21/5/2005	17/9/2007	1	State	Karratha	Natural Causes	27 September 2007
**UNDABI Robert	25/2/2005	12/10/2007	1	State	Fitzroy Crossing	Natural Causes	14 January 2008
(*)**TRIMMER Billy	Between 18-19/10/2005	17/10/2007	1	State	Kununurra	Natural Causes	31 March 2008
EVANS Susan Denise	25/11/2004	27-28/11/2007	2	Deputy	Perth	Natural Causes	6 February 2008
WOODS Carl John	11/4/2006	10-19/10/2007	9	Deputy	Perth	Accident	28 November 2007

NAME	DATE OF DEATH	DATE OF INQUEST	NUMBER OF SITTING DAYS	CORONER	COURT SITTING	FINDING	DATE OF FINDING
**DAVIES				State	Perth	Adj sine die	
HAYWARD Nikkola	20/1/2006	5-7/12/2007	3	State	Perth	Unlawful Homicide	20 March 2008
**BENTLEY Cory Jay	1/5/2004	10-14/12/2007	4	Deputy	South Hedland	Accident	14 December 2007
*BIRNIE David John	7/10/2005	18-21/12/2007 16-17/4/2008	6	Deputy	Perth	Suicide	13 June 2008
**RILEY Edward	14/4/2005	4-5/10/2007	24	State	Derby/Perth	Suicide	25 February 2008
HENRY Rachel	25/12/2005				Derby/Perth	Suicide	
ATKINS Chad	12 /1/2006				Fitzroy/Perth	Natural Causes	
BEHARRELL Teddy	28/1/2004				Fitzroy/Perth	Accident	
BROWN Maitland	26-27/12/2006				Fitzroy/Perth	Suicide	
DICK Jonathon	18/10/2005				Fitzroy/Perth	Unlaw Homicide	
DAWSON Lloyd	18/10/2005				Fitzroy/Perth	Suicide	
DICKENS Benjie	26/5/2000				Fitzroy/Perth	Accident	
GEPP Ivan Barry	13-16/3/2000				Fitzroy/Perth	Accident	
HALE Owen	7/10/2005				Fitzroy/Perth	Open Finding	
LAUREL Ernest	18/11/2005				Fitzroy/Perth	Suicide	
MIDDLETON Joshua	14/2/2002				Fitzroy/Perth	Suicide	
MILLER William	16/4/2006				Fitzroy/Perth	Suicide	
OSCAR Gordon	11/10/2006				Fitzroy/Perth	Suicide	
SHAW Celeste	30/11/2006				Fitzroy/Perth	Suicide	
SURPRISE Shawn	15/4-21/5/2000				Fitzroy/Perth	Open Finding	
EDWARDS Davina	4/1/2005				Kunun/Perth	Suicide	
COX Nathalia	13/8/2005				Kunun/Perth	Suicide	
SAMPI Desley	4/4/2006				Broome/Perth	Suicide	
SAMPI Llewellyn	2/4/2007				Broome/Perth	Suicide	
O'SULLIVAN Troy	25/1/2006				Broome/Perth	Suicide	
YAMERA Zedrick	26/10/2006				Broome/Perth	Suicide	

NAME	DATE OF DEATH	DATE OF INQUEST	NUMBER OF SITTING DAYS	CORONER	COURT SITTING	FINDING	DATE OF FINDING
**JENNINGS Wayne	14/3/2005	17/1/2008 21-22/1/2008	3	Deputy	Kalgoorlie/Perth	Natural Causes	9 March 2008
*HENDERSON Gordon	3/9/2005	8/2/2008	1	State	Perth	Natural Causes	7 April 2008
*BROWN Robert Geoffrey	2/8/2006	8/2/2008	1	State	Perth	Natural Causes	7 April 2008
RINALDI Anne Lorraine	2/9/2002	8/2/2008	1	State	Perth	Unlawful Homicide	1 April 2008
*ZUPEC John	12 June 2006	8/2/2008	1	State	Perth	Natural Causes	1 April 2008
VALEROTTI Guiseppe	19/7/2005	19-21/2/2008	3	Deputy	Perth	Accident	7 March 2008
NIGHTINGALE Karl Jason	17/4/2006	10-14/3/2008 17-18/3/2008	6	Deputy	Perth	Accident	13 June 2008
McCABE Daniel	26/6/2005	8/2/2008	1	State	Perth	Natural Causes	11 April 2008
SULLIVAN Arlen	25/5/2995	14-16/5/2006	3	Deputy	Perth	Adj sine die	
STOCKDALE David Alan	31/3/2007	19/3/2008	1	State	Perth	Accident	9 April 2008
ANSTY Blake Andrew	22/7/2005	26-27/5/2008	2	Deputy	Perth	Natural Causes	6 May 2008
**HOSHINO Ryo	13/3/2006	10-13/3/2008	3	State	Perth	Accident	11/7/2008
ALMAZOOREI Sultan Salem Abdulla	28/6/2004					Accident	
IVICEVICH Damien Frane	17/9/2004					Accident	
IRVINE Lee David	26/11/2005					Accident	
TIEN Yick Min	10/1/2006					Accident	

NAME	DATE OF DEATH	DATE OF INQUEST	NUMBER OF SITTING DAYS	CORONER	COURT SITTING	FINDING	DATE OF FINDING
REX Alicia	12/12/2005	28/4/2008 – 2/5/2008 12-13/6/2008	7	State	Kununurra And Perth	Suicide	18 July 2008
ALBERTS Esmay	16/4/2005						
FARRER Boyd Lyle	27.3.2005						
MITCHELL Paul	4/3/2006						
TAYLOR Patrick	3/4/2006						
STEWART Tanya Maree	13/7/2006	8-10/4/2008	3	State	Perth	Suicide	10 June 2008
KIDNER Ronald Gregory	25/10/2004	8-9/5/2008 20/5/2008	3	Deputy	Karratha and Perth	Accident	28 July 2008
ROLPH Daniel Paul	11/1/2007	27-30/5/2008 3-6/6/2008	8	State	Perth	Self-defence	7 July 2008
SLATER Kirsty Anne	19/4/2006	26-27/6/2008	2	State	Perth	Open Finding	7 July 2008
REGAN James Martin	3/4/2004	27-28/5/2008 16-20/6/2008	7	Deputy	Tom Price and Perth	Adj sine die	
THUBEAVILLE Bridgette	2/11/2005	17/6/2008	1	Deputy	Perth	Adj sine die	

Mr Hope heard 20 Inquests 73 sitting days
Ms Vicker heard 17 Inquests 66 sitting days

6 Prison Deaths In Custody conducted
17 Country deaths conducted by the State Coroner and Deputy State Coroner

Total Inquests heard 37
Number of Sitting Days 139

* Death In Custody (DIC)

** Country death

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

Leendert Guyt

The inquest into the death of Leendert Guyt was held at the Bunbury Court House on 31 July – 3 August 2007 and the findings delivered by the Deputy State Coroner on 3 August 2007.

Leendert Guyt (the deceased) was 43 years of age. On 5 December 2002 the deceased was involved in a boating accident while he was crayfish diving. In the accident the deceased incurred severe injuries from which he never recovered. He was wheelchair bound, blind in his left eye, unable to talk, or eat and suffered seizures. By November 2003 he was cared for at home by his wife. On 11 November 2003 he collapsed when attempting to manoeuvre from his wheelchair into the family car. He was transferred to hospital but could not be revived.

A post mortem examination was carried out by Dr Karin Margolius, Pathologist on 13 November 2003. Dr Margolius found the deceased had a large thrombus occluding the femoral and iliac veins on the right. A large thrombus had gone into the pulmonary arterial supply obstructing the supply to both lungs. She also noted old cerebral necrosis from the original injury.

At the conclusion of the post mortem examination Dr Margolius determined the cause of death to be Pulmonary Thromboembolism due to right Pelvic (Ilio-femoral) Vein thrombosis.

The Deputy State Coroner was satisfied that the deceased died on 11 November 2003 as the result of complications from injuries he received from a boating accident on 5 December 2002.

The Deputy State Coroner was further satisfied the deceased and his dive partner where experienced divers and were diving using hookah equipment with regard to the applicable regulations. Their boat was displaying a diving flag and there is no evidence it was not seen by other vessels in the area.

The Deputy State Coroner was further satisfied that whilst diving a problem arose which caused the deceased to approach the surface of the ocean in the vicinity in which they were then diving. The air hose they were using was 100-metres in length with an additional 15-metres to each regulator. This was a considerable distance outside a 50-metre radius from the dive flag located in their boat. It is obvious while the deceased approached the surface he was unaware of the imminent approach of a vessel and was struck in the head, dislodging his regulator, and injuring him severely. There is no indication as to the reason why the deceased was so close to the surface.

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

The Deputy State Coroner made recommendations with respect to recreational divers to recognise there are risks to safety in the following terms -

> "I recommend DPI revisit regulation 19E of the Navigable Waters Regulation to –
>
> (a) determine whether or not it is practicable to extend the zone
>
> (b) consider whether or not the wording ought to more closely reflect the International Convention with respect to **''safe speed and caution''** while recognising this is open to interpretation especially where offences are considered.
>
> (c) consider effective ways to educate and remind recreational boat users of the very dire consequences for a diver if stuck by a vessel even at very slow speeds."

In a letter received for the Minister for Planning and Infrastructure dated 31 March 2008 the Minister advised of the steps taken by the Department to address Regulation 19E of the Navigable Waters Regulations as follows –

> *"Recommendation (a)*
> *Following consultation by DPI officers with professional diving operators and instructors, considering the comments of the Deputy State Coroner with regard to the appropriateness of the 50 metre zone and a review of the findings of the Task Force into Diving Safety, it has been determined that an extension of the zone to 100 metres is impractical; it would not be possible to enforce and it would render large areas of Western Australian waters (e.g. channels at Rottnest) inaccessible to vessels.*
>
> *Recommendation (b)*
> *A number of proposed amendments to Regulation 19E of the Navigable Waters Regulations are currently being processed. These amendments have the effect of more closely aligning the Regulation with the meaning and intent of the use of Code Flag A as described in the International Code of Signals and the concept of safe speed in Rule 6 of the International Regulations for the Prevention of Collisions at sea (adopted by the Western Australian Marine Act 1982) providing for more clarity in application and interpretation.*
>
> *Recommendation (c)*
> *The DPI currently has an effective public education program involving the use of mobile displays and participation on public boating related*

events such as Boat Shows. The displays are being modified to place a greater emphasis on diver/boating safety.

The Recreation Skippers Ticket Workbook, an intrinsic part of the successful Recreational Skippers Ticket campaign to educate and train recreational boaters, is to be amended to also emphasise boater/diving safety matters, including the use of warning flags, safe speed and lookouts.

Consideration is also being given to the development of a heightened diver safety awareness campaign to coincide with the start of the summer boating season".

Adrian Peter Stonehouse

The inquest into the death of Adrian Peter Stonehouse was held at the Perth Coroners Court on 7 August 2007 and the findings delivered by the Deputy State Coroner on 16 August 2007.

Adrian Peter Stonehouse was a happy, healthy, active 23-month old toddler who was born on 2 July 2003. He lived with his parents. Adrian had been put to bed on the evening of 31 May 2005 and later checked by his mother before she went to bed. He appeared to be sleeping soundly. On the morning of 1 June 2005 when his mother went into his room to find him at approximately 8:00 o'clock in the morning she found him lying underneath the toppled chest of drawers. He was unresponsive, not breathing and cold to touch. His mother immediately rang for an ambulance and commenced CPR until he could be taken to hospital. Unfortunately, Adrian could not be revived.

The chest of drawers in Adrian's room had been made in 2003 and purchased locally by his mother. It was made of pine and had five drawer units, the top drawer space being divided into two smaller drawers and the bottom drawer having a larger capacity than those in the middle. The unit stood 1.2-metres high and was 1.00-metre in width. The chest of drawer unit looks perfectly stable when all the drawers are closed, however, investigations indicated when some or all of the drawers are extended it can become very unstable.

A post mortem examination was conducted by Dr Gerard Cadden on 2 June 2005. Dr Cadden found the cause of death to be consistent with mechanical asphyxia.

Police attending at Adrian's home determined Adrian had attempted to climb the chest of drawers by pulling out the bottom drawer and standing in it, which caused it to become unstable and fall onto him, pinning him to the floor, compressing his chest and lungs.

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

The Deputy State Coroner noted that in July 2000 the State Coroner held an inquest into the death of a three-year-old child as a result of crush asphyxiation and that the circumstances of that particular death were similar to the death of the deceased. In that inquest the State Coroner made a number of recommendations.

The Deputy State Coroner found that in the death of the deceased and the previous child were accidents as a result of a stable, when steady, chest of drawers toppling onto a child when the stability is affected by the child doing perfectly normal child like things. In this context the Deputy State Coroner made the following recommendation –

> "I recommend – Department of Consumer and Employment Protection Retail and Services branch work with:-
> (i) retail groups to encourage their manufactures to provide specific safety advice with respect to individual items of furniture, and
> (ii) consumer groups to put pressure on retailers to be aware of safety issues and ensure manufactures indicate safe options for domestic furniture use".

A response was received from the Minister for Consumer Protection dated 26 September 2007 in which the Minister advised the following advice had been sought from the Consumer Protection about actions they have taken to ensure that the public are well informed of the potential dangers of products such as chests of drawers –

"I am informed that on 5 September 2007 a representative from Consumer Protection attended the Standards Australia Residential and Commercial Furniture Standards Committee (RCFS Committee) in Launceston, Tasmania. The RCFS Committee agreed at this meeting to develop an Australian Standard (the Standard) that will provide guidance to the furniture industry for stability testing of storage furniture to prevent the furniture being toppled by children up to age five years. The Standard's scope will in the first instance, cover chests of drawers, bookshelves and wardrobes.

If an item of furniture fails the Standard, then it will be considered intrinsically unsafe and the Standard will include a further requirement for the provision of informative labelling and/or affixing devices to assist consumers in stabilising the furniture.

This Standard will be voluntary and, provided the RCFS Committee agree, it should be introduced in November 2007. The Standard will require rigorous testing for suitability and practicality prior to being introduced.

As Consumer Protection considers the matter to be of national importance, it will seek support from the Commonwealth and other State and Territory

jurisdictions to develop a national mandatory regulation based on the voluntary Australian Standard once it is introduced.

In April 2007, the Australian Competition and Consumer Commission (ACCC) agreed to consider other strategies to raise public awareness about the dangers associated with household furniture such as chests of drawers. They agreed that strategies could include issuing a safety brochure to furniture retailers and manufacturers for distribution to customers. To date the ACCC has not taken any action with regards to this issue. Consumer Protection will seek an urgent commitment from the ACCC to progress this matter. Should the ACCC be reluctant to prioritise this issue, Consumer Protection will take responsibility and undertake this task".

22 Kimberley Deaths

The inquest into the deaths of Edward John RILEY, Rachael HENRY, Chad ATKINS, Teddy BEHARRAL, Maitland BROWN, Jonathon DICK, Lloyd DAWSON, Benjie DICKENS, Ivan Barry GEPP, Owen Gordon Jonathan HALE, Ernest James LAUREL, Joshua MIDDLETON, William Robert MILLER, Gordon OSCAR, Celeste Antoinette SHAW, Shawn SURPRISE, Davina Kaye EDWARDS, Nathalia Maree COX, Desley SAMPI, Llewellyn SAMPI, Troy James O'SULLIVAN, Zedrick YAMERA, with an inquest held at Derby on 4-5 October 2007, Fitzroy Crossing on 8-12 October 2007, Kununurra on 15-16 October 2007, Broome on 12-23 November 2007 and Perth on 7, 18 and 21 December 2007 and 16-17 January 2008 before the State Coroner and which was delivered on 25 February 2008.

These 22 deaths were inquested in one inquest pursuant to section 40 of the *Coroners Act 1996*. The inquest was held to explore the reasons for a large number of deaths of Aboriginal persons in the Kimberley whose deaths appeared to have been caused or contributed to by alcohol abuse or cannabis use and also, if possible, to identify reasons for an alarming increase in suicide rates.

The suicide rates of Aboriginal people in the Kimberley increased dramatically in 2006. In that year there were 21 Aboriginal self-harm deaths in the Kimberley (an increase of over 100%). By contrast in the non-Aboriginal Kimberley population there was no increase and there were only 3 deaths by self-harm for a larger total population.

The Aboriginal suicide rates for the Fitzroy Crossing region were particularly bad with 8 self-harm deaths in 2006 in a population of about 3,500.

During the inquest a number of Aboriginal remote communities were visited, particularly in the Fitzroy Crossing area. Inquest hearings took place in Broome, Derby, Fitzroy Crossing and Kununurra and in each of

those locations witnesses spoke about living conditions in nearby communities and some more remote communities.

It was clear that the living conditions for many Aboriginal people in the Kimberley were appallingly bad. The plight of the little children was especially pathetic and for many of these the future appears bleak. Many already suffer from foetal alcohol syndrome and unless major changes occur most will fail to obtain a basic education, most will never be employed and, from a medical perspective, they are likely to suffer poorer health and die younger than other Western Australians. In this context the very high suicide rates for young Kimberley Aboriginal persons were readily explicable.

Evidence at the inquest revealed that there is no real leadership or coordination in the response to the disaster of Aboriginal living conditions in the Kimberley on the part of either the State or Commonwealth governments.

The evidence also revealed a lack of accountability in the response.

In addition to Commonwealth funding, the State is providing $1.2 billion each year for services and programs targeted to indigenous people in Western Australia which is allocated to 22 government agencies under 16 Ministers. In spite of this allocation of funding conditions are getting even worse for Aboriginal people in the Kimberley and the gap between the well-being of Aboriginal and non-Aboriginal people is now a “vast gulf”.

The system, which has applied $1.2 billion or thereabouts each year for Aboriginal people and has achieved the results described in these reasons, is clearly seriously flawed. In spite of the lack of results, it appears that no individual or organisation in government has been monitoring the performance of the various government agencies and that no identified individual or organisation has been held responsible for achieving improved outcomes for Aboriginal people.

The Department of Indigenous Affairs is not, and never has been, capable of providing leadership in addressing the major problems facing Aboriginal people in the Kimberley.

The Department of Child Protection acts in a reactive rather than a proactive way and does not have sufficient staff to provide comprehensive child protection throughout the Kimberley.

The level of education attained by Aboriginal students in the Kimberley generally and the Fitzroy Crossing region in particular is pathetically low. The majority of Aboriginal children in the Kimberley do not attain a standard of education which would provide them with basic skills sufficient to obtain meaningful employment.

Much of the existing public housing in which Aboriginal people in the Kimberley live is in a disgraceful condition and until recently there was no system in place to ensure that the housing would be maintained or even monitored. There is now in place such a system which has identified a need for 1,000 houses to be constructed for remote Aboriginal communities in the state.

Alcohol abuse is both a cause and a result of many other problems for Aboriginal people living in the Kimberley. Of the many problems faced by Kimberley Aboriginal people, the problems associated with alcohol abuse are the most obvious and most pervasive.

Aboriginal people in the Kimberley are experiencing a health crisis.

There are serious challenges being faced by the Kimberley Mental Health and Drug Service and it is extremely difficult to provide comprehensive mental health and drug and alcohol care in the Kimberley Region. There is no secure mental health facility in the Kimberley and, as a result, severely ill Aboriginal patients must be sent to Perth for treatment in circumstances which are extremely upsetting for the patients and require considerable resources in effecting the transfers.

The State Coroner's reasons attempt to address the above issues as well as the effectiveness of the system of Community Development and Employment Projects (CDEP) program which pays for work done by unemployed people in remote communities and the recent positive action taken to increase the police presence in remote locations through multi-function police facilities.

27 Recommendations were made suggesting a range of actions which could be taken to address these issues.

These Recommendations have been provided to the relevant Federal and State Ministers. At the time of publishing this annual report the following Minister's Offices had responded as follows –

The Hon Jenny Macklin MP, Minister for Families, Housing, Community services and Indigenous Affairs who wrote to the State Coroner on 12 May 2008 in the following terms –

"Thank you for your letter of 26 February 2008 enclosing the copy of the Record of Investigation into the deaths of 22 Aboriginal persons in the Kimberley region.

Thank you for the work you have undertaken in preparing this valuable report which has, once again, highlighted the extreme disadvantage of many Indigenous people in remote areas of this country. As you would be aware, I

have announced that, in response to Recommendation 11 and 20 of your report, the Australian and West Australian governments will partner to deliver a trial of income management and improve parenting skills in selected Western Australian communities, including in the Kimberley.

This trial will form part of the Australian Government's larger project of Closing the Gap on Indigenous disadvantage by meeting the targets discussed by the Prime Minister in his apology given on 13 February 2008 and the statement of intent signed at the Indigenous Health Equality Summit on 20 March 2008. These targets are –

- *closing the 17 year life expectancy gap by 2030;*
- *halving the gap in mortality rates between Indigenous and non-Indigenous children under five within a decade; and*
- *halving the gap in reading, writing and numeracy achievement within a decade.*
- *halving employment outcomes between Indigenous and non-Indigenous Australians within the next decade; and*
- *over the next five years, every Indigenous four-year-old in a remote Aboriginal community will be enrolled and attending an early childhood education centres and engaged in proper pre-literacy and pre-numeracy programs.*

Achieving sustained progress in Indigenous outcomes is a complex and challenging task. We will direct our polices and programs at a specific set of measurable goals and will work co-operatively with Indigenous people to enlist their active support and commitment.

The Australian Government, in collaboration with state and territory governments will be meeting these targets by following a 'building blocks' approach. They focus on –

- *Safety and Freedom from Violence*
- *Early Childhood Development Interventions*
- *Education and Supporting School Attendance*
- *Health Home Environment*
- *Access to Primary Health Services*
- *Economic Participation and Active Welfare*
- *Leadership and Governance*

In addition, the Council of Australian Governments (COAG), and particularly the COAG Working Group on Indigenous Reform that I chair, will work to identify overlap and duplication between the Commonwealth and States and ensure that the new Commonwealth/State agreements in health, schools and housing contain specific targets for Indigenous Australians. The Working Group will also identify further joint reforms in the building block areas identified above. And where specific needs might sit outside the general Commonwealth/State funding agreements, there exists the possible opportunity to address particular

issues through the new National Partnership agreements currently being developed through COAG.

The Prime Minister has also proposed a bipartisan Joint Policy Commission to be led by him and the Leader of the Opposition. This announcement was part of the Government's historic apology to Australia's Indigenous people on 13 February 2008. The mandate of the Joint Policy Commission is to develop and implement an effective housing strategy for remote communities over the next five years. The mandate of the Joint Policy Commission is to develop and implement an effective housing strategy for remote communities over the next five years. The Prime Minister is in discussion with Dr Nelson on the formation, structure and operations of the Joint Commission.

Once again, thank you for your contribution to identifying and addressing this important issue".

The Minister for Indigenous Affairs, Hon Michelle Roberts MLA, wrote to the State Coroner by letter on 3 April 2008 in the following terms –

"Thank you for your letter of 26 February 2008, attached a copy of the Record of Investigation into Death.

Following the release of your report on 25 February, I instructed my Department to convene an out-of-session meeting of the Directors General Group on Indigenous Affairs to ensure an immediate, collaborative and appropriate response to the findings across the public sector. As you are aware, many of the issues that you raise in your report require long-term strategies that build upon the work that the State Government is already undertaking in the Kimberley.

I have instructed the Directors General Group to provide regular progress reports on the development of a strategic response to your report to the Cabinet Standing Committee on Indigenous Affairs. This response, which will be led by the Department of Indigenous Affairs, will be based on three key platforms: government leadership and accountability, engagement of Indigenous people in sustainable solutions, and a strong partnership between all levels of government. The response will also recognise the joint responsibility of the State Government and Indigenous Western Australians in securing positive outcomes.

I take this opportunity to commend you and your staff for the important work that you have undertaken and for the contribution that you have made to improving the lives of Indigenous Western Australians".

The State Coroner received a letter from Mr Terry Murphy, Director General, Department for Child Protection, dated 26 May 2008 in which Mr Murphy advised the following –

"On 13 May 2008, the Premier, the Hon Alan Carpenter and the Australian Government Minister for Families, Housing, Community Services and Indigenous Affairs (FaHCSIA), the Hon Jenny Macklin MP, announced Compulsory Income Management (CIM) as a child protection measure.

CIM is one of the strategies aimed at addressing child neglect in the National Child Protection Framework, which is being developed by the Australian Government in consultation with States and Territories child protection agencies.

The Department and the Australian Government's National and State Office of FaHCSIA and Centrelink are working towards a staged implementation of CIM, as a child protection measure in Western Australia from July 2008. Subject to all necessary processes being in place, there will be a staged roll-out, commencing in the East Kimberley District and the metropolitan district of Cannington, followed by the West Kimberley District.

Under this measure, the Department for Child Protection will have the authority to make a referral to Centrelink to manage a family's government payments (such as Newstart, Family Tax Benefit and the Baby Bonus) where children are being neglected. Arrangement will be made for essential expenses to be paid from the person's income management account. There will also be a debit card for use for food, clothing and fuel. People will have access to the portion of their income support payment that is not income managed. Under CIM, a person's welfare payments will not be reduced; instead, payments will be redirected to priority needs. Up to 70 percent of a person's income can be managed.

The Western Australian model in a case management approach used by the Department where children are being neglected. The model is being developed with appropriate financial and other support services, as well as checks and appeal processes, to ensure people are not unfairly disadvantaged".

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.

The following chart details the outstanding position in respect of all deaths in care 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
14/9/04	13-15 & 20-22/6/2007	**MOURISH** Jack Richard	Prison	Hakea Prison	Natural Causes
21/5/05	17/9/2007	**HICKS** Lawrence	Prison	Nickol Bay Hospital Karratha	Natural Causes
10/7/05		**WHEELOCK** Laurence Noel	Prison Parole	Carnarvon	
3/9/05	8/2/2008	**HENDERSON** Gordon James	Prison	Casuarina Prison	Natural Causes
8/9/2005	16/1/2007	**GARTSIDE** Andrew	Police	Berrigan Drive Jandakot	Accident
7/10/05	21/12/2007 16-17/4/2008	**BIRNIE** David John	Prison	Casuarina Prison	Suicide
19/10/05	17/10/2007	**TRIMMER** Billy	Prison	Wyndham Work Camp	Natural Causes
20/1/2006	5-7/12/2007	**HAYWARD** Nikkola Tara	Police	William Street Beckenham	Unlawful Homicide
11/4/2006	10-19/10/2007	**WOODS** Carl John	Police	Parmelia	Accident
17/4/2006	17-18/3/2008	**NIGHTINGALE** Karl Jason	Police	Dixon Road Rockingham	Accident
1/5/2006	16/7/2008	**PARRE** Donald Edwin	Prison	Albany Regional	Adjourned sine die
19/5/2006	9-24/7/2008	**ROCHFORD** Simon	Prison	Albany Regional	Adjourned sine die
12/6/2006	8/2/2008	**ZUPEC** John	Karnet Prison	Fremantle Hospital	Natural Causes
14/7/2006	8-10/4/2008	**STEWART** Tanya Maree	Police	At her home in Girrawheen	Suicide
2/8/2006	8/2/2008	**BROWN** Robert	Prison	Bethesda Hospital	Natural Causes
8/9/2006		**HANSON** Colin	Police	In police presence Kalgoorlie	
17/9/2006		**WRIGHT** Ryan	Police	In police presence Nollamara	
3/12/2006		**BRIGGS** Lenny Mark	Prison	Casuarina Prison	
27/4/07		**NUNDLE** Lee James	Prison	Wooroloo	
21/6/2007		**VOJINOVIC** Slavko	Police	Police chase Armadale	
26/7/2007		**McDONALD** Charles	Prison	Hakea Prison	
14/8/2007		**CONWAY** Mark	Police	Sally Port Fremantle Police Station	
26/8/2007		**GALLOP** Benjamin	Police	Bush track Boulder	
18/8/2007		**LOVELESS** Simon	Prison	Roebourne Regional Prison	
27/1/2008		**WARD** Ian	Prison	Transported in Prison van	
28/4/2008		**BRENNAN** Declan	Prison	Acacia Prison	
15/6/2008		**GARDINER** Terrence	Prison	RPH	
1/6/2008		**NJAMME** Dennis	Prison	Greenough Regional Prison	

Inquests – Deaths In Care – Department for Corrective Services

During the year 7 Inquests were conducted into the deaths of persons who died while in the custody of the Department for Corrective Services.

Jack Richard Mourish

The inquest into the death of Jack Richard Mourish was held at the Perth Coroners Court on 13-14 June and 20-22 June 2007 and the findings delivered by the State Coroner on 6 July 2007.

Jack Richard Mourish (the deceased) was a sentenced prisoner housed at Hakea Prison, Nicholson Road, Canning Vale who died on 14 September 2004 at the age of 37 years.

The deceased had been kicking a football with another prisoner when at about 4pm he collapsed.

Shortly afterwards resuscitation attempts were commenced and an ambulance was called for. Resuscitation efforts ceased at about 5pm.

A post mortem examination was conducted on the body of the deceased on 17 September 2004 by forensic pathologist Dr G A Cadden who concluded that the cause of death was ischaemic heart disease. In a brief explanation of his findings Dr Cadden noted that severe heart disease was apparent with hardening and narrowing of the vessels supplying the heart being very evident. Extensive scarring of the heart muscle was also evident.

Toxicology analysis of blood taken from the deceased revealed that he had recently consumed cannabis. It was also determined that he had taken buprenorphine (also marketed as Subutex) which had not been prescribed for him.

According to prisoners who gave evidence at the inquest, Subutex was readily available within the prison and was considered by prisoners to be a form of “cheap heroin”.

At the time when resuscitation efforts were being made following the collapse of the deceased, a prisoner warned those involved that the deceased had recently taken Subutex. This prisoner subsequently made admissions that he had injected the deceased with the Subutex prior to his death.

Following the death, a search was conducted and police officers located a syringe wrapped in tissue paper under a mattress. The syringe was

seized and forwarded to the Chemistry Centre of Western Australia for analysis. The result of the analysis revealed traces of buprenorphine (Subutex) and methylamphetamine.

On the morning of 15 September 2004 police forensic officers searched the deceased's cell where they located three half tablets which were after analysis identified as mohexal. This medication was not prescribed for use by the deceased.

In addition, in the blood of the deceased taken at post mortem, diazepam and desmethyldiazempam were found. Diazepam was not prescribed for use by the deceased.

As the deceased was a sentenced prisoner who had regularly been in prison (he had twenty-two previous adult admissions to prison recorded in his records), it was important to review his medical treatment while in prison.

In the context of the deceased's obvious access to drugs at the time of his death it was also necessary for the State Coroner to review the circumstances in which he had access to illicit drugs and medications not prescribed for him while in prison.

The State Coroner noted that there was an extensive family history of heart disease and he concluded Coroner concluded that the deceased had suffered from very serious heart disease for a number of years prior to his death.

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

The State Coroner noted that since the disbanding of the Police Prison Unit the Department of Corrective Services had been experiencing difficulties in encouraging WA Police to take an active role in intercepting drugs and charging offenders.

The State Coroner also noted that a perceived factor in the relatively low priority apparently given to this issue by WA Police was the fact that the quantities of drugs involved were relatively small and so any penalties imposed on offenders would be relatively light. He expressed the view that supplying drugs to prisoners was a serious offence even when quantities involved are relatively small.

In this context the State Coroner made Recommendations 1 and 2 which were directed to the WA Police Service.

Recommendation No. 1

I recommend that WA Police review the priorities presently allocated to strategies designed to prevent the supplying of drugs

into prisons and work with the Department of Corrective Services with a view to playing an important role in apprehending and prosecuting offenders bringing drugs into prisons so as to reduce this endemic problem.

Recommendation No. 2

I recommend that consideration should be given to amending the Misuse of Drugs Act 1981 –

- so as to provide that a person in possession of a prohibited drug or plant in the carpark of a prison should be presumed to have the intention of selling or supplying that prohibited drug to a prisoner; and
- providing that it should be a circumstance of aggravation to a crime of supplying a prohibited drug or prohibited plant when the recipient of the drug or plant is at the time in custody.

The State Coroner received a letter dated 6 July 2007 from Superintendent Jeff Byleveld APM, Of the Major Crime Division, who responded to the State Coroner's recommendations in the following terms -

"The Prison Unit was formed on 1 November 1999 as an agency response to address the issue of "Deaths in Custody" and proactively included in their "Charter of Responsibility" the following areas –

- *State-wide investigation of all deaths in custody of sentenced and remand prisoners;*
- *Investigation of serious criminal offences within prisons;*
- *Management/co-ordination of investigations into riots within prisons;*
- *State-wide investigation/co-ordination of all escapes of sentenced and remand prisoners;*
- *Investigation of organized drug supply within prisons;*
- *Investigation into defined serious criminal activity/corruption by Ministry of Justice personnel, agents and contractors within prisons;*
- *Gathering of intelligence from within the prison system, dissemination and sharing of such information to appropriate parties;*
- *Co-ordinate the response of other WA Police specialist services and resources, when required.*

...

A review of the Major Crime Division in 2004 determined there was considerable duplicity of service and resulted in the Prison unit being devolved into the Major Crime Squad where the emphasis was placed on specialized death investigation that included the death of sentenced and remand prisoners.

Major Crime Squad maintained the former Prison Unit responsibilities with the exception of the intelligence component which was transferred to the State Intelligence Division and is still maintained by that area.

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In 2006, the Specialist Crime Portfolio underwent an extensive review and re-structure resulting in the creation of two new Divisions and numerous changes to areas of responsibility.

WA Police have the capacity to respond to issues arising from the location, possession and trafficking of illicit substances in prisons, regardless of the quantity, and that response will be determined in accordance with established procedures with local police and if considered necessary, specialist investigative areas.

In relation to the state Coroner's consideration regarding amendments to the Misuse of Drugs Act to include a circumstance of aggravation for the supply of drugs to prisoners, I acknowledge the State Coroner's concern and intent, but having examined the said Act it is my view that current penalties are sufficient providing they are applied appropriately".

Further recommendations were directed to the Department for Corrective Services –

Recommendation No. 3

I recommend that the Department of Corrective Services take steps to ensure that the possible risks to prisoners associated with using other persons' medications are highlighted and that all prisoners found to be misusing medications in this way should be counselled in strong terms as to the dangers associated with the practice.

Recommendation No. 4

I recommend that the Department of Corrective Services review its procedures to ensure that middle aged aboriginal men complaining of chest pains are allocated adequate priority within the system and are counselled as to the potential risk of sudden death in the event that they are not compliant with efforts to diagnose their condition and, if their problem is identified as being of cardiac cause, aggressive management of their condition.

Recommendation No. 5

I further recommend that consideration should be given to provision of improved education to prisoners in respect of health issues as part of the ongoing process of upskilling prisoners for their eventual return to the community.

Recommendation No. 6

I recommend that in each prison in Western Australia action should be taken to identify items which could be used to screen a body from prisoners in the event that a death occurs in an open area in a prison.

Recommendation No. 7

I recommend that the Department of Corrective Services review procedures to ensure that prison superintendents are aware of Policy Directive 30 and comply with that policy.

In a response by the Department of Corrective Services (Professional Standards, Integrity and Compliance) the Department advised the State Coroner the following –

Recommendation No. 3
"The Department of Corrective Services supports this recommendation and will review its evaluation practices concerning the effectiveness of its established misuse of medications strategies".

Recommendation No. 4
"The Department of Corrective Services supports this recommendation and will continually improve its procedures concerning the management of chest pain complaints from middle aged Aboriginal men with respect to prioritization, counseling and the management of their condition".

Recommendation No. 5
"The Department of Corrective Services supports this recommendation and have a process of continuous improvement which will continue to be implemented".

Recommendation No. 6
"The Department of Corrective Services supports this recommendation in terms of all prisons and detention centres".

Recommendation No. 7
"The Department of Corrective Services supports this recommendation. The Department shall review the Checklist currently provided as part of the Generic Component in Standing Order B20, with a view of updating the checklist with recent changes and ensuring the availability to PDIC [prisoner death in custody] procedures and incorporating the checklist into Policy Directive 30".

Lawrence Hicks

Lawrence Hicks (the deceased) was a 42 year old aboriginal male who died on 21 May 2005 at the Palliative Care Room, Nickol Bay Hospital, Karratha.

The deceased had a very extensive history of prior convictions, he first came to the attention of the justice system in 1973 when at the age of ten years he appeared in the Roebourne Children's Court charged with stealing and was given a good behaviour bond.

The deceased appeared regularly in a number of Magistrates Court from 1980 to 2003 and during that period was convicted of 96 offences.

The deceased made one appearance before the Carnarvon District Court, when in March 1990 he was sentenced to three months imprisonment for Robbery with Violence in Company.

The deceased made one appearance in the Port Hedland Supreme Court, in June 1981, when he was sentenced to two years imprisonment for Manslaughter. He also made one appearance in the Karratha Supreme Court in December 1994 when he was sentenced to four years and three months imprisonment for offences of Indecent Assault and Sexual Penetration of a Child Under 16 years of Age.

On 17 January 2003 the deceased was sentenced to twelve months imprisonment for Assault Occasioning Bodily Harm and at that stage was imprisoned in Roebourne Prison.

On 14 May 2003 the deceased was sentenced to eight years and one month imprisonment at the Karratha Supreme Court for a series of offences including Aggravated Burglary, Threats to Kill, Unlawful Wounding and Unlawful Assault.

At the time of his death the deceased had served almost two years and four months in custody. That period was served in Roebourne Regional Prison until 3 June 2004 and then in Casuarina Prison until 20 May 2005.

The deceased died on 21 May 2005 in palliative care, Nickol Bay Hospital, Karratha, in Western Australia as a result of an aggressive cancer from which he suffered which had been diagnosed a relatively short period prior to his death.

A post mortem examination was conducted on the body of the deceased by forensic pathologist Dr K A Margolius on 25 May 2005.

Following that examination and after receipt of the results of ongoing investigations, Dr Margolius formed the opinion that the cause of death was complications of hepatocellular carcinoma with metastases.

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

The State Coroner found that the Investigations conducted by the police and by the Internal Investigations Unit of the Department of Corrective Services had not revealed any issues or concerns relating to the last period of custody of the deceased.

The State Coroner found that the deceased was treated with compassion and provided appropriate medical treatment.

It was the view of the State Coroner that the quality of supervision, treatment and care of the deceased while in custody was appropriate and in the period leading up to his death was at a high level.

The Department for Corrective Services (Professional Standards, Integrity and Compliance) responded to the State Coroner by letter acknowledging the State Coroner's findings and noting that no action needed to be taken by the Department in respect to any recommendations in relation to the death of the deceased.

Billy Trimmer

Billy Trimmer (the deceased) was a 45 year old Aboriginal male sentenced prisoner who died on the evening of 18 October 2005 or the early hours of 19 October 2005.

The deceased was managed as a minimum security prisoner during his initial placement at the Broome Regional Prison and subsequently at the Wyndham Work Camp. The deceased was returned to the Broome Regional Prison on 21 May 2005 for the convenience of family visits, but on 22 September 2005 at his request was returned to the Wyndham Work Camp.

At the time of his death the deceased was a sentenced prison at the Wyndham Work Camp which is a low security facility located approximately five kilometers from the Wyndham Townsite.

The deceased appears to have died suddenly and unexpectedly as a result of ischaemic heart disease in association with coronary arteriosclerosis with thrombosis.

The death could not have been foreseen by prison staff.

The other prisoners at the Camp were interviewed and the interviews established that the deceased was well liked and that in the days prior to his he did not complain about feeling unwell.

There is no reason to suggest that the supervision, treatment and care of the deceased while an inmate of the Wyndham Work Camp or the Broome Regional Prison was not adequate or contributed in any way to the death.

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

The Department for Corrective Services (Professional Standards) responded to the State Coroner by letter dated 15 May 2008 acknowledging the State Coroner's findings and noting that no action

needed to be taken by the Department in respect to any recommendations in relation to the death of the deceased.

David John Birnie

David John Birnie (the deceased) was a 54 years of age and at the time of his death he was a long-term sentenced prisoner at Casuarina Prison. On the morning of 7 October 2005 he was discovered suspended by his neck in his cell in the self-care unit.

The deceased was received into prison on 13 November 1986 and was located in the then CW Campbell Remand Centre following his arrest for the wilful murder of three women and numerous associated offences. His de-facto Ms Birnie was arrested for the same offences.

Prior to sentencing he was seen by a psychiatrist in January 1987 who indicated the deceased had suffered psychological damage from his childhood. There was reference to his relative stability during his stable relationships but the assessment was he had commenced a period of feeling he needed revenge against women once he recommenced his relationship with Ms Birnie.

On 10 February 1987 he was sentenced to strict security life imprisonment, a term of 99 years, and was received into Fremantle Prison on that date. During his entire prison history from that time he was always treated as a protected prisoner because of the status of his offences. Once incarcerated the deceased experienced bouts of depression.

While at Fremantle Prison in May 1987 the deceased overdosed on prescription medication and was sent to Fremantle Hospital.

On 26 September 1991 he was sent to Casuarina Prison (Casuarina) and housed in the self-care unit in Unit 6 as a protected and vulnerable prisoner. Whenever the opportunity arose he shared a cell with his brother as this was believed to be a protective factor.

Once at Casuarina the deceased used the services of the Prison Counselling Service (PCS) whenever he needed psychological assistance. They supported him through periods of depression arising out of incidents occurring during his incarceration.

In February 2002 he was transferred to the Crisis Care Unit (CCU) for a period as the result of a letter he had written which had been discovered when censored. In that he had expressed suicidal ideation.

By July 2005 the deceased had spent 19 years in custody, and had no expectation of release. His computer was very important to him. Due to

earlier periods of confiscation arising out of his self-acknowledged misuse of the privilege of having a personal computer, he well knew the risks he ran when not conforming to prison procedures.

As a result of an audit the deceased's computer was screened and pornographic material located. This was the fourth time the deceased had committed such a transgression and as a result he was informed his computer would be removed for the term of his sentence which effectively meant he would never have it returned.

On 5 October 2005 the lack of his medication and his concern it may be terminated in the future were brought to the attention of a psychologist who attempted to do what she could to rectify the situation but for reasons which the Deputy State Coroner did not consider to be satisfactory, his medication was not reinstituted nor was a plan for its proper withdrawal implemented.

The Deputy State Coroner was of the view that when the deceased did not receive his anti-depressant medication, after knowing it had been brought to the attention of the medical services, he suspected it may not be reinstituted. He was pre-disposed to "not coping" with that fact.

The Deputy State Coroner was satisfied that soon after midnight in the early hours of 7 October 2005 the deceased fashioned a relatively loose ligature and held the two bottles in place on each side of his neck until his weight had captured the bottles in the ligature. He then further suspended himself and hanged himself in his cell with the full intention of taking his life and with the expectation he would be well and truly deceased by the time of the next body and cell muster.

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

The Deputy State Coroner made the following recommendations –

(i) The authorisation of restricted medications policy be amended to require medications, whose TGA written documentation advises against abrupt cessation, be continued where there is a valid prescription until authorisation is specifically rejected.

(ii) Medication which is recommended to be withdrawn gradually by TGA approved documentation not be ceased until specific risk management procedures are put in place no matter what the authorisation status, unless the person provided with the medication proves to have an individual adverse reaction which is life threatening.

(iii) Risk management plans be put in place for all prisoners requiring essential medications as a back-up in the event there is an abrupt cessation of that medication for any lawful reason.

The Department of Corrective Services responded to the recommendations made by the Deputy State Coroner in September 2008 and that response can be found at Annexure "A" attached to this report.

Gordon Henderson

Gordon James Henderson (the deceased) was a 76 year old sentenced prisoner who died on Saturday 3 September 2005 at Casuarina Prison.

On 22 December 2004 the deceased was found guilty of one count of Attempt Carnal Knowledge, six counts of Indecent Dealings with a Child (under the age of 14) and one count of Indecent Dealings with a Child (under the age of 14). In respect of these offences he received a sentence of 15 months imprisonment and was given an earliest date of release of 5 August 2005.

The State appealed the length of the sentence imposed and on 3 June 2005 the sentence was varied to a total of 27 months imprisonment with a new earliest release date of 4 February 2006.

In addition the deceased faced outstanding charges which were five counts of Rape and fifteen counts of Indecent Dealings with a Girl Under 13 years. On 8 August 2005 the deceased was remanded in custody until 19 September 2005 in relation to the pending charges.

The deceased was received at Hakea Prison on 22 December 2004 and "Admission Check List Details Form" was completed on that day as well as an "At Risk Check List".

On 20 January 2005 the deceased was transferred to Casuarina Prison Infirmary as a result of his impaired mobility and extensive medical issues. He remained at Casuarina Prison either in the infirmary, Crisis Care or Unit 6 until 20 April 2005 when he was transferred to Bunbury Regional Prison. This transfer was made to facilitate visits by his family and friends. In addition, the deceased wished to have access to his Bunbury based lawyer who was preparing his case in respect of the additional charges of Rape and Indecent Dealings which he faced.

On 30 May 2005 Dr Peter Terren of the St John of God Medical Centre reviewed the deceased and found him to be in such ill health that he immediately admitted him to the Emergency Department of Bunbury Regional Hospital.

On 3 June 2005 the deceased was discharged from hospital and transferred to Casuarina Prison Infirmary. He was later moved to the

Crisis Care Unit until 3 August 2005 when he applied for, and was granted, a transfer back to Bunbury Regional Prison.

The deceased remained at Bunbury Regional Prison until 24 June 2005 when he was transferred to hospital to investigate bad circulation in his legs.

On 24 August 2005 the deceased was transferred to Casuarina Prison for medical treatment and to attend specialist appointments. While at the prison he was housed at the Prison Infirmary and was to be returned to the Bunbury Regional Prison.

A post mortem examination was conducted on the body of the deceased by forensic pathologist, Dr J White, on 7 September 2005.

At the completion of all investigations on 18 November 2005 Dr White formed the opinion that the cause of death was –

1a Iscahemic Heart Disease;
1b Severe Coronary arteriosclerosis; and
2 Chronic renal impairment (disease)

In a brief explanation of her findings Dr White stated that –

> "The examination of this elderly gentlemen showed an enlarged and dilated heart with scarring and congestion of the heart muscle. There was severe narrowing and hardening of all three coronary arteries with almost complete blockage of the circumflex and left anterior descending coronary arteries".

A toxicological analysis was completed as part of the investigation and that showed therapeutic levels of prescribed medication.

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

The State Coroner noted in his findings that Detective Sergeant Brennan, the police officer responsible for the investigation into the circumstances of the death, concluded that –

> "It would appear that the Department of Corrective Services provided excellent health care for Mr Henderson during his time spent in custody".

The State Coroner having reviewed all the evidence relating to the circumstances of the death was satisfied that the deceased was adequately and appropriately cared for from a medical perspective.

The State Coroner also noted in his findings that he was satisfied that the quality of the supervision, treatment and care of the deceased while in custody was of a high standard.

The Department for Corrective Services (Professional Standards) responded to the State Coroner by letter dated 15 May 2008 acknowledging the State Coroner's findings and noting that no action needed to be taken by the Department in respect to any recommendations in relation to the death of the deceased.

Robert Geoffrey Brown

Robert Geoffrey Brown (the deceased) was a 59 year old man, who at the time of his death was in custody but who died at Bethesda Hospital, Claremont, on 2 August 2006 of left lung malignancy.

On 23 January 2006 in the District Court, Perth, the deceased was found unfit to stand trial on two charges of threats to kill and three charges of threats with intent to gain a benefit. A custody order was made under section 19 of the *Criminal Law (Mentally Impaired Accused) Act 1996*.

The initial place of custody was to be Hakea Prison, but the custody order was amended on 10 March 2006 to the effect that he was to be detained at the Frankland Centre or a prison as appropriate.

The deceased was a severely mentally ill man who at the time of his death was in custody pursuant to the Criminal Law *(Mentally Impaired Accused) Act 1996.*

While in custody the deceased suffered from lung cancer but after it was decided that was the likely diagnosis, he refused all further investigation and interventions despite consultations with prison and hospital doctors.

He was referred to the Palliative Care Clinic at Sir Charles Gairdner Hospital on 3 May 2006, 14 June 2006 and 18 June 2006 to further assess his condition and on each occasion refused medical intervention.

On 16 July 2006 the deceased presented to the Sir Charles Gairdner Hospital Emergency Department with neurological confusion. On this occasion he changed his mind and asked for a review of his condition. Palliative care was instituted and he continued to decline. He was admitted to Sir Charles Gairdner Hospital on 24 July 2006 and then he consented to be transferred to the Bethesda Palliative Care team on 26 July 2006. He passed away on 2 August 2006.

A post mortem examination was conducted on the deceased on 3 August 2006 by forensic pathologist, Dr Gerard Cadden, who having reviewed the hospital notes formed the opinion that the cause of death was left lung malignancy.

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

The Department for Corrective Services (Professional Standards) responded to the State Coroner by letter dated 15 May 2008 acknowledging the State Coroner's findings and noting that no action needed to be taken by the Department in respect to any recommendations in relation to the death of the deceased.

John Zupec

John Zupec was a 64 year old male sentenced prisoner who died in Fremantle Hospital Palliative Care Ward on 12 June 2006.

On 15 April 2003 the deceased was charged with a number of sexual offences alleged to have been committed upon his wife's natural grand-daughter. On 16 January 2004 the deceased was convicted in the Perth District Court on ten counts of indecent dealing of a child under 13 years, four counts of sexual penetration of child under 13 years and one count of procuring a child to engage in sexual behaviour. The deceased was sentenced to a total of six years and four months imprisonment to date from 7 August 2003.

The deceased's period of incarceration began on 7 August 2003 at Hakea Prison. On 8 August 2003 he was medically examined and stated that he had no serious health problems.

On 21 March 2004 the deceased attended the Hakea Prison Medical Centre complaining of problems and was referred to the medical officer for examination.

On 5 April 2004 the medical officer at Hakea Prison examined the deceased and testing indicated that he had a raised level of prosthetic specific antigen (PSA) (an indicator of abnormal prostate function). At that stage the deceased indicated that his general practitioner had located a lump on his prostate just prior to his admission to prison.

The deceased was referred to the urology clinic at Sir Charles Gairdner Hospital for an appointment.

An appointment was made for the deceased to attend Sir Charles Gairdner Hospital urology section on 10 June 2004 and this appointment was later cancelled by telephone by Dr Goss of Hakea Prison and a new appointment was made for 29 July 2004.

There is no record on the deceased's prison medical file of an appointment being made or cancelled for 10 June 2004.

The deceased's appointment made for 29 July 2004 was cancelled as a result of AIMS staff and transport vehicles not being available on that day.

The relevant record in the prison Total Offender Management System (TOMS) was, "Cancelled – AIMS – no staff or vehicles".

According to prison medical records the deceased refused to attend an appointment made for him at Sir Charles Gairdner Hospital on 30 September 2004 and there is a "refusal to attend medical appointment form" signed by him dated that day. The reason for refusal has been given as "Appointment has been re-booked for a later date. Will notify of the new date".

It also appears that an appointment was made for 18 November 2004, which appears to have been cancelled. Again there is no record on the deceased's prison medical file of an appointment having been made or cancelled for that day.

The deceased was transferred to Karnet Prison on 16 June 2005 where his appointment to attend Sir Charles Gairdner Hospital was reorganised.

On 8 August 2005 an annual nursing assessment was conducted when it was noted that the deceased was suffering significant urinary symptoms and his weight was 55kg.

On 15 September 2005 the deceased attended the Sir Charles Gairdner Hospital Department of Urology and was seen by urologist, Dr John Stanley.

On 22 March 2006 the deceased attended Sir Charles Gairdner Hospital for a trans rectal needle biopsy of the prostate.

On 20 April 2006 the deceased attended Sir Charles Gairdner Hospital Urology and was informed that his prostate biopsy had revealed cancerous areas. A medical review conducted on 26 April 2006 showed no change in his condition.

The condition of the deceased continued to deteriorate and on 25 May 2005 he was transferred from the Armadale/Kelmscott Memorial Hospital to Palliative Care Fremantle Hospital, where he died on 12 June 2006.

A post mortem examination was conducted on the body of the deceased on 14 June 2006 by forensic pathologist, Dr J White.

At the conclusion of that examination Dr White formed the opinion that the cause of death was disseminated malignancy – (primary pancreatic adenocarcinoma) complicated by pneumonia.

In a brief explanation of her findings Dr White stated that examination of this 64 year old man showed widely disseminated tumour within the abdomen with malignant ascites, peritoneal carcinomatosis encasing the

small and large intestine with obstruction of the small bowel and metastatic spread to the liver.

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

The State Coroner noted that an issue of concern in the care and management of the deceased was the delay in having him assessed by a specialist urologist in relation to his elevated PSA which was noted in March 2004, and that he was not seen by the urologist at Sir Charles Gairdner Hospital until 15 September 2005.

A number of failures to record the reasons for the cancellations of the appointments and what appears to have been inadequate attempts to ensure that the deceased was adequately assessed was a matter of concern.

The State Coroner found that this case has, however, highlighted the importance of maintaining prison medical notes which detail the reasons for cancellation of important appointments and provide an adequate history in that regard and ensure that on subsequent reviews adequate steps are taken to ensure that appointments are met.

The State Coroner recommended -

> **I recommend that the Department of Corrective Services review its procedures to ensure that adequate records are retained of all appointments made for prisoners to attend specialist medical practitioners and when appointments are cancelled for any reason, the reasons for the cancellation and any steps taken to book later appointments are recorded.**

The Department for Corrective Services (Professional Standards) responded to the State Coroner by letter dated 15 May 2008 acknowledging the State Coroner's findings and supporting the State Coroner's recommendation.

The Department advised that it has reviewed its procedures and will amend Health services Policy CC-19 Hospital Referral Admission & Discharge to state that "the clinical nurse manager is responsible for ensuring that all cancelled appointments and the reason for the cancellation, and any future appointment dates booked are comprehensively documented in the medical record". This policy amendment will be communicated to all Health Services staff.

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.

William John Watkins

William John Watkins (the deceased) was a 38 year old male who died on the North West Coastal Highway, Karratha in Western Australia on 31 January 2006 as a result of a gunshot wound to the chest.

The deceased was shot by a police officer.
At the time when the deceased was shot it appears that he was attempting to avoid arrest in relation to the deaths of two sisters, Colleen Marie Irwin and Laura Jane Irwin.

On 31 January 2006 a police officer intercepted the deceased who at the time was driving his Toyota Lexcen stationwagon in a northerly direction on the North West Coastal Highway, approximately 20 kilometres south of Karratha, in Western Australia.

At the time when the deceased was intercepted, he was stopped because he had taken fuel without paying for it from the Fortescue Roadhouse.

At the time when the police officer approached the deceased, he was not aware of the fact that the deceased had killed and raped two sisters only three days earlier in Victoria.

The deceased suddenly attacked the police officer, taking him by surprise. The attack was extremely violent and the deceased made it clear to the police officer that he intended to kill him.

The police officer fired two shots at the deceased, one of which struck the deceased to the right side of the top of his chest. That shot caused his death.

At the time when the shot was fired the deceased was within about half a metre of the police officer and was in the process of attacking him. It was the view of the State Coroner that it was clear that the police officer fired the fatal shot in self defence.

A post mortem examination was conducted on the deceased on 2 February 2006 by forensic pathologists, Dr C T Cooke and Dr J White.

At the conclusion of the examination the doctors formed the opinion that the cause of death was "gunshot wound to the chest".

The State Coroner found that the death arose by way of self-defence.

At the time of the incident the police officer was conducting a single officer patrol, attempting to intercept the deceased for stealing petrol.

It was the view of the State Coroner that there is a very high risk associated with police officers acting on their own attempting to apprehend unknown offenders in respect of any offences. While it was clear that there will be occasions when officers will have to work alone and times when it would not be practicable for officers to do otherwise, this case highlighted the fact that when it can be avoided officers should not attempt to apprehend offenders or conduct investigations alone.

In this context the State Coroner made the following recommendation –

> **I recommend that Western Australia Police and the WA Police Union of Workers continue to work together with a view to limiting the number of single officer patrols which occur to cases where exceptional circumstances require officers to act alone and cases where the need for use of force is extremely unlikely.**

The State Coroner also found that although a computer check was conducted on both the deceased and his vehicle prior to the police officer attempting to apprehend him in respect of the offence of stealing petrol, no information was available either as to the recently committed offences or even in respect of the prior criminal record of the deceased.

In this context the State Coroner made the following recommendation –

> **I recommend that Western Australia police prioritise the actions required to obtain access to the Minimum Nationwide Person Profile System and the integration of that system with the current Incident Management System to allow automated searches and to make that system available to front line police.**

In a letter dated 18 January 2008 the Commissioner of Police wrote to the State Coroner in respect to those two recommendations in the following –

"I can advise that both of these recommendations have been implemented by the Western Australia Police. The Single Officer Patrols policy was updated in November 2007 to include amendments to the policy statement and definition

of 'Patrol". These changes were broadcasted to all members and the relevant amendments are being made to the Commissioner's Orders and Procedures and other relevant administrative documents.

The first phase of National Search was implemented in November 2007 and is available as a stand alone application on the Western Australia Police intranet limited to personal information only. National Search replaces the mainframe NEPI Search. The second phase of National Search will be implemented from around June 2007 and will include an automated search linked to the Incident Management System. A third planned phase of National Search will involve access to vehicle information, firearms and missing persons. To date, National Search provides direct and enhanced access to personal information held in Victoria and New South Wales and by the Australian Federal Police, although it is anticipated that National Search will be implemented by other States and Territories in the near future".

Robert Unbadi

Robert Undabi was a 52 year old aboriginal male who was born at Bililuna Community near Halls Creek in Western Australia.

Robert Undabi (the deceased) collapsed in the rear of a police vehicle near Muludja Community, near Fitzroy Crossing, on 25 February 2005. In spite of efforts to resuscitate him, the deceased died at that location.

The deceased and his defacto wife lived at Muludja Community, approximately 35 kilometres from Fitzroy Crossing. They had five children and had been together for about 32 years.

Prior to his death the deceased had been complaining about chest pain for approximately one year and had been prescribed medications for both diabetes and heart problems.

On 25 February 2005 the deceased cut his defacto with a knife, following which an ambulance was called for.

The call was received at the Fitzroy Valley Health Services at approximately 7:20pm. The ambulance was not sent directly as another request for help was given a higher priority and this involved the ambulance travelling to Bungardi Community to treat a patient who was experiencing chest pain.

At about 8pm police officers were contacted and advised of the situation. They travelled to Muludja Community and arrived there at approximately 9pm.

An ambulance arrived at Muludja Community not long after police arrived.

The ambulance left the community at about 9pm but after about twenty minutes received a call by satellite telephone to turn back because police had someone in the back of their van who was having a fit and they needed assistance.

At the community the police officers had seized the knife used by the deceased and he agreed to go with the officers to the Fitzroy Crossing Police Station to sort out the matter. Prior to leaving the community the deceased asked if he could take some tablets with him and went back into the house and obtained his tablets.

The deceased got into the rear of the police van and made no complaints at that time.

At about 9:17pm Senior Constable Hinch heard a thump after which he looked into the rear of the van and saw the deceased lying on his left hand side with his eyes open. At the time the deceased appeared to be convulsing. Upon opening the door the deceased appeared to be breathing but appeared to be gasping for air. The officers placed the deceased in a coma position and attempted to clear his airway.

The ambulance returned to assist with the deceased. A check of the deceased found that there was no pulse. Efforts continued to provide cardiopulmonary resuscitation without success for about 15 minutes after which two other nurses arrived at the scene and assisted.

The deceased was subsequently placed on a stretcher and placed in the ambulance where cardiopulmonary resuscitation was continued.

The deceased was then taken by ambulance back to the hospital where a doctor certified life extinct.

A post mortem examination was conducted on 2 March 2005 by the Chief Forensic Pathologist, PathCentre, Dr C T Cooke.

At the conclusion of his examination Dr Cooke formed the opinion that the cause of death was ischaemic heart disease in a context of coronary arteriosclerosis.

In a brief explanation of his findings Dr Cooke noted that the examination showed an enlargement of the heart with thickening of the heart muscle (left ventricular hypertrophy). There was discolouration of the heart muscle indicating a recent “heart attack”. The arteries showed arteriosclerotic hardening and there was consequent narrowing of the arteries on the surface of the heart (coronary arteriosclerosis).

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

In the report to the State Coroner dated 3 June 2005 Superintendent Matson made the following observation –

> "The only recommendation emanating from the investigation is the inclusion of a Guedel device which is used for airway assistance on unconscious patients. Police are trained in the use of this device however they are not presently included in the police vehicle First Aid Kits".

It was the view of the State Coroner that this case had highlighted the importance of these devices being included in first aid kits for police vehicles in remote areas of the State and in that context the State Coroner made the following recommendation ·

> **I recommend that Guedal devices be included in police vehicle first aid kits.**

In a letter dated 8 March 2008 Superintendent Ian Thomas of the Kimberley District Police Office, wrote to the State Coroner in the following terms –

"I acknowledge receipt of your findings in relation to this death. I advise that your recommendation concerning the inclusion of Guedal devices being included in police vehicle first aid kits has been adopted and implement throughout the Kimberley Police District.

I have forwarded your report to the Assistant Police Commissioner, Regional Western Australia with a recommendation that this initiative be extended to all police vehicles in regional Western Australia".

Carl Woods

Carl John Woods (the deceased) was a 35 year old Aboriginal man. On the evening of 11 April 2006 the deceased was arrested by police officers after he broke into a house in Parmelia in which a woman and her grandson were present. The deceased resisted the police, was restrained and carried to the front of the house then, shortly after, placed in the rear of a police van where he stopped breathing. Efforts were made to resuscitate him en route to Rockingham Kwinana District Hospital (RKDH) which were unfortunately unsuccessful.

In the months leading up to April 2006, the deceased had been using amphetamine and cannabis on a regular basis. During the day of 11 April 2006 the deceased began to behave strangely especially after injecting

methylamphetamine in the late afternoon at the home of his wife's brother.

Paranoid behaviour was observed intermittently throughout the evening and the deceased also exhibited signs of suffering delusions and hallucinations. This behaviour was noticed by Giovanni Gerardi, his wife and the occupants of two homes he wandered into, having left his house after an argument. The deceased was often detached from reality and confused as he went from house to house. His preoccupation switched from feelings of love toward someone or threatening to harm someone, concern with the state of the wounds on his legs to, fear that someone was threatening to kill him.

This escalation in his behaviour and delusional beliefs over the evening suggests he was suffering a psychotic episode brought on by amphetamine use. This growing agitation and unpredictability, particularly as described by a witness when he forced his way into her house the first time, culminated in his first encounter with police officers as they approached him outside a house. The deceased, in his heightened state clearly believed in his own mind these were the people intent on harming him and resulted in him fleeing into a house where a violent struggle with police ensued.

The deceased, fuelled by amphetamines and cannabis along with his delusional beliefs, fought strongly against police both inside and outside the house for a period of about 14 minutes.

This intense exertion, coupled with a severely diseased heart which was further compromised by the effects of methylamphetamine upon it, and possibly also by the pressure on his chest during the efforts to restrain him, caused the deceased to suffer a cardiac arrhythmia which resulted in his death. His naturally occurring physical state certainly compromised his ability to withstand any additional physical stress.

Dr Gerard Cadden, Forensic Pathologist, conducted a post mortem examination on the body of the deceased on 12 and 13 April 2006.

On 31 August 2006 Dr Cadden formed the view cause of death was as the result of Cardiac Arrhythmia due to Ischaemic Heart Disease (Severe Coronary Atherosclerosis), Associated with Acute Methylamphetamine Toxicity, Following Recent Violent Exertion and Manual Restraint.

Blood tests revealed the presence of Tetrahydrocannabinol in the amount of 10ug/L and Carboxytetrahydrocannabinol in the amount of 110 ug/L. This suggested the deceased had used cannabis about two to three hours before that time and would have been "overtly intoxicated" and also suggested he was a "regular heavy user" of cannabis.

Methylamphetamine was found in the quantity of 0.47 mg/L which Dr Joyce commented was high and indicates "either a very large recent dose of methylamphetamine or the accumulation of methylamphetamine in a person who is habitually using large doses because he has become tolerant to the drug".

Associate Professor David A Joyce, Clinical Pharmacologist and Toxicologist made the following comments in respect to the deceased's behaviour - "The behaviour at the house and the behaviour displayed at Rockingham Hospital earlier on the day therefore could have been manifestations of amphetamine-induced psychiatric disturbance".

Methylamphetamine also has a physiological affect on the body, in particular the heart. Dr Joyce stated, "there is a well-recognised, but low, incidence of sudden death occurring in stimulant users hours...after drug use...The cause of death is understood to be a sudden disturbance in heart rhythm...Where there has been opportunity to observe the cardiac rhythm disturbance, it has been ventricular fibrillation or ventricular tachycardia. Ventricular fibrillation is the rhythm that was observed in Mr Woods' case at Rockingham Hospital".

Dr Joyce went on to explain during intense exertion noradrenalin is sent to the heart to make it function more efficiently but methylamphetamine enhances its effect on the rhythm of the heart. Blood vessels supplying the heart constrict, reducing the blood supply and making the heart more vulnerable to arrhythmias. In the context of a man with pre-existing severe heart disease, Dr Joyce was of the view the deceased would be pre-disposed to "lethal rhythm disturbance in the presence of high concentrations of cardiac stimulants" like amphetamines.

Dr Cadden was supportive of Dr Joyce's conclusion. Dr Cadden considered it important to look at the entirety of the evidence in determining the cause of death rather than just concentrating on individual factors in isolation of each other, such as the restraint by police.

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

The Deputy State Coroner made the observation that the four police officers who attended at the scene on that night had limited information about the incident they were to face.

They had been given some idea of the unusual behaviour of the deceased by a witness during their brief conversation prior to arriving at the address although at that stage they could not be sure whether this witness was talking about the same person.

Certainly limited information was conveyed to them over the radio even though the 000 operator was still on the phone to the occupier of the house and was located in the same room as the VKI operator.

The police officers also had limited opportunity to discuss what was to happen when they arrived as almost immediately the deceased saw them and ran back into the house. The police officers clearly then had an obligation to follow the deceased as they knew he was committing several offences by entering the house whilst the owner and her grandson were inside.

In respect to these communication issues the Deputy State Coroner made the following recommendations –

> **1. As far as is practicable police officers attending a disturbance should be informed as fully as possible by VKI as to relevant events as they unfold.**
> **2. The WA Police 'Use of Force Manual' be amended to more accurately define ''Positional Asphyxia'' and to additionally make police officers aware that:**
> - **When dealing with disturbances involving possibly drug affected or mentally disturbed persons there is a potential for sudden death, most critical once a situation is brought under control,**
> - **There is consequently a need to be vigilant as to the possibility they may need to resuscitate and the more rapidly resuscitation is implemented the greater the chances of survival, and**
> - **In the circumstances of a disturbance being brought under control there is a need to consider the best method (including the security of the general public) in which to ensure competent monitoring of recently violent persons and the possibility there may be a medical emergency requiring the attendance of paramedics.**
> -

On the 6 June 2008 the Minister for Police and Emergency Services wrote to the State Coroner responding to those recommendations in the following terms –

"The Western Australia Police have advised that the Deputy Coroner's recommendation that police officers attending a disturbance should be informed as fully as possible by VKI in relation to events as they unfold has been brought to the attention of the Officer-in-Charge of the Police Communication Branch for his information and appropriate action as necessary.

In relation to the second recommendation of the Coroner's Finding, I am advised by WA Police that the Agency's Use of Force Manual, used in both the initial training of police recruits and the annual critical skills requalification of

police officers, has been amended to more accurately define "Positional Asphyxia". The amendments also raise the awareness of the potential for sudden death or need for urgent medical attention when dealing with disturbances involving possibly drug affected or mentally disturbed persons".

Nikkola Tara Hayward (Powell-Pepper)

Nikkola Tara Hayward (Powell-Pepper) (the deceased) was a 16 year old female who died on 20 January 2006 following a motor vehicle collision. A subsequent post mortem examination conducted on her body by forensic pathologist, Dr K A Margolius, revealed that the cause of death was head and neck injuries.

At the time of her death the deceased was a passenger in a motor vehicle being driven by Gregory Farmer. A short time before the crash the vehicle had been followed by a police vehicle and at the time of the crash Mr Farmer was attempting to avoid arrest by police.

Following the incident which led to the death Mr Farmer was charged by police and subsequently appeared in the District Court in Perth on an indictment which contained 17 counts. These were 6 counts of stealing motor vehicles, 5 of aggravated burglary, 1 of burglary, 1 of robbery in company, 1 of unlawful killing and 3 of unlawfully doing bodily harm. Mr Farmer pleaded guilty to all counts and was initially sentenced to a total sentence of 8 years and 8 months imprisonment. That sentence was subsequently varied on appeal and on 19 October 2007 the sentence was reduced to a total effective sentence of 7 years and 4 months imprisonment. Counts 13-17 on the indictment related to the incident which resulted in the death of the deceased.

The family of the deceased, through the Aboriginal Legal Service, wrote to the Coroners Court by letter dated 18 April 2006 expressing concerns in relation to the circumstances surrounding the police pursuit which took place shortly before the collision and expressing concern as to why it was that Mr Farmer was not stopped by police prior to his entering the car which he was driving at the time of the collision.

In the context of the above submission this inquest was held in order to examine the circumstances surrounding the death.

The State Coroner in his findings noted that all of the civilian witnesses who viewed the two vehicles were of the view that the police vehicle was driven in a relatively safe manner and at no stage was it close to the vehicle driven by Mr Farmer. The State Coroner commented that it was significant to note that even at the stage while the pursuit was ongoing after the intersection of Hamilton Street with Welshpool Road, the police vehicle was described as travelling in a safe manner and did not appear to

be endeavouring to overtake the vehicle driven by Mr Farmer. The distance from the location of the police vehicle when the pursuit was aborted at about the junction of Gibbs Street with Welshpool Road, to the location of the crash was approximately 2.6 kilometres.

The pursuit was, therefore, over a relatively short distance and the police car was not close to the stolen vehicle driven by Mr Farmer for a significant distance prior to the crash.

In evidence Mr Farmer accepted that he was driving a car he had stolen, that he had never had a licence, that he was on parole at the time, that he had taken amphetamines and that he was worried about going back to gaol. He also stated that the vehicle he was driving was running out of petrol and that he was trying to get out of sight of police quickly before lack of petrol caused it to stop. He said that he had previously been chased by police when he was driving stolen cars but on those occasions he had not been caught. He accepted that he had driven recklessly and said he was extremely sorry for causing the death of the deceased.

The State Coroner was satisfied that the actions of police did not cause or contribute to the crash and the resulting death. In that context I note that it was very properly conceded by Mr Collins, who represented the family of the deceased at the inquest, that the driving of police could not be said to have in any way caused the death.

In the above circumstances the State Coroner found that the death arose by way of Unlawful Homicide.

During the course of inquest hearing the State Coroner examined the policy in relation to the training of police officers with regards to priority driving. The State Coroner made an observation that in this case it was a concerning feature of this policy that in the event of a pursuit, there appears to be no real distinction drawn between Priority 1 and Priority 2 drivers, while in respect of training Priority 1 drivers are required to undergo significantly more training than Priority 2 drivers and Priority 1 drivers are required to requalify at least once every three years.

The State Coroner also noted that although the Court was told that requalification for Priority 2 drivers is completed as determined by the Officer in Charge, Traffic Training Unit, it would appear that often this requalification does not occur over extended periods of time, if at all. It certainly had not happened in the case of the officers involved in this pursuit.

In this context the State Coroner made recommendations as follows –

I recommend that Priority 2 drivers not be permitted to drive police vehicles in pursuits unless they are in receipt of ongoing training similar to that provided to Priority 1 drivers, or they are subject to additional constraints which recognise their lack of training compared to Priority 1 drivers.

In a letter dated 13 May 2008 received from C J Dawson APM, Deputy Commissioner (Operations) advised the State Coroner that he had considered the State Coroner's recommendations regarding urgent duty driving in the following terms –

"The current Urgent Duty Driving Guidelines restrict the priority pursuit category of driving to Priority 1 qualified pursuit drivers and only after authorization from the Police Operations Centre (POC) Duty Inspector.

Priority 2 drivers will not be authorized to engage in this category of driving.

...

All POC staff have been made aware of the need to prevent secondary vehicles delaying the POC's assessment of the incident circumstances through untimely radio communications.

In summing up, I can advise that the current guidelines and policies in place provide the level of governance that the Coroner's recommendation is referring to. I am satisfied that the measures that have been put in place ensure that this matter has been addressed appropriately".

Deaths Referred to the Coroners Court
1 July 2007 – 30 June 2008

A total of 2,341 deaths were referred to the coronial system during the year.

Of these deaths, in 572 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 1,287 Coroner's cases and in the country regions there were 482 Coroner's cases, a total of 1,769 cases.

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

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

Deaths referred to a Coroner for investigation for the Metropolitan area

1 July, 2007 - 30 June, 2008

Natural		696
Suicides		219
Accidents		195
Traffic		128
Homicide		24
Open		5
Misadventure		0
Inconclusive		20
	TOTAL	**1287**

Deaths referred to a Coroner for investigation for the Country area

1 July, 2007 - 30 June, 2008

Natural		230
Suicides		82
Accidents		51
Traffic		97
Homicide		14
Open		0
Inconclusive		7
Misadventure		0
No Jurisdiction		1
	TOTAL	**482**

Annexure "A"

The Deputy State Coroner made the following 4 recommendations in relation to the death of Mr Birnie.

1. ***I recommend the authorisation of restricted medications policy be amended to require medications, whose TGA written documentation advises against abrupt cessation, be continued where there is a valid prescription until authorisation is specifically rejected.***

   The Department of Corrective Services supports this recommendation. *Health Services Policy CC 54 - Attachment 3 - Prescribing Change/Cease Medication* currently states "a follow up appointment with a medical officer must be made where necessary when the authority is due to expire". This policy will be further amended to specifically state that those medications whose TGA [Therapeutic Goods Administration] written documentation advises against abrupt cessation, be continued where there is a valid prescription until authorisation is specifically rejected." This amendment and the rationale for it will be communicated to all Health Services staff.

2. ***Medication which is recommended to be withdrawn gradually by TGA approved documentation not be ceased until specific risk management procedures are put in place no matter what the authorisation status, unless the person provided with the medication proves to have an individual adverse reaction which is life threatening.***

   The Department of Corrective Services supports this recommendation. The current Medication Change/Cessation Advice form outlines a range of risk management strategies/instructions for prescribing doctors. These include:

   - ensuring the medication list in the electronic prescribing software has been updated and that appropriate prescriptions have been issued;
   - ensuring the patient has been advised of changes to their medications;
   - ensuring the patient has been advised of possible omissions of non essential medications in the interim period;
   - ensuring the doctor has identified any medications that must for reasons of patient safety be continued in the interim period prior to arrival of legally dispensed Webster packs;
   - ensuring the doctor has accessed and dispensed urgent supply medication packs (if necessary); and,
   - ensuring that all current prepacked medications containing ceased medication after the cessation date have been removed for return to pharmacy.

   The Medication Change/Cessation Advice form will be amended to include the following additional instruction for prescribing doctors: "Medication which is recommended to be withdrawn gradually by the Therapeutic Goods

Administration should not be ceased until specific risk management procedures are put in place no matter what the authorisation status, unless the person provided with the medication proves to have an individual adverse reaction which is life threatening". This amendment and the rationale for it will be communicated to all Health Services staff.

3. ***Risk management plans be put in place for all prisoners requiring essential medications as a back-up in the event there is an abrupt cessation of that medication for any lawful reason.***

The Department of Corrective Services does not support this recommendation. The Department of Corrective Services is of the view that the amendments that will be made to *Health Services Policy CC 54 - Attachment 3 - Prescribing Change/Cease Medication* and the Medication Change/Cessation Advice form, as agreed to in the Department's response to recommendations 1 and 2, provide sufficient additional guidance for doctors prescribing/ceasing essential medications. The Department does not intend to instruct prescribing doctors to specifically develop risk management plans for all prisoners' receiving essential medications; however, will continue to provide support and training to doctors in relation to appropriate prescribing and cessation of medication procedures. No further action proposed in respect of this recommendation.

4. ***The Department of Corrections continue with implementation of its Support At Risk Management System (SAMS) which in theory may have assisted in this case if available.***

The Department of Corrective Services supports this recommendation. A collaborative multi-disciplinary case management system for prisoners that are not considered to be at immediate risk to self, however, are identified as requiring additional support, intervention or monitoring whilst in custody is currently under development (i.e., Support and Monitoring System). Significant progress has been made on this project, with the development of the purpose built electronic module on TOMS nearing completion. Supporting documentation (i.e., procedural manuals, training modules) has been developed by Offender Services Suicide Prevention, in preparation for the implementation of the Support and Monitoring System. Once developed, the electronic system will be trialled at Hakea and Bandyup, and one regional facility (yet to be determined) prior to implementation across all facilities.