

Review of Coronial Practice in Western Australia

BACKGROUND PAPER

Project No 100

September 2010

Law Reform
Commission of
Western Australia

The Law Reform Commission of Western Australia

Commissioners:

Chair: Ms MA Kenny, BJuris, LLB (Hons) (UWA), LLM (Iowa)

Members: Mr R Mitchell SC, BJuris (Hons), LLB, LLM (UWA)

Mr R Douglas, BA (Hons), LLB (Hons) (ANU)

Executive Officer: Ms HJ Kay, LLB, LLM (UWA)

© Government of Western Australia

ALL RIGHTS RESERVED

Law Reform Commission of Western Australia
Level 3, BGC Centre
28 The Esplanade
Perth WA 6000
Australia

Telephone: 011+61+8+9321 4833

Facsimile: 011+61+8+9321 5833

ISBN: 978-1-74035-063-1

Printed by Quality Press, Western Australia

Portions of text in this Background Paper may be reproduced with due acknowledgement.

Except for the purposes of research—and subject to the provisions of the *Copyright Act 1968* (Cth)—all other forms of graphic or textual reproduction or transmission by any means requires the written permission of the Law Reform Commission of Western Australia.

This document can be provided in alternative formats for people with disabilities.

Acknowledgements

Author Dr Tatum Hands, LLB (UNSW), PhD (UWA)

Research Assistants Mimi Yeung
Joanna Yoon
Elizabeth Scaife

Technical Editor Cheryl MacFarlane

Executive Assistant Sharne Cranston

The Commission wishes particularly to thank Dawn Wright and Gary Cooper from the Office of the State Coroner for their invaluable assistance during the initial research phase of this reference.

Contents

Introduction	1
Chapter One: Coronial Law in Western Australia	3
History of coronial law in Western Australia	5
Chapter Two: The Coronial Process in Western Australia	13
The current coronial process	15
Inside the Office of the State Coroner	24
Chapter Three: Statistical Overview of the Coronial Jurisdiction in Western Australia	29
Statistical overview	31
Chapter Four: Issues with the Coronial Process: Results of Consultations	41
Issues with the coronial process	43
Role of the coroner	44
Systemic issues	47
Investigations, offences and penalties	52
Role, rights and support of the family	55
Appendices:	59
A: List of People Consulted	61
B: When a Person Dies Suddenly	65

Introduction

The Law Reform Commission of Western Australia (the Commission) has been asked by the Attorney General to review coronial practices and procedures in Western Australia with a view to highlighting any areas that may be in need of reform. In carrying out its review, the Commission has been asked to consider:

- (a) any areas where the *Coroners Act 1996* (WA) can be improved;
- (b) any desirable changes to jurisdiction, practices and procedures of the coroner and the office that would better serve the needs of the community;
- (c) any improvements to be made in the provision of support for the families, friends and others associated with a deceased person who is the subject of a coronial inquiry, including but not limited to, issues regarding autopsies; cultural and spiritual beliefs and practices; and counselling services;
- (d) the provision of investigative, forensic and other services in support of the coronial function; and
- (e) any other related matter.

PURPOSE OF THIS BACKGROUND PAPER

The purpose of this Background Paper is to gain insight into the Western Australian community's experience of the coronial jurisdiction. The Commission has already consulted extensively with recognised experts in coronial law both in Western Australia and elsewhere. It has also consulted with those intimately involved with the delivery of coronial services in Western Australia. The issues or concerns about current coronial practices and procedures raised in these consultations are set out in Chapter Four. However, it is important that reforms to the current system take account of those who ultimately are the 'users' of the system. The Commission is therefore seeking submissions or comments from people who have experienced the coronial process to help it make recommendations to improve coronial practices and procedures for the benefit of the community. We are interested in hearing of people's experiences at all points during the coronial process, from the time of death to the finalisation of the case by the coroner.

Survey

The Commission has compiled a specific survey for families or friends of deceased who have experienced the coronial system. To receive an electronic copy of the survey, please email the Commission at Ircwa@justice.wa.gov.au with the words 'Coroners Survey' in the subject line. The survey may be completed electronically and emailed to the Commission as an attachment or may be printed out, filled in and mailed to the Commission. It may be completed anonymously – see boxed text below.

Comments and submissions

The Commission invites interested parties to make comments or submissions touching on aspects of the coronial system in Western Australia. Submissions will assist the Commission in formulating its initial proposals for reform of the law in this area. All submissions will be considered by the Commission in its forthcoming Discussion Paper.

Submissions may be made by telephone, fax, letter or email to the address below. Alternatively, those who wish to request a face-to-face meeting with the Commission may telephone for an appointment.

Law Reform Commission of Western Australia
Level 3, BGC Centre
28 The Esplanade, Perth WA 6000
Telephone: (08) 9321 4833
Facsimile: (08) 9321 5833
Email: Ircwa@justice.wa.gov.au

Confidentiality

Submissions from members of the public are considered an important form of evidence to the Commission's inquiries. However, the Commission is mindful of the sensitive nature of the subject matter of this reference and wishes to inform respondents that submissions or information can be provided on an anonymous basis. If you do not wish your name to appear in any Commission publication, then please make that clear in your submission and we will respect your wishes.

Chapter One

Colonial Law in Western Australia

Contents

History of coronial law in Western Australia	5
Early colonial history	5
The Coroners Act 1920	5
Subsequent amendments	6
Coronial practice in Western Australia 1920-1996	7
The Ad Hoc Committee Inquiry	8
The Honey Inquiry	8
The Coroners Act 1996	9
Reviews of the Coroners Act 1996	10
The Chivell Review 1999	10
The Barnes Review 2008	11

History of coronial law in Western Australia

EARLY COLONIAL HISTORY

Soon after settlement of Western Australia in 1829, Lieutenant Governor Stirling issued a proclamation declaring that British statute law and common law would apply to the new colony.¹ The first laws governing the coronial jurisdiction in Western Australia were, therefore, of imperial provenance and already significantly antiquated. It soon became clear that the laws governing coronial practice in England were not appropriate in Western Australia, because of both the climate, which necessitated early burial, and 'the dispersal of the population'.² In 1856 an ordinance was passed by the Governor of Western Australia to 'facilitate and expedite' coronial inquests.³ This ordinance authorised justices of the peace to perform the duties of coroner including holding inquests into 'sudden, violent or apparently not natural' deaths with a jury of between three and six 'free men'.⁴ It also established an offence for failing to report such a death on the finding of a person deceased and gave justices of the peace the power to exhume a body where the justice had reason to believe that the deceased did not die a natural death.⁵ In 1863 a further ordinance was passed to amend the powers and duties of coroners, permitting them to hold inquests on Sundays to enable the early burial of bodies otherwise at the mercy of 'speedy decomposition' in the Western Australian climate⁶ and to compel the attendance of jurors and witnesses.⁷ Together, these ordinances governed the coronial jurisdiction in Western Australia until 1920.⁸

1. See further, Hands TL, 'The Legal System of Western Australia' in Kritzer HM (ed), *Legal Systems of the World: A political, social and historical encyclopaedia*, vol 4 (California: ABC-CLIO, 2002) 1776.
2. 19 Vict 10, preamble.
3. 19 Vict 10.
4. 19 Vict 10, cl 1.
5. 19 Vict 10, cl 2, 4 and sch.
6. 27 Vict 1, cl 1 and preamble.
7. 27 Vict 1, cl 2.
8. Residual coronial powers were retained from Imperial Acts and the common law in England (as received into Western Australia on 1 June 1829), though it was not until 1887 that the role of coroner, as we know it today, was established by legislation in England.

THE CORONERS ACT 1920

Following criticisms in the local press lamenting the poor state of coronial law in Western Australia,⁹ the Western Australian Parliament enacted the *Coroners Act 1920* (WA). This Act sought to redress the shortcomings of the colonial ordinances, which largely left the powers and duties of coroner open to the interpretation of justices of the peace who had no particular training in law, nor other qualifications appropriate to the role.¹⁰ It also sought to professionalise the role of coroner, providing for the specific appointment of coroners and deputy coroners and giving ex officio coronial power to resident magistrates.¹¹ However, not all persons appointed coroners were necessarily legally trained. The Act assumed that (as was the case in other states)¹² some coroners might be medical practitioners and precluded those coroners from presiding over an inquest into the death of a person they had 'attended professionally at or immediately before' death.¹³

While based largely upon the existing Imperial Act,¹⁴ the *Coroners Act 1920* contained a number of innovations. It removed the requirement that a coroner must view the body of a deceased:¹⁵ a requirement that had existed since mediaeval times and was the original means by which a coroner would obtain jurisdiction in relation to a particular death.¹⁶ The Act also removed the requirement that coronial inquests be compulsorily heard before juries.¹⁷ Henceforth only inquests involving mining and

9. Western Australia, *Parliamentary Debates*, Legislative Assembly, 2 September 1920, 470 (Mr TP Draper, Attorney General).
10. Ibid 471. It was also recognised that the work of a coroner was arduous and often unpleasant and that justices of the peace were unpaid for their work.
11. *Coroners Act 1920* (WA) ss 4 & 5. Justices of the peace could only 'act' as coroners under special authority from the Attorney General: s 5.
12. Eg, South Australia and Victoria.
13. *Coroners Act 1920* (WA) s 8.
14. *Coroners Act 1887* (UK).
15. *Coroners Act 1920* (WA) s 10.
16. It is interesting to note that this requirement existed in legislation in New South Wales until 1961: McKeough J, 'Origins of the Coronial Jurisdiction' (1983) 6 *University of New South Wales Law Journal* 191, 207.
17. *Coroners Act 1920* (WA) s 9. The Act permitted the Attorney General to direct that an inquest be held before a jury and for a relative of the deceased or person knowing of the

factory deaths required empanelment of a jury¹⁸ and, in the case of mining deaths, jurors with a working knowledge of mines were required to be empanelled where practicable.¹⁹

Under the Act a coroner was required to examine the evidence given under oath provided by such witnesses whom the coroner thought 'expedient to examine'. The coroner's findings²⁰ were required to be recorded in writing and include, if proved: the identity of the deceased; how, when and where the deceased died; and, if the death was found to be an unlawful killing, the persons 'found to have been guilty of such offence'.²¹ The coroner was also obliged to record the particulars required to register the death.²² While generally a coroner's findings were tied directly to the death and the circumstances immediately surrounding the death, the *Coroners Act 1920* contained an exception in the case of infant deaths. In respect of those deaths, a coroner was permitted to extend the ambit of the inquest to enable inquiry

not only into the immediate cause of death, but also into all such circumstances as may throw light upon the treatment and condition of the infant during life, and into such other matters as, in the opinion of the coroner, require investigation in the interests of public justice.²³

Where the infant had died in the care of a state facility, the coroner was required to report to the Attorney General the cause of death and any 'remarks with respect to the matter' the coroner deemed fit.²⁴ This power may be understood as an early form of the power to make comment about the 'supervision, treatment and care' of a person which presently exists under s 25(3) of the *Coroners Act 1996* (WA).

circumstances leading up to the death to request an inquest before a jury.

18. *Coroners Act 1920* (WA) ss 9 & 30. A provision removing the requirement for juries in all cases was defeated in the Legislative Assembly, where considerable concern over the working conditions in mines and factories was expressed. Members also noted the need for practical knowledge of mining operations in the coronial inquiry into a mining death, recommending changes to the Bill to require, where practicable, a jury of men with a working knowledge of mining operations to be empanelled: Western Australia, *Parliamentary Debates*, Legislative Assembly, 9 September 1920, 541 (Mr Chesson); 16 September 1920, 644 (Mr Munsie).
19. *Coroners Act 1920* (WA) s 32. It being recognised that coroners did not have 'an intimate knowledge of the technicalities of the industry': Western Australia, *Parliamentary Debates*, Legislative Council, 19 October 1920, 1058 (Mr RG Ardagh).
20. Or the jury's verdict (as the case may be).
21. *Coroners Act 1920* (WA) s 11(3).
22. *Coroners Act 1920* (WA) s 11(4).
23. *Coroners Act 1920* (WA) s 11(5).
24. *Coroners Act 1920* (WA) s 43(3). This followed from the *Report of the Royal Commission into the Operations and Administration of the State Children & Charities Department* (Western Australia, 10 November 1920), which was tasked with examining 'all institutions within the meaning of the State Children Act 1907-1919'.

Other important features of the *Coroners Act 1920* included the power of the coroner to order a post mortem examination in any case²⁵ and to charge a person with wilful murder, murder or manslaughter consequent upon a finding of liability in an inquest.²⁶ The jurisdiction to investigate the cause of fires (whether with or without death) was given to Western Australian coroners in 1887²⁷ and was retained in the *Coroners Act 1920*.²⁸ The coroner was further empowered to commit to trial any person found upon inquest to have wilfully lit a fire that caused damage to property.²⁹

Subsequent amendments

During its lifetime a number of important amendments were passed to the *Coroners Act 1920*. These included:

- the requirement that a coroner adjourn an inquest in cases where a person had been charged with an offence of causing the death or the fire the subject of the inquest;³⁰
 - the addition of coronial jurisdiction to inquire, at the direction of the Attorney General, into the suspected deaths of missing persons;³¹
 - that coroners shall not frame findings 'in such a way as to appear to determine any question of civil liability' or guilt of a criminal offence;³²
 - that coroners shall not express an opinion outside the scope of an inquest except in a rider, which was expressly for the purposes of prevention of similar deaths;³³
 - the direction that a rider was not part of the 'decision or finding of a coroner' (and in consequence was not appealable);³⁴
 - the power for a coroner to commit a witness who has refused to take an oath or answer questions at an inquest 'without just excuse' to jail for up to seven days;³⁵
25. *Coroners Act 1920* (WA) s 40.
 26. *Coroners Act 1920* (WA) s 16. In 1954 the Act was amended to also enable a charge of reckless or dangerous driving to be preferred by a coroner.
 27. 51 Vict. 14, s 1.
 28. *Coroners Act 1920* (WA) s 6(2).
 29. 51 Vict. 14, s 2; *Coroners Act 1920* (WA) s12.
 30. *Coroners Act Amendment Act 1960* (WA) s 5, inserting new s 13A into the principal Act.
 31. *Coroners Act Amendment Act 1979* (WA) s 6.
 32. *Coroners Act Amendment Act 1960* (WA) s 11.
 33. *Coroners Act Amendment Act 1960* (WA) s 11.
 34. *Coroners Act Amendment Act 1960* (WA) s 11.
 35. *Coroners Act Amendment Act 1979* (WA) s 23.

- acknowledgement of a witness' rights against self incrimination;³⁶ and
- the power to refer evidence obtained in an inquest or investigation to a disciplinary body.³⁷

CORONIAL PRACTICE IN WESTERN AUSTRALIA 1920–1996

Although power existed under the *Coroners Act 1920* for the Governor to appoint dedicated coroners and deputy coroners, no such appointment was ever made.³⁸ Resident magistrates (later to become known as stipendiary magistrates) acted as ex officio coroners and assumed jurisdiction over deaths within their defined magisterial districts.³⁹ As the population increased after the Second World War and with it the number of deaths, there was sufficient coronial work to justify a full-time coroner in Perth. Although there was never an official appointment of a coroner under the Act, from 1947 the Chief Stipendiary Magistrate directed one Perth-based magistrate to perform the duties of 'City Coroner' on a full-time basis.⁴⁰ This practice continued until the establishment of a state coroner system under the *Coroners Act 1996* (WA).

During the 1970s the City Coroner's office was located at the Court of Petty Sessions in Perth.⁴¹ Around this time a dedicated coronial inquiry squad was established within the Western Australia Police to investigate metropolitan coronial cases, but the City Coroner evidently had no direct control over the work of the squad. In the early 1980s the City Coroner's office moved away from the law courts and was housed in a city office building. The City Coroner's staff consisted at that time of two police sergeants (who prepared inquest briefs and assisted the coroner during inquests), a court typist and a junior typist.⁴² A number of problems with the operation of the coronial jurisdiction were observed during this time.⁴³ An important concern was that there was no system of direct daily reporting of coronial deaths to the City Coroner. Deaths were reported to the Clerk at the Court of Petty Sessions and, possibly as

a result of the move away from the law courts, the coroner was not immediately notified. The coroner first learned of a relevant death when the typed post mortem report arrived at the Coroner's Office.⁴⁴ This had undesirable consequences because, although the power to order a post mortem examination rested with the coroner,⁴⁵ the decision to post mortem was effectively taken out of the coroner's hands.⁴⁶ It was also observed that the structures constituting the forensic medicine arm of the coronial process, such as forensic pathology, toxicology, neuropathology and others were housed in different locations with 'no guiding hand to coordinate their efforts or resources'.⁴⁷ Because the coronial system depended upon regional magistrates acting as ex officio coroners, there were different approaches to the performance of the duties of coroner and different interpretations of coronial practice in different parts of the state.⁴⁸ There was also little, if any, contact between the coroner's office and the family of the deceased.⁴⁹

When David McCann SM took office as City Coroner in 1982, he sought immediately to rectify these problems. A system of direct daily death reporting was instituted, enabling the City Coroner to give directions in appropriate cases for post mortem examinations. Certain protocols were established with the forensic services, including the formalising of requests to the coroner to approve use of tissue samples for research purposes. Coronial practice guidelines were issued by the City Coroner for the consideration of regional magistrates and the City Coroner began to assist regional magistrates by undertaking some of the more lengthy inquests in country areas. McCann also effected contact with relatives of a deceased by letter at an early time in the investigation. This letter explained the coronial process and invited contact with the coroner's office if the family had any queries.⁵⁰

In the late 1980s the disparities between coronial practice in Perth and the regions remained a concern and 'inefficiencies and difficulties arising from' the regionalised system were noted.⁵¹ A committee was formed in 1989 to review the coronial system and

36. *Coroners Act Amendment Act 1979* (WA) s 23.

37. *Coroners Amendment Act 1982* (WA) s 2.

38. McCann DA, 'Coronial Inquests – Current Issues' (Paper presented to the Law Society of Western Australia's Continuing Legal Education Seminar, Perth, 3 March 1994) 3.

39. *Ibid.* There were nine coronial districts including Perth.

40. *Ibid.* City Coroners were long serving; the three last city coroners serving for 15, 17 and 13 years respectively.

41. David McCann, correspondence (28 October 2009) 4.

42. *Ibid.*

43. *Ibid.*

44. *Ibid.*

45. *Coroners Act 1920* (WA) s 40.

46. David McCann, correspondence (28 October 2009) 4.

47. *Ibid.* 6.

48. *Ibid.* 7.

49. *Ibid.* 5.

50. *Ibid.* 8–11. A more detailed letter was sent to the family in cases of sudden infant death.

51. *Report of an Ad Hoc Committee for the Review of the Coroners Act* (August 1989) 6.

the *Coroners Act 1920*.⁵² This was followed by an inquiry into aspects of coronial autopsies following public concern about retention of organs without consent. The reports of these committees of inquiry are discussed below.

The Ad Hoc Committee Inquiry

The Ad Hoc Committee for the Review of the Coroners Act ('the Committee') was constituted by David McCann (who held the position of City Coroner at the time), Christine Wheeler (representative of the Crown Solicitor's Office) and Dominic Bourke (representative of the Law Society of Western Australia). The Committee noted concerns with the existing system in Western Australia. These included the lack of clarity about what types of death should be reported to a coroner; the problems noted above in relation to differences of coronial practice in Perth and the regions; and the lack of statutory support for coroners' investigative and discretionary powers.⁵³ It also noted that many of these concerns had already been expressed in the interim report of the Royal Commission into Aboriginal Deaths in Custody and that Western Australia was lagging behind other jurisdictions that had abolished the coroner's power to commit to trial and investigate fires.⁵⁴

The Committee reported in August 1989 recommending the repeal of the *Coroners Act 1920* and substantial changes to the jurisdiction of the coroner.⁵⁵ A major structural change following the model adopted in Victoria was recommended. This involved the abolition of the regional system of independent coronership and institution of a centralised system constituted by a legally trained State Coroner of the status of a District Court judge and a Deputy State Coroner of the status of magistrate.⁵⁶ However, the Committee noted that the geography of the state was such that regional magistrates must retain the powers of a coroner serving 'under the direction and guidance of the State Coroner, where necessary and appropriate'.⁵⁷ The Committee also made recommendations to remove the coroner's jurisdiction into the cause of fires not resulting in death;⁵⁸ to clearly define what types of death should be reported to the coroner;⁵⁹ to empower the State Coroner to issue guidelines

52. Ibid.

53. Ibid 18.

54. Ibid 8–9.

55. Ibid, recommendation 1.

56. Ibid, recommendations 2 & 3.

57. Ibid 12 & recommendation 4.

58. Ibid, recommendation 6.

59. Ibid 13 and recommendations 7 & 8.

to police, hospitals, medical practitioners and others outlining responsibilities in relation to reporting of deaths and investigation of deaths;⁶⁰ to abolish the power of the coroner to commit to trial;⁶¹ to abolish the use of coronial juries;⁶² and to legislate as to what categories of person should be entitled to appear as interested persons at an inquest.⁶³

A particular concern raised by submissions to the Committee involved the role of police officers in investigating deaths in custody.⁶⁴ The Committee recommended that a 'group of civilian investigators responsible directly to the State Coroner' be established to 'assist in the investigation of complex and contentious cases, including deaths in custody'.⁶⁵

The Honey Inquiry

In May 1992, amidst growing community concern about post mortem practices and 'dealings with body parts in particular',⁶⁶ the Minister for Justice established a committee to inquire into issues relating to coronial post mortem. The committee was constituted by Colin Honey (ethicist), Wendy Silver (social welfare administrator), Derek Pocock (retired forensic pathologist) and Dominic Bourke (lawyer). The terms of reference for the inquiry asked the committee to examine the purpose and conduct of coronial post mortem examinations with particular reference to 'the ways in which the body is examined'.⁶⁷ The focus of the terms of reference was the role of the next of kin in the coronial post mortem process and how much information about the process they should be given in respect of their deceased relative. An important aspect of the inquiry was to examine the circumstances under which tissue, which had been removed for the purposes of post mortem examination, may be used for teaching and research.⁶⁸

The Honey Inquiry made a total of nine recommendations. It embraced the recommendations of the Ad Hoc Committee and recommended implementation of a unified state coronial system. To facilitate the process of communication between

60. Ibid 14 and recommendation 9.

61. Ibid, recommendation 13.

62. Ibid, recommendation 11.

63. Ibid, recommendation 10.

64. Ibid 17.

65. Ibid, recommendation 5.

66. As expressed in the Committee's terms of reference: *Report of the Committee of Inquiry into Aspects of Coronial Autopsies* (December 1992) 1.

67. Ibid 1.

68. Ibid 2.

coronial entities and a deceased's relatives it recommended that a coronial counselling service be established. This focus on informing relatives of a deceased about the coronial process can be seen in many of the remaining recommendations, which included that the coroner be resourced to undertake public education about the coronial process, that next of kin be notified about decisions to post mortem and that an information brochure about the coronial process be given to next of kin at the earliest opportunity. The Honey Inquiry also recommended that there be a right of appeal against a coroner's decision to conduct or not to conduct a post mortem examination and that an ethics committee be established to consider requests for access to post mortem material for research purposes.⁶⁹

When government received the report of the committee in December 1992 it refrained, for some time, from making it public. When it did finally release the full report for public consultation the government received over 2,700 submissions.⁷⁰ These submissions primarily showed concern about three areas of coronial practice: 'communication between the next of kin and those involved in the post mortem examination and coronial inquiry; the rights of the next of kin; and retention or use of body parts or tissue'.⁷¹ In 1995 a Bill was introduced into Parliament to respond to the reports of the abovementioned Western Australian committees of inquiry,⁷² the report of the Royal Commission into Aboriginal Deaths in Custody⁷³ and to the public demands for changes to coronial procedures.⁷⁴ After lengthy debate, the Bill was passed in May 1996 and became the *Coroners Act 1996* (WA).

THE CORONERS ACT 1996

The *Coroners Act 1996* (WA) responded to community concerns about the coronial process by ensuring that relatives of the deceased were involved in the decision-making processes surrounding the death of their loved one, including the ability to

apply to the coroner for a public inquest into the death⁷⁵ and to apply for or object to a post mortem examination.⁷⁶ It also provided for the ability to appeal against a decision of a coroner in these respects.⁷⁷ Other innovations of the *Coroners Act 1996* were a statutory requirement that certain information be provided to the next of kin⁷⁸ and the establishment of a coronial counselling service to assist people to understand the coronial process.⁷⁹

The Act also implemented many of the recommendations of the Ad Hoc Committee, including removal of the fire jurisdiction, the institution of a coordinated statewide coronial system with a separately constituted coroners court,⁸⁰ a state and deputy state coroner⁸¹ based in Perth, and magistrates undertaking coronial work in regional areas.⁸² It provided for the appointment of independent coronial investigators,⁸³ as well as making every member of the police force contemporaneously a coronial investigator.⁸⁴ It gave investigators powers to control access to scenes of death and the power to search and seize material relevant to an investigation into the death.⁸⁵

A particular advance of the *Coroners Act 1996* was the implementation of the majority of the coronial recommendations of the Royal Commission into Aboriginal Deaths in Custody. These included mandatory reporting and inquest of all deaths in custody,⁸⁶ the requirement that death in custody coronial investigations include investigation into the quality of care, treatment and supervision of the deceased;⁸⁷ that the family may have an independent doctor attend the post mortem examination;⁸⁸ and that the coroner be assisted by legal counsel in death in custody cases.⁸⁹

69. Ibid 24–25.

70. Western Australia, *Parliamentary Debates*, Legislative Assembly, 22 June 1995, 5703 (Ms C Edwardes, Attorney General).

71. Ibid.

72. *Report of an Ad Hoc Committee for the Review of the Coroners Act* (August 1989) ('the Ad Hoc Committee Report'); *Report of the Committee of Inquiry into Aspects of Coronial Autopsies* (December 1992).

73. *Report of the Royal Commission into Aboriginal Deaths in Custody* (Canberra: Australian Government Publishing Service, 1991).

74. Such demands, including a lengthy media campaign primarily in the *West Australian* newspaper, are recounted at length in the parliamentary debates on the Coroners Bill 1995.

75. *Coroners Act 1996* (WA) s 24.

76. *Coroners Act 1996* (WA) ss 36 & 37.

77. *Coroners Act 1996* (WA) ss 24(2) & 37(3).

78. *Coroners Act 1996* (WA) s 20.

79. *Coroners Act 1996* (WA) s 16.

80. *Coroners Act 1996* (WA) s 5.

81. *Coroners Act 1996* (WA) ss 6 & 7. Although the position of the State Coroner was not established at District Court judge level as recommended by the Ad Hoc Committee. Instead the State Coroner is a head of jurisdiction on the same level as a Chief Stipendiary Magistrate in relation to tenure and conditions only, while the Deputy State Coroner is a magistrate.

82. *Coroners Act 1996* (WA) s 11. Under direction of the State Coroner (with approval of the Chief Magistrate).

83. *Coroners Act 1996* (WA) s 14(1).

84. *Coroners Act 1996* (WA) s 14(2).

85. *Coroners Act 1996* (WA) ss 32 & 33.

86. *Coroners Act 1996* (WA) ss 3 & 22(1).

87. *Coroners Act 1996* (WA) s 25(3).

88. *Coroners Act 1996* (WA) s 35.

89. *Coroners Act 1996* (WA) s 45(2). There are now three legal counsel assisting in the Coroner's Office and in practice they undertake the majority of coronial inquests, in particular contentious or complex cases.

REVIEWS OF THE CORONERS ACT 1996

The *Coroners Act 1996* commenced on 4 May 1997 and is the existing legislation governing the coronial jurisdiction in Western Australia. To ensure that it continued to reflect community needs,⁹⁰ the Attorney General promised an initial review of the operation of the Act after 12 months. This review (the Chivell Review) is discussed below. Section 57 provides for ongoing review of the operation of the Act 'as soon as practicable after every fifth anniversary' of its commencement. Although some 13 years have passed since commencement of the *Coroners Act 1996*, only one review has ever been undertaken pursuant to this section. That review (the Barnes Review) is also discussed below.

The Chivell Review 1999

In August 1998 Wayne Chivell, State Coroner of South Australia, was invited to conduct an independent review of 'the operation of the new legislation, protocols, guidelines and the Ethics Committee [to] address any deficiency in the system'.⁹¹ Chivell travelled to Perth and undertook consultations with a wide range of people involved in or associated with the coronial system.⁹² In his report of May 1999, Chivell noted that the new system had been 'smoothly and successfully implemented, despite the radical nature of some of the changes made'.⁹³ He observed that the recommendations of the Royal Commission into Aboriginal Deaths in Custody, as they relate to the coronial system, had been implemented in Western Australia to a greater extent than any other state.⁹⁴ Chivell made a total of 15 recommendations which included the need for development of protocols addressing the qualifications of coronial investigators and to deal with transport of bodies from regional Western Australia to Perth for post mortem examination. Chivell made a number of recommendations about the definition of senior next of kin in s 37(5) of the Act. He suggested that consideration should be given to including partners in same-sex couples as

having priority under s 37(5)⁹⁵ and that a provision be inserted to enable a person to apply to the State Coroner seeking an order that he or she be regarded as the senior next of kin having regard to the customary law of the deceased.

Chivell noted the lack of coronial counselling services in regional areas and recommended that consideration be given to how these could be improved, particularly in relation to Aboriginal Western Australians.⁹⁶ He also noted the lack of an appropriate computer system in the Coroner's Office, which had contributed to communication problems between the office and external services supporting the coronial system.⁹⁷ Those involved in the forensic medicine arm of the coronial system suggested that there should be an ability to directly transfer information by computer between the relevant offices so as to reduce reliance on outmoded technologies such as facsimile and a recommendation was made to this effect.⁹⁸

So far as investigations were concerned Chivell's consultations revealed that police had concerns about their ability effectively to undertake investigations of a specialist nature, in particular in respect of medical and workplace deaths. While not making a recommendation in this regard, Chivell noted that if issues continue it may become necessary to appoint non-police specialist investigators to investigate specific cases.⁹⁹ Responding to other concerns of police, Chivell recommended that police officers attending a scene of death be empowered to search and seize relevant material without requiring a formal application for warrant.¹⁰⁰

Many of Chivell's recommendations for legislative reform, including the recommendations regarding search and seizure and the status of partners in same-sex couples, were implemented by the *Coroners Amendment Act 2003* (WA). Certain other recommendations were implemented by the State Coroner by means of establishing protocols and issuing guidelines for police deaths in custody.¹⁰¹

90. Western Australia, *Parliamentary Debates*, Legislative Assembly, 22 June 1995, 5702 (Ms C Edwardes, Attorney General).

91. Chivell W, *Report on Review of the Coroners Act 1996* (WA) (May 1999) 5.

92. A list of people consulted for the review may be found in the report: *ibid* 5–6.

93. *Ibid* 1.

94. *Ibid* 11. That is, by the legislation as well as by the coroner's guidelines.

95. This was ultimately implemented by the *Coroners Amendment Act 2003* (WA) s 12 and the *Equality of Status Act 2003* (WA) s 27.

96. *Ibid* 27–29.

97. *Ibid* 30.

98. *Ibid* 31.

99. Chivell W, *Report on Review of the Coroners Act 1996* (WA) (May 1999) 38.

100. *Ibid* 40.

101. Recommendations of the Chivell Review that remain relevant but unimplemented will be discussed in detail in the Commission's Discussion Paper on this reference.

The Barnes Review 2008

In 2008 Michael Barnes, State Coroner for Queensland, conducted a review of the operation of the *Coroners Act 1996* pursuant to s 57, which provides that the review should consider:

- (a) the attainment of the objects of this Act
- (b) the administration of this Act;
- (c) the effectiveness of the operation of the court; and
- (d) such other matters as appear to be relevant to the operation and effectiveness of this Act.

The review was conducted with the knowledge that the Law Reform Commission of Western Australia had been given a contemporaneous reference to undertake a wider review of the coronial jurisdiction. Barnes was invited to make specific comment on practical and resourcing issues for the Coroners Court and to refer to the Commission any issues that arose during the review that he considered to be beyond the scope of the s 57 statutory review.¹⁰² Barnes reported to the Attorney General in August 2008¹⁰³ making a total of eight recommendations for substantive reform and a number of smaller recommendations for technical reforms to the Act. Barnes' primary recommendations included:

- that an objects clause be inserted into the Act;
- that the Commission consider in its reference the development of a 'normative theory' of the role of coroners and the scope and function of the system;
- that resources provided to the Coroners Court reflect the 'continuing evolution of the role of the coroner and the added demands this generates';
- that consideration be given by the Commission as to whether the Office of the State Coroner should be administratively independent from the Magistrates Court;
- that budget for conduct of post mortem examinations and tissue testing be separate to the Coroners Court budget;
- that all coronial work be centralised to the Office of the State Coroner in Perth; and
- that the workforce of the Office of the State Coroner be augmented by the addition of a

102. Barnes M, *Review of the Coroners Act 1996 (WA)* (August 2008) 1.

103. The Barnes Review is not yet available publicly.

senior coronial counsellor, two further legal counsel, an additional coroner and a number of administrative assistants.¹⁰⁴

A number of opportunities for desirable statutory amendment were also flagged by Barnes. These included the insertion of a reporting requirement for health-care related deaths; the extension of the definition of 'person held in care' to include deaths of those in care or custody of Commonwealth agencies or pursuant to a Commonwealth Act; review of the level of certain penalties in the existing Act; the adoption of partial, external post mortem examinations at first instance; the institution of directions hearings; statutory recognition of Western Australian participation in the National Coronial Information System; and the obligation of agencies to respond to coronial recommendations or findings.¹⁰⁵ The Attorney General has invited the Commission to consider these proposed amendments in its review of the coronial jurisdiction.¹⁰⁶

104. Barnes M, *Review of the Coroners Act 1996 (WA)* (August 2008), recommendations 1–7. Recommendation 8, pertaining to the retention of police positions within the Coroner's Office, had been implemented at the time of this report.

105. *Ibid* 21–29.

106. Christian Porter MLA, Attorney General for Western Australia, correspondence (21 January 2009).

Chapter Two

The Colonial Process in Western Australia

Contents

The current coronial process	15
Criteria for coronial cases	15
Post mortem process	16
Next of kin notification	16
Control of the body	16
Objection to post mortem	16
Post mortem examination and report	17
Investigation Process	18
Police investigation	18
Investigation by non-police entities	19
Coronial determination	19
Inquests	19
Mandated inquests	20
Administrative findings	20
Findings and comments	21
Recommendations	21
Inside the Office of the State Coroner	24
Resourcing	24
Key staff	24
Office manager	25
Registry manager	25
Office administrator	25
Medical adviser	25
Legal counsel assisting	26
Police sergeants	26
Coronial counsellors	26
Officer of the State Coroner – structure	27

The current coronial process

CRITERIA FOR CORONIAL CASES

Coroners in Western Australia only investigate deaths (and suspected deaths)¹ that fall into the definition of 'reportable deaths' under s 3 of the *Coroners Act 1996* (WA). Reportable deaths include deaths that appear to have been 'unexpected, unnatural or violent or to have resulted, directly or indirectly, from injury'. Examples of deaths that fall into these categories include suicides, traffic deaths, accidents, sudden unexplained deaths of infants (SUDI), deaths following an injury or fall, deaths from drug overdose, unexpected deaths during or following a surgical procedure, deaths from drowning and homicides.

Deaths are also reportable if they occur during or as a result of an anaesthetic, if the deceased person's identity is unknown or if the death 'appears to have been caused or contributed to by any action of a member of the police force'. Finally, deaths of a 'person held in care' are reportable to the coroner. A person held in care is defined to include a person in prison, juvenile detention or police custody, an involuntary inpatient at a mental health facility, a person on a community treatment order under the *Mental Health Act 1996* (WA), a person admitted to a centre under the *Alcohol and Drug Authority Act 1974* (WA), and a child who is the subject of a care and protection order.²

Under the *Coroners Act* a person is obliged to report deaths falling into the above categories to the coroner or a police officer immediately upon becoming aware of the death.³ In the case of some natural causes deaths, deaths of the elderly at

home, or deaths at a nursing home or a hospital, a doctor may be called to attend the scene of death and may certify life extinct.⁴ Under s 44 of the *Births, Deaths and Marriages Registration Act 1998* (WA), a doctor may also provide a certificate as to cause of death if the death is not reportable under the *Coroners Act* and the doctor was responsible for the person's medical care immediately before death or if he or she has examined the deceased's body.⁵ Often a doctor (or coronial investigator) will telephone the Coroner's Office if he or she is unsure whether a death is reportable. After discussion with the coroner's registrar,⁶ the doctor is advised if a death certificate will be accepted in respect of the particular death or whether the death requires a coronial investigation. In some cases the deceased's body may be transported to the state mortuary before a determination as to acceptance of a death certificate can be made.⁷ Once a death certificate is issued the coronial case falls away, unless information later comes to light to suggest the death is reportable.⁸ An example might be where an elderly person has died in hospital of a brain aneurysm, but the doctor was not aware that the deceased had fallen and sustained an injury prior to admission.

1. Section 23 of the *Coroners Act 1996* (WA) provides that 'where a person is missing and the State Coroner has reasonable cause to suspect that the person has died and that the death was a reportable death, the State Coroner may direct that the suspected death of the person be investigated'. Examples of suspected deaths investigated by the coroner have included suspected death by drowning where a body has not been recovered after a boating or fishing accident or following a failed rescue attempt. Where an investigation of a suspected death is investigated by the coroner an inquest must be held into the circumstances of the suspected death: s 23(2). Often inquests are held many years after the suspected death of the person.
2. *Coroners Act 1996* (WA) s 3.
3. Unless 'the person has reasonable grounds to believe that the death has already been reported': *Coroners Act 1996* (WA) s 17.

4. Life extinct certification is only required where a death certificate (showing cause of death) is not issued. A doctor may do so in circumstances where he or she is not comfortable issuing a death certificate because of inability to reliably determine cause of death.
5. Special provisions apply in relation to certifying the deaths of still-borns and neonates: *Births, Deaths and Marriages Registration Act 1998* (WA) s44(2) & (3).
6. This duty may be performed by the registry manager, assistant registry manager or manager of the Office of the State Coroner in Perth or the registrar of a Magistrates Court in the regions. These officers act as 'coroner's registrars' under delegation of power under the *Coroners Act 1996* (WA) s 10. Either the registry manager or manager of the Office of the State Coroner is on-call on a 24-hour basis to advise doctors, hospitals and coronial police as to whether a particular death requires a full coronial investigation.
7. Hope A, 'Inside the Coroners Court' (2010) 37(1) *Brief: Journal of the Law Society of Western Australia* 8, 9. For example, in cases where the cause of death is known and the death may be dealt with by death certificate but the deceased's treating doctor is not available to issue the certificate. If a death certificate has not been issued by a doctor within a reasonable period the death will be classified as reportable and a full coronial investigation will follow: Gary Cooper, Manager Coroner's Office (WA), email (23 June 2010).
8. Sometimes a funeral director, family member or mortuary manager of a hospital may bring information about a deceased, for whom a death certificate has been issued, to the coroner's attention. The coroner may then ask for the body to be delivered to the State Mortuary to determine whether the death is reportable and requiring of a full coronial investigation.

The fact that the aneurysm (as the immediate cause of death) may have been indirectly caused by the fall makes this case a reportable death under the *Coroners Act*.

In cases of deaths from non-natural causes (eg, suicides, traffic accidents, deaths in suspicious circumstances, drug deaths, mining and workplace accidents)⁹ the police and/or ambulance officers will often be called to the scene of the death. Ambulance officers, nurses and doctors may certify life extinct in all cases,¹⁰ but police officers may only do so in cases where there is 'obvious death' (ie, in cases of extensive trauma, well-established or advanced decomposition).¹¹ In these cases a death certificate will not be issued until the investigation of the coroner is complete; however the Registrar of Births, Deaths and Marriages must be notified of the death¹² within 14 days of the date of death, finding of the deceased's body or 'placement'¹³ of the body. In coronial cases the registration of particulars of death will generally be designated as 'incomplete'; full registration will follow after the coroner has made a finding about the cause of death.¹⁴

POST MORTEM PROCESS

Next of kin notification

As soon as practicable after the coroner assumes jurisdiction to investigate a death, he or she must notify the next of kin that a post mortem examination is likely to be performed on the body and that there is a right to object to the examination or to have an independent doctor present at the examination.¹⁵ In practice this legislative requirement is met by police serving a brochure, 'When a Person Dies

Suddenly',¹⁶ on the next of kin. The brochure provides basic information about the role of the coroner, the rights of the next of kin, and organ and tissue donation. Police are required to explain the contents of the brochure to the next of kin, including their right to object to post mortem examination of the deceased.¹⁷ The time of notification of service of the brochure is recorded in the Mortuary Admission Form. Under coronial guidelines the next of kin has 24 hours from this time in which to object to the performance of a post mortem examination and this is noted on the brochure.¹⁸

Control of the body

Once a death becomes a coronial case the coroner investigating the death assumes control of the body of the deceased.¹⁹ At the earliest opportunity police or the hospital will telephone the designated coronial body transport contractor to collect the body and transfer it to the State Mortuary. In Perth the body will be transferred directly to the State Mortuary, but in regional areas the body will usually remain at the local hospital morgue until the post mortem objection period has passed, after which time the body will be transported to the State Mortuary in Perth for post mortem examination. While the body is under control of the coroner the family of the deceased are permitted to view the body and also to touch the body, unless the coroner determines that it is 'undesirable or dangerous to do so'.²⁰

Objection to post mortem

Under s 37 of the *Coroners Act*, the senior next of kin²¹ of the deceased may object to a post mortem examination being performed on the deceased. No time period for objection is stated in the *Coroners Act*, but in practice 24 hours, including one full working day, is usually given before a direction to perform a

9. 'Non-natural causes' is the terminology employed by the Office of the State Coroner to describe these types of deaths.
10. After having made the assessments required to complete the Coroners Court of Western Australia, 'Life Extinct Form' (that is, to discover no pulse, heart sounds or breathing sounds; no response to centralised stimuli; and the presence of fixed, dilated pupils).
11. See Coroners Court of Western Australia, 'Life Extinct Form'.
12. Notification is the responsibility of the funeral director who arranges for disposal of the deceased's remains: *Births, Deaths and Marriages Registration Act 1998 (WA)* s 42.
13. The Commission is advised that 'placement' in this context refers to placement of the body at a scientific or educational institution under s 42(b): Rohan Quinn, Registry Manager, Registry of Births, Deaths and Marriages, consultation (6 August 2010).
14. *Births, Deaths and Marriages Registration Act 1998 (WA)* s 48. A death certificate may be issued upon request to the Registrar of Births, Deaths and Marriages following complete registration of particulars of death after a coronial finding has been made.
15. *Coroners Act 1996 (WA)* s 20.

16. A copy of 'When a Person Dies Suddenly' is appended to this paper at Appendix B.
17. Coroners Court of Western Australia, 'Guidelines for Police' (undated) guideline 5. Guideline 5 directs that 'all reasonable steps should be taken to ensure [the next of kin] understands the rights contained in the brochure. This includes providing for a translator if necessary.'
18. Coroners Court of Western Australia, 'When a Person Dies Suddenly' (August 2007). See also Coroners Court of Western Australia, 'Guidelines for Coroners' (undated) guideline 9.
19. *Coroners Act 1996 (WA)* s 30.
20. *Coroners Act 1996 (WA)* s 30(2). For example, in a case of potential homicide (where evidence may be tainted by permitting family to touch the deceased) or infection.
21. *Coroners Act 1996 (WA)* s 37(5) defines senior next of kin as the 'first person who is available' from a list of persons beginning with the spouse or de facto spouse of the deceased and followed by a child of the deceased over the age of 18 years, a parent of the deceased, a sibling of the deceased, an executor of the deceased's will and a person nominated by the deceased to be contacted in an emergency.

post mortem is made by the coroner or his or her delegate.²² In some cases it is necessary that a post mortem examination be performed immediately (eg, where there are suspicious circumstances surrounding the death of the person or in suspected cases of severe and potentially dangerous infection).²³ In these cases a coroner will direct that the post mortem examination be performed immediately and give notice in writing to the next of kin.

Where an objection has been made, the coroner must make a determination whether to direct a post mortem taking into account 'the views of any person who has asked the coroner to perform a post mortem on the body or the views of the senior next of kin of the deceased if that person has asked a coroner not to direct a post mortem examination'.²⁴ If the coroner rejects the application he or she must give notice to the next of kin and the next of kin may apply (within two working days) to the Supreme Court for an order that no post mortem examination be performed.²⁵

In practice, when a person makes a formal objection to a post mortem examination a coronial counsellor will contact the next of kin to discuss the objection and ascertain the reason for the objection. The counsellor will explain the process and how a post mortem examination can benefit the family by providing a more precise answer about the cause of death and, sometimes, by identifying a genetic cause of death that may affect descendants of the deceased.²⁶ Data recorded in the State Coroner's annual reports show that objections to post mortem examination are received in around 10–12% of coronial cases with approximately one-third of these objections being subsequently withdrawn prior to a ruling by the coroner.²⁷

Post mortem examination and report

Post mortem examinations of deceased who died within Western Australia are undertaken at the State Mortuary, which is part of the PathWest

complex at QEII Medical Centre in Perth.²⁸ PathWest has a team of experts who may contribute to a coronial investigation. These experts include forensic pathologists (who conduct post mortem examinations), odontologists (who specialise in identification of a deceased from dental records), forensic anthropologists (who specialise in the retrieval, examination and identification of skeletal remains), and forensic biologists (who specialise in DNA analysis). PathWest also utilise the services of specialist clinicians attached to the nearby Sir Charles Gairdner Hospital, in particular in the areas of neuropathology and radiology.²⁹

In Western Australia it appears that in the majority of coronial cases, unless there has been a successful objection lodged by the next of kin, a full post mortem examination will be performed. A full post mortem examination involves external examination of the body (including, photography and examination of the clothing); assessment of any known medical information; imaging, such as by x-ray and, infrequently, by CT scan; and examination of the internal body organs, both microscopically (histopathology) and by dissection and 'naked eye' inspection.³⁰ Testing of tissue, urine, blood and other samples following post mortem is also performed. In some cases there will be testing for infection (microbiology and virology), which is performed by PathWest on-site.³¹ In most coronial cases, samples³² will be taken for toxicological analysis to establish the presence of drugs, alcohol and poisons. This analysis is done off-site at ChemCentre, which is a statutory authority. In some cases (such as sudden unexplained infant death) there will be an examination of nervous tissue, in particular the intact brain (neuropathology).

Following gross examination of the body of a deceased, an interim post mortem report is forwarded to the coroner. This may contain a preliminary determination as to cause of death, but will usually be subject to the receipt of toxicological analysis and other tests ordered by the forensic pathologist. The completed

22. This means that if a person dies on a Thursday evening the post mortem examination would be scheduled for the Monday and if an objection was lodged prior to the post mortem examination beginning it would be considered by the coroner under s 37. Likewise, if a person died on the weekend then the 24 hours would start from the Monday and the post mortem examination would be scheduled for the Tuesday. See Coroners Court of Western Australia, 'Guidelines for Coroners' (undated) guideline 9.

23. Ibid, guideline 8.

24. Ibid, guideline 12.

25. *Coroners Act 1996* (WA) s 37(3).

26. Coronial Counsellors, consultation (22 August 2008) 28–29.

27. LRCWA, *Post Mortem Objection Data Study 1997–2007* (May 2009).

28. Albany is the only location outside metropolitan Perth which has a doctor who performs post mortem examinations. This doctor will only perform post mortem examinations in cases where the death is a suspected natural causes death.

29. PathWest, consultation (19 August 2008).

30. Cooke CT, Chief Forensic Pathologist, 'Submission to the Inquiry into Aspects of Coronial Autopsies from the Forensic Pathology Division, QEII Medical Centre', *Report of the Committee of Inquiry into Aspects of Coronial Autopsies* (December 1992) Appendix III.

31. PathWest, consultation (19 August 2008) 3.

32. Generally these samples are taken from liver tissue, urine, blood, bile from the gall bladder and stomach contents.

post mortem report can take from 3–18 months³³ to be received by the coroner. Neuropathology can result in significant delays because it is a very specialised area and, until recently, there was only one neuropathologist working in Western Australia (in both clinical and forensic areas). Further, because of the necessity to ‘harden’ the brain in formalin for a period before neuropathological examination can be undertaken, it is likely that the body will be released without the brain where neuropathology is required.³⁴

INVESTIGATION PROCESS

Police investigation

Under s 14(2) of the *Coroners Act* all police officers are contemporaneously coroner’s investigators and in every coronial case there will be some degree of police investigation. There are a number of different units or divisions within the Western Australia Police that investigate reportable deaths:

- **Coronial Investigation Unit:** investigate non-suspicious deaths, natural causes deaths, drug-related deaths,³⁵ hospital or medical-related reportable deaths, and sudden unexplained infant deaths.³⁶ The Coronial Investigation Unit (CIU) is staffed by a team of approximately 20 uniformed police officers headed by an Inspector and covers the entire metropolitan area.
- **Major Crime Squad:** investigate suspected homicides or suspicious deaths, deaths in police custody or presence (oversighted or jointly investigated by Internal Affairs), deaths in prison custody or juvenile detention (oversighted or jointly investigated by Internal Affairs),³⁷ and deaths in mental health facilities.

- **Special Crime Squad:** investigate unsolved (cold case) suspected homicides.
- **Major Crash Investigation Unit:** investigate traffic deaths and deaths where police have been in pursuit of a vehicle or involved in a traffic accident (oversighted or jointly investigated by Internal Affairs).
- **Local Police:** investigate some deaths in the metropolitan area (eg, natural causes deaths and drug-related deaths) and most deaths in regional areas (unless referred to a metropolitan squad such as Major Crime).

Police investigation will usually begin immediately upon discovery of the body. In many cases local police or ambulance officers will attend the scene of death and they will notify the CIU immediately of the death. For a suspected homicide the scene will be ‘locked down’ at the first opportunity and officers from the Major Crime Squad will be notified and attend the scene with forensic crime scene investigators. For suspected suicides, drug overdoses, hospital deaths, workplace accidents and sudden unexplained infant deaths³⁸ the scene is preserved as well as possible by local police until the CIU officer attends at the scene. It is not always possible for officers from the CIU to attend the scene of every death, so deaths that are most likely deaths by natural causes are sometimes attended by local police and CIU become involved at the stage that the report is formulated for the coroner.³⁹

Investigations in natural causes deaths generally take between three and six months (depending on when the post mortem examination report is received), but for non-natural, non-suspicious deaths (such as suicides and traffic deaths), the investigation and provision of a report to the coroner appears to take a lot longer.⁴⁰ When completed investigation reports are forwarded to the coroner they are checked by the two sergeants based at the Coroner’s Office. These sergeants act as a liaison between the coroner and the investigating officers to ensure that everything required for inquest or to finalise a coronial finding

33. Toxicology results and other external reports can be expedited in urgent cases (such as suspected homicides); however, in cases where charges are pending the coroner is unable to process the file and close the case until all prosecutions have finished.

34. Cooke CT, Chief Forensic Pathologist, ‘Submission to the Inquiry into Aspects of Coronial Autopsies from the Forensic Pathology Division, QEII Medical Centre’, *Report of the Committee of Inquiry into Aspects of Coronial Autopsies* (December 1992) Appendix III.

35. If illicit drugs are involved there may also be an investigation by the Organised Crime Unit or Drug Squad.

36. Sudden unexplained infant deaths are jointly attended by an officer from the Major Crime Squad to ensure that there is no criminality involved in the death. According to police approximately 1% of child death cases feature suspicious circumstances: Western Australia Police, consultation (18 August 2008).

37. In relation to deaths in custody the Department of Corrective Services (Standards and Review Directorate) also undertakes an internal review of the prison’s compliance with departmental standards, policies and processes. This is provided to the coroner prior to inquest: Sue Holt, Manager Critical Review

Team, Department of Corrective Services, consultation (24 September 2008).

38. A pilot ‘first response’ protocol, operating since August 2008 in Perth, is employed with sudden unexplained deaths of infants and children under the age of 14 years. In these cases an on-call nurse attends the scene with police to get an immediate medical history of the case and liaise with the parents: SIDS and Kids, consultation (1 September 2008).

39. Western Australia Police, consultation (26 November 2009) 8.

40. Ibid 14.

has been provided. Where additional statements or inquiries are required by the coroner, these are requested of the investigating officer or inquiries are made directly by the in-house sergeants.⁴¹

Investigation by non-police entities

There are a number of cases where additional specialist investigations are undertaken by non-police investigators. These investigations run concurrently with a police investigation and may contribute to the coronial investigation by provision of specialist reports or advice. Specialist investigators (and areas of investigation) include:

- **WorkSafe:** industry-based WorkSafe inspectors investigate workplace deaths or industrial accidents and prosecute offences under the *Occupational Safety and Health Act 1984* (WA).
- **Department of Mines and Petroleum (WA):** mines inspectors from the Resources Safety Division investigate mining deaths and prosecute offences under the *Mines Safety Inspection Act 1994* (WA).
- **Australian Transport Safety Bureau (ATSB):** ATSB investigators conduct investigations into aviation, maritime and rail deaths under the *Transport Safety Investigation Act 1993* (Cth). The investigators are independent of regulatory authorities and other bodies. They conduct 'no-blame investigations' which focus on formulating recommendations to enhance transport safety.⁴²
- **Western Australian Review of Mortality:** clinical teams investigate inpatient deaths in public hospitals and licensed private health care facilities to establish recommendations for system improvements to prevent future harm of death from similar circumstances.⁴³

Other reviewers of deaths in Western Australia include:

- **Office of the Chief Psychiatrist (WA):** following a death in a mental health facility (in particular, sentinel events such as suicide of an inpatient),⁴⁴

41. Sergeant Geoff Sorrell, Coroner's Office (WA), consultation (27 October 2008) 2–3.

42. Australian Transport Safety Bureau (ATSB), *Analysis, Causality and Proof in Safety Investigations*, Aviation Research and Analysis Report AR2007-053 (2008) 4.

43. Western Australian Review of Mortality (WARM), *Policy and Guidelines for Reviewing Inpatient Deaths* (2008).

44. Sentinel events are adverse events (causing harm or death) in nationally endorsed categories which require mandatory

a root cause analysis (RCA) is conducted by the facility. The Chief Psychiatrist examines the RCA reports to determine whether the death warrants a targeted review by his office to assess practices and procedures that may have impacted on the death.⁴⁵

- **Ombudsman (WA):** Under Division 3A of the *Parliamentary Commissioner Act 1971* (WA) the Ombudsman conducts reviews into the unexpected deaths of children known to the Department for Child Protection. Reviews are undertaken for the purposes of ascertaining the circumstances of the death, identifying any patterns or trends in child deaths, and making recommendations to improve policies and practices for the prevention of deaths of children in similar circumstances.⁴⁶

Most of these specialist investigators undertake death investigations in order to make relevant changes to practices, procedures and policies that could prevent similar deaths in the future; however, some (such as WorkSafe and the Department of Mines and Petroleum) have authority under their legislation to prosecute for negligent practices or actions resulting in deaths. Section 53 of the *Coroners Act* provides that where a person has been charged with an offence in respect of a death, any coronial inquest into the death must not commence (or must be adjourned) until after the criminal proceedings have been concluded. Delays in notification of an intention to prosecute can, therefore, impact on completion of a coronial finding or a decision whether or not to go to inquest.

CORONIAL DETERMINATION

Inquests

An inquest is a public inquiry into a particular death or deaths. In addition to the mandatory requirement to hold an inquest into particular specified deaths (discussed below), a coroner may hold an inquest into a death if he or she believes it desirable to do so.⁴⁷ Issues that may impact on a coroner's decision

reporting to the Office of Safety and Quality Health. Sentinel events include where a surgeon has left instruments in the body cavity, maternal death or serious morbidity, infant abduction, intravascular embolism, patient suicide and procedures involving the wrong patient or body part: Office of Safety and Quality in Healthcare, Department of Health (WA), *Sentinel Event Policy* (undated) 3.

45. Office of Chief Psychiatrist (WA), consultation (27 October 2008) 2–3.

46. *Parliamentary Commissioner Act 1971* (WA) s 19B.

47. *Coroners Act 1996* (WA) s 22(2).

whether or not to hold an inquest include the views of the family and the public interest in exploring the death in a public forum. In determining whether or not a particular case should be inquested a coroner may seek an initial report from the in-house medical adviser who may recommend that independent reports be sought from specialists in a relevant area.

Under s 24 of the *Coroners Act* a person may apply in writing to the coroner to hold an inquest into a death. If the coroner refuses to hold an inquest he or she must give reasons in writing for the refusal and this decision may be appealed to the Supreme Court within a specified time.⁴⁸ The Supreme Court may make an order that an inquest be held if it is 'satisfied that it is necessary or desirable in the interests of justice'.⁴⁹

Most inquests deal with single deaths, although it is usual for a coroner to inquest deaths together if they arise from the same incident. Less frequently a coroner will choose to hold a joint inquest into deaths arising from separate incidents where the deaths have occurred in similar circumstances or have similar features. Examples of such joint inquests in Western Australia include:

- an inquest into two deaths involving motorcycles hitting raised (walled) suburban roundabouts;⁵⁰
- an inquest into five suicide deaths in Oombulgarri, a remote Aboriginal community over a 12-month period;⁵¹
- an inquest into two suicide deaths of teenagers involving solvent abuse in Balgo, a remote Aboriginal community, within 10 months of each other;⁵²
- an inquest into 22 (primarily suicide) deaths of young Aboriginal people in the Kimberley;⁵³ and
- an inquest into five skydiving deaths in York over a four-year period.⁵⁴

48. Currently the time period for appeal is within seven days of receiving notice from the coroner that the request to inquest has been refused: *Coroners Act 1996* (WA) s 24(2).

49. *Coroners Act 1996* (WA) s 24(3).

50. Inquest No 31/03.

51. Inquest No 13/08.

52. Inquest No 13/04.

53. Inquest No 37/07.

54. Inquest No 12/08. The State Coroner is currently holding an inquest into the traffic deaths of four men between October 2007 and December 2009 during police pursuits where police exceeded the permitted pursuit speed.

Each of these joint inquests resulted in recommendations for prevention of future deaths in similar circumstances. In some cases a joint inquest of this nature has brought much-needed attention to public health or safety concerns surrounding a series of deaths.

Mandated inquests

Under the *Coroners Act* certain deaths must (mandatorily) be the subject of a public inquest. These are:

- deaths of persons in, or escaping from, prison or police custody;
- deaths of persons in juvenile detention;
- deaths of persons being transported to or from custody;
- where it appears that a member of the police force contributed to or caused the death;
- deaths of children in state care under the *Children and Community Services Act 2004* (WA);
- deaths of involuntary patients within the meaning of the *Mental Health Act 1996* (WA), including deaths of persons on community treatment orders under that Act;
- deaths of persons admitted to a centre under the *Alcohol and Drug Authority Act 1974* (WA);
- where the Attorney General or State Coroner directs that an inquest be held; and
- suspected deaths.⁵⁵

As shown in the statistical overview in Chapter Three, in recent years more than half the inquests held in Western Australia have been inquests mandated by the *Coroners Act*.

Administrative findings

As discussed below, approximately 1,700 deaths per year become coronial cases.⁵⁶ Of these, around 40 will be subject to public inquest. Deaths that do not go to inquest are the subject of 'administrative findings', which record the identity of the deceased, a simple narrative of the circumstances of death and a finding as to cause of death. These are the necessary particulars to register the death under

55. *Coroners Act 1996* (WA) ss 22 and 23(2).

56. While approximately 2,350 deaths are reported to the coroner each year, approximately 600–700 are subsequently dealt with by the treating doctor issuing a death certificate recording the cause of death. These cases fall away and are not accepted as coronial cases.

the *Births, Deaths and Marriages Registration Act 1998* (WA).

In Perth administrative findings are drafted by administrative or registry staff and are then reviewed and signed off by a coroner.⁵⁷ The practice in regional areas varies. In some cases the regional Magistrates Court registrar will draft the administrative finding for review and signature of the regional magistrate acting as coroner, while in others the regional magistrate will draft the findings.

Findings and comments

Under s 25 of the *Coroners Act* a coroner investigating a death must find, if possible:

- the identity of the deceased;
- how the death occurred (ie, circumstances of the death);
- the cause of death; and
- the particulars needed to register the death under the *Births, Deaths and Marriages Registration Act*.

These constitute the 'findings' for the purposes of the legislation. Section 25 also provides that a coroner 'may comment on any matter connected with the death including public health or safety or the administration of justice'. In cases where the deceased was a 'person held in care' under s 3 of the *Coroners Act* (ie, a person in the care of the state, whether in custody, in foster care, in involuntary mental health care, etc) the coroner must make comments as to 'the quality of the supervision treatment and care of the person while in that care'.⁵⁸ However, coroners are not permitted to frame a finding or a comment in any way 'so as to appear to determine any question of civil liability or to suggest that any person is guilty of any offence'.⁵⁹

Recommendations

A feature of many coronial inquests in Western Australia and elsewhere is the making of recommendations aimed at improving practices, procedures or policies of agencies, hospitals or workplaces in order to prevent, so far as possible,

deaths in similar circumstances in the future.⁶⁰ Under s 27 of the *Coroners Act* the State Coroner may make recommendations in connection with any death that a coroner has investigated, including non-inquested deaths. Unlike some jurisdictions,⁶¹ in Western Australia coronial recommendations are not restricted in type and may be on any matter connected with the death, 'including public health or safety, the death of a person held in care or the administration of justice'.⁶²

Coronial recommendations are usually communicated to the relevant agency, entity or Minister within one month of the delivery of the inquest findings. The standard letter sent by the Administrator of the Office of the State Coroner seeks advice on the implementation (or otherwise) of the recommendations for the purposes of the State Coroner's annual report to the Attorney General.⁶³ Currently in Western Australia there is no obligation on parties the subject of coronial recommendations to respond to the coroner⁶⁴ and no coherent study has been undertaken into the implementation of coronial recommendations in this state.

As part of its research for this reference the Commission undertook a review of coronial recommendations for Western Australian inquests performed in 2007.⁶⁵ The review studied the incidence of coronial recommendations, the responsiveness of agencies to coronial commentary and the rate of substantive implementation of recommendations. In that year, 22 of the 39 inquests featured recommendations with a total

57. Administrative findings for deaths by non-natural causes are drafted by the registry manager and office manager (both of whom are well experienced in this work), while the administrative findings for natural causes deaths are drafted by the junior clerks.

58. *Coroners Act 1996* (WA) s 25(3).

59. *Coroners Act 1996* (WA) s 25(5).

60. Although it is obviously related to the historical power of rider (which was expressly for the purpose of prevention under the *Coroners Act 1920*) the position regarding recommendations in the current *Coroners Act 1996* is not at all clear. For example, recommendations are made by all coroners and yet s 27(3) permits only the State Coroner to make recommendations directed to the Attorney General in the context of reports. This is one area the Commission will look at clarifying in its coronial system reforms.

61. See, for example, the *Coroners Act 2003* (SA) s 25(2) which restricts recommendations to matters that may 'prevent, or reduce the likelihood of, a recurrence of an event similar to the event that was the subject of the inquest'. In 2008 the Supreme Court of South Australia held that any recommendations that related to events occurring beyond the time of death could not be the subject of coronial recommendations. This would appear to prevent the South Australian coroner from making recommendations about, for example, the signing of death certificates or the investigation of deaths: *Saraf v Johns* [2008] SASC 166.

62. *Coroners Act 1996* (WA) s 27.

63. Pursuant to *Coroners Act 1996* (WA) s 27.

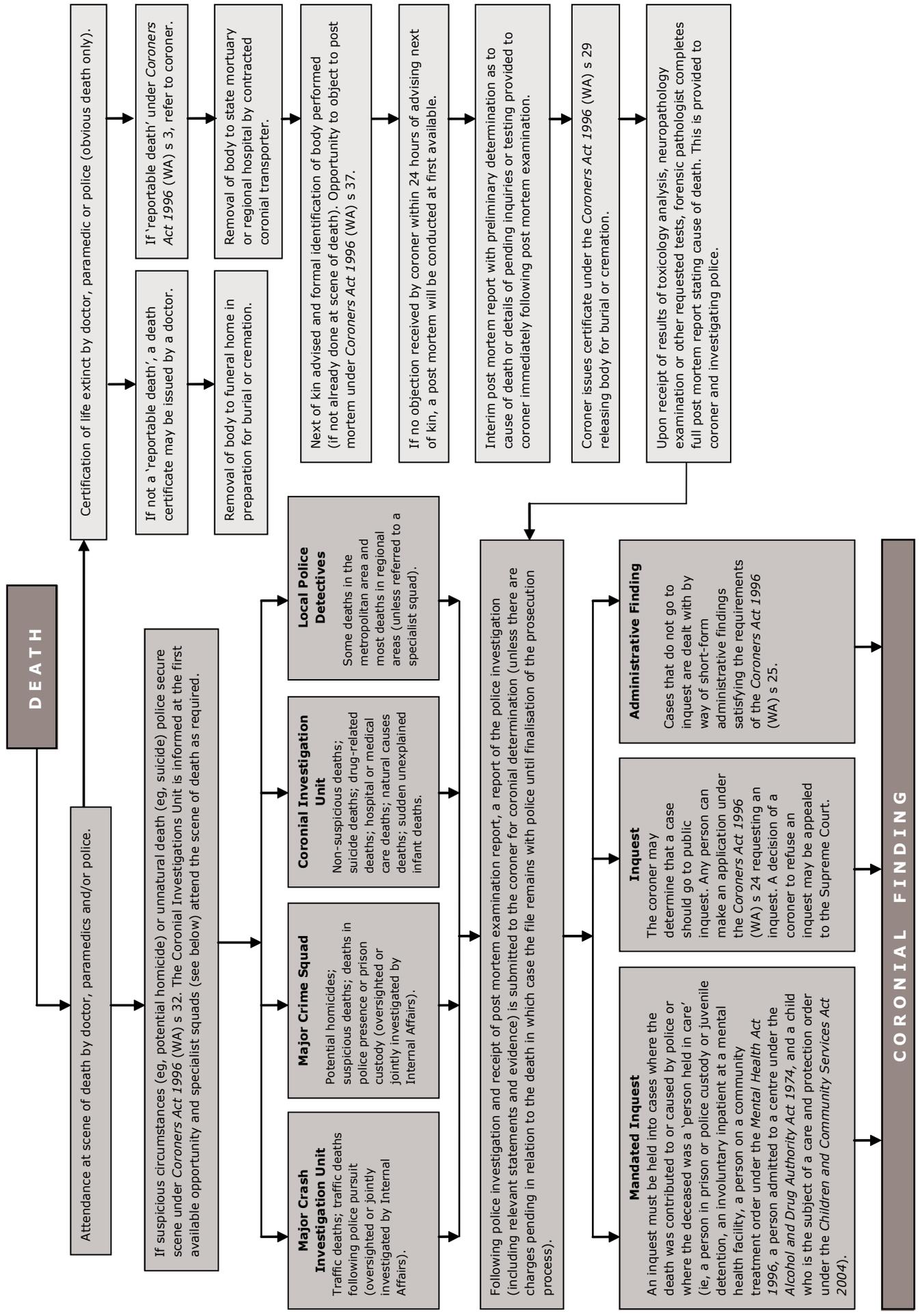
64. The obligation of certain parties to respond to coronial recommendations or reports is encapsulated in legislation or policy in several Australian jurisdictions. The potential for such an obligation in Western Australia will be explored in the Commission's Discussion Paper on this reference.

65. Hands TL, 'Coronial Recommendations Evaluation and Implementation 2007' (19 December 2008).

of 88 recommendations made. Recommendations addressed such matters as:

- changes to pharmacy registration/licensing procedures relating to warning labels for dispensed anti-depressant medications;
- the creation of non-legislative legal obligations relating to assessment of trees on camping grounds;
- the creation of legal obligations for reporting of medical conditions to vehicle licensing authorities for drivers suffering from epilepsy;
- the mandatory inspection of silos prior to each harvesting season;
- review of access to the Med-Alert system in public hospitals;
- the supervision of trainee doctors in general practice;
- the development of a checklist procedure to identify potential triggers for seizures in certain patients;
- provision of improved education of health issues to prisoners;
- amendments to the *Road Traffic Act 1974* (WA) to increase the time limit and circumstances in which a police officer may demand a blood sample from a driver in the event of a fatal traffic crash;
- manufacturer advice as to safety warnings on certain furniture;
- access for Western Australian police to nationwide police profiling systems;
- improvements to police training procedures; and
- improvements to public health and government service delivery in the Kimberley region.

The Commission's review found that medical care and mental health recommendations had a high rate of substantive implementation and a high level of responsiveness with ongoing progress updates provided by the Department of Health (Office of Safety and Quality) and the Office of the Chief Psychiatrist every six months. The Department of Corrective Services and Western Australia Police also provided a high level of responsiveness to recommendations, but with varying levels of implementation. The Commission found that recommendations directed to private entities or vaguely directed to 'the government' received poor or no responses. Recommendations that were broad in nature or not targeted to specific actions tended to receive platitudinous responses with little likelihood of implementation. The Commission's review, and its conclusions, will be examined in more detail in the Commission's forthcoming Discussion Paper on this reference.



Inside the Office of the State Coroner

The Office of the State Coroner and the Coroners Court of Western Australia come within the umbrella of the Specialist Courts and Tribunals division of the Department of the Attorney General. The office is currently located at the Central Law Courts building in Perth, occupying one whole floor and with a dedicated courtroom.¹

RESOURCING

In his 2006–2007 Annual Report the State Coroner laid bare the resourcing concerns of the Coroners Court stating:

It is with regret that I must report that as a result of inadequate resources being provided to the Coroners Court by the Department of the Attorney General, it is possible that I will not be able to adequately perform the functions of the State Coroner set out in section 8 of the *Coroners Act 1996* and I may not be able to ensure that an adequate counselling service is available as required under section 16 of that Act.²

The State Coroner noted the following difficulties with service delivery:

- that the staffing levels for the court had remained static while ‘the volume of work has increased in line with the increasing population and, more importantly, the increase in public expectation of the need or right to know’;³
- that staff were working unpaid overtime and foregoing leave in order to address the backlog of cases;⁴
- that there was a lack of legal counsel assisting, leading to the ‘possible need to cancel or postpone indefinitely inquest hearings’;⁵
- that there were only two coronial counsellors to service the entire state;⁶

- that budgetary items outside of the court’s control (such as body removal, post mortem and toxicology services) were overrunning on a regular basis;⁷ and
- that the court lacked a computerised case management system.⁸

In August 2009 the Attorney General approved an additional funding allocation of \$622,000 for salaries and \$200,000 to improve court services.⁹ As discussed below, this has enabled the court to employ (on contract) a number of necessary staff, as well as reduce the backlog of coronial cases.¹⁰ While not recurrent, the funding was approved again in the 2010 budget.

According to the Coroners Court, its current budget is \$7.7 million of which the largest outlay is pathology services (\$3 million), followed by toxicology (\$1.47m) and salaries (\$1.2 million).¹¹ An amount of \$1.1 million is set aside for body transport. Once a death becomes a coroner’s case, control of the body is assumed by the coroner and body removal must be performed by a designated coronial contractor. The actual expenditure for body removal services can fluctuate from year to year for while it is possible to estimate the approximate number of coronial cases each year, it is not possible to accurately predict where the deaths will take place. For example, in a recent case the Office of the State Coroner was required to hire a helicopter at a cost of \$7,000 in order to transport the body from an otherwise inaccessible bushland area in the north of the state to an airport to be flown to Perth.¹²

KEY STAFF

Until relatively recently the Office of the State Coroner was staffed by 11.8 FTE staff providing

1. This latest move was made in December 2008. The Commission is advised that the Office of the State Coroner has moved four times since 2003.
2. Office of the State Coroner (WA), *Annual Report 2006–2007* (2008) 3.
3. Ibid 4. Coronial cases have increased by 300 cases per year from 2000 to 2009 with a 200 case increase occurring between 2006 and 2007. For a statistical overview of the Coroner’s Court workload refer to Chapter Three.
4. Ibid 5.
5. Ibid 7.
6. Ibid 6.

7. Ibid 13–16.
8. Ibid 9.
9. Western Australia, *Parliamentary Debates*, Legislative Assembly, 1 June 2010, 108c–125a (Mr CC Porter, Attorney General).
10. See further below, Chapter Three, ‘Backlog in the Coronial Jurisdiction’.
11. Gary Cooper, Manager Coroner’s Office (WA), email (12 July 2010).
12. Ibid.

support to the State Coroner and Deputy State Coroner. The recent non-recurrent budget increase described above has enabled the creation of five new full-time positions¹³ and a part-time position of medical adviser to the coroner. In addition to these 18 staff, two police sergeants are attached to the Office of the State Coroner and are paid separately by the Western Australia Police. The current staffing situation of the Office of the State Coroner is found in the chart on page 27. The responsibilities of some of the office's key staff are described below.

Office manager

The manager of the Office of the State Coroner is akin to an executive officer and handles procurement and budget development, management of staff and facilities, human resources, and implementation of organisational policies and procedures. In addition, the office manager carries out the role of coroner's registrar under s 12 of the *Coroners Act* and holds delegated coronial power under s 10 of the *Coroners Act*. In this role the manager is involved in taking reports of deaths and making decisions as to whether or not a death certificate should be accepted or whether a full coronial investigation is required into the death. The role also involves the authorisation of post mortems, tissue and organ donation, and retention and restriction to premises under s 32 of the *Coroners Act*.¹⁴

The manager is on-call (shared on a fortnightly rotational basis with the registry manager) to advise coronial police, hospitals and doctors about the coronial status of a particular death and to make the determinations described above. This service must be provided on a 24-hour basis because many deaths occur at night and bodies must be removed from the scene of death at the first opportunity for health and safety reasons.

Registry manager

The registry manager is responsible for managing six registry staff including data entry officers responsible for inputting data into the National Coroners' Information System (NCIS). He controls relevant court documentation and liaises with country court staff about coronial cases in regional areas. As

coroner's registrar, the registry manager shares the on-call responsibilities of making the determinations about coronial cases described above as well as handling such issues within business hours. The registry manager is also responsible for researching and preparing draft findings on non-natural deaths (which are not going to inquest) for sign off by a coroner.¹⁵

Office administrator

The office administrator provides direct administrative support to the State Coroner and acts as liaison between the State Coroner and the public, media and others. An important part of the administrator's function is to identify potential cases for inquest and coordinate the listing of inquests, including the allocation of cases to counsel assisting. The administrator also handles all travel and accommodation arrangements for coroners on circuit and sits in court as the State Coroner's associate.

Medical adviser

The Office of the State Coroner currently has a part-time medical adviser from general practice with further qualifications in psychiatry. The medical adviser assists the coroners (and on occasion the coronial police) to interpret medical records and post mortem examination findings. The medical adviser's primary role is to study the medical management of a deceased and provide an opinion to the coroner. Where issues arise outside the medical adviser's area of expertise he will source an opinion from a specialist colleague.¹⁶ These opinions are treated as internal advice to the coroner and do not go to family members of the deceased or other interested persons (eg, doctors or nurses) involved in any inquest. The current medical adviser has written a medical terminology handbook for staff of the office and has played a role in furthering the education of doctors, psychiatrists and medical students about the coronial jurisdiction.¹⁷ On occasion the medical adviser will perform quasi-clinical work (eg, speaking to families to explain post mortem results at the request of a coronial counsellor) and will assist the coroners to formulate appropriate recommendations in relevant cases.¹⁸

13. The new full-time positions created by the allocation of resources in August 2009 are two legal counsel assisting the coroner, a court officer, a receptionist and a senior coronial counsellor.

14. Gary Cooper, Manager Coroner's Office (WA), email (12 July 2010).

15. This responsibility is also often shared by the office manager.

16. Dr Robert Turnbull, consultation (19 August 2008).

17. Ibid.

18. Ibid.

Legal counsel assisting

Legal counsel assisting primarily assist the coroners with the preparation, management and conduct of inquest hearings.¹⁹ Pursuant to recommendation 26 of the Royal Commission into Aboriginal Deaths in Custody, they appear in all death in custody matters. Legal counsel assisting will also appear (in preference to the police sergeants who also assist the coroner) in matters where a member of the police force may have contributed to or caused the deceased's death.

They are required to liaise with solicitors and counsel appearing for interested persons, and identify and obtain evidence from suitably qualified expert witnesses. While independent of the family's interests, counsel assisting do liaise closely with family members of deceased persons to ensure that any relevant concerns they may have about the death are explored in the inquest forum. Counsel assisting also play a role in coordinating the activities of the Coronial Ethics Committee and in providing advice on matters pertaining to the *Coroners Act*. Presently there are three full-time counsel assisting at the Coroner's Court, one of whom has qualifications in medicine as well as law.²⁰

Police sergeants

The two police sergeants attached to the Office of the State Coroner also act as counsel assisting the coroner and appear in court. However, their primary task is to undertake quality assurance reviews of all police coronial files to ensure that the reports are thorough and that the investigation meets the needs of the coroner. The police sergeants are also responsible for process service under the *Coroners Act*. Importantly, the police sergeants provide a critical link between the Office of the State Coroner and the Coronial Investigation Unit within the Western Australia Police.²¹

Coronial counsellors

Coronial counselling is one of the key services provided for in the Office of the State Coroner. Section 16 of the *Coroners Act* states that the State Coroner is to 'ensure that a counselling service is attached to

the court' and that 'any person coming into contact with the coronial system may seek the assistance of the counselling service of the court'. There are three coronial counsellors (one senior counsellor/manager and two counsellors) currently employed by the Office of the State Coroner.²² These staff provide clinical counselling services and act as the 'interface between families of deceased persons and the coronial system'.²³

One of the important roles of the counsellors is to provide information to families about the coronial process. For example, apart from being on-call for clinical work, counsellors will telephone the next of kin to discuss organ retention issues²⁴ and, in some cases,²⁵ to discuss the forensic pathologist's findings as to cause of death or to explain that a finding is pending certain specialist inquiries (eg, toxicology).²⁶ As noted earlier, the counsellors also play a role in the post mortem objection process by speaking to families and explaining the benefits of post mortem examination. On occasion families will wish to view the coronial file of their deceased relative and counsellors are involved in preparing them for what is in the file or staying with them while they view the file, if requested.

Coronial counsellors also manage and coordinate the Disaster Victim Identification counselling response for Western Australia in the event of a mass fatality incident in Australia or overseas, involving Western Australian residents.²⁷ The counselling service was always intended to have a role in educating the community about the coronial system. While in recent years this has not been possible, this function has been resumed since the provision of extra resources to the Office of the State Coroner.²⁸

19. Including managing inquest files and advising the coroner on whether an inquest should be held.

20. It is noted that until late 2009 only one legal counsel assisting was assigned to the Office of the State Coroner and external barristers were retained as counsel assisting for long and complex cases.

21. Gary Cooper, Manager Coroner's Office (WA), email (12 July 2010).

22. Coronial counsellors are required to have qualifications in social work or psychology.

23. Office of the State Coroner (WA), *Annual Report 2006–2007* (2008) 6.

24. Organ retention issues arise in approximately 200 cases per year: Kristine Trevaskis, Senior Counsellor, Office of the State Coroner, email (16 July 2010).

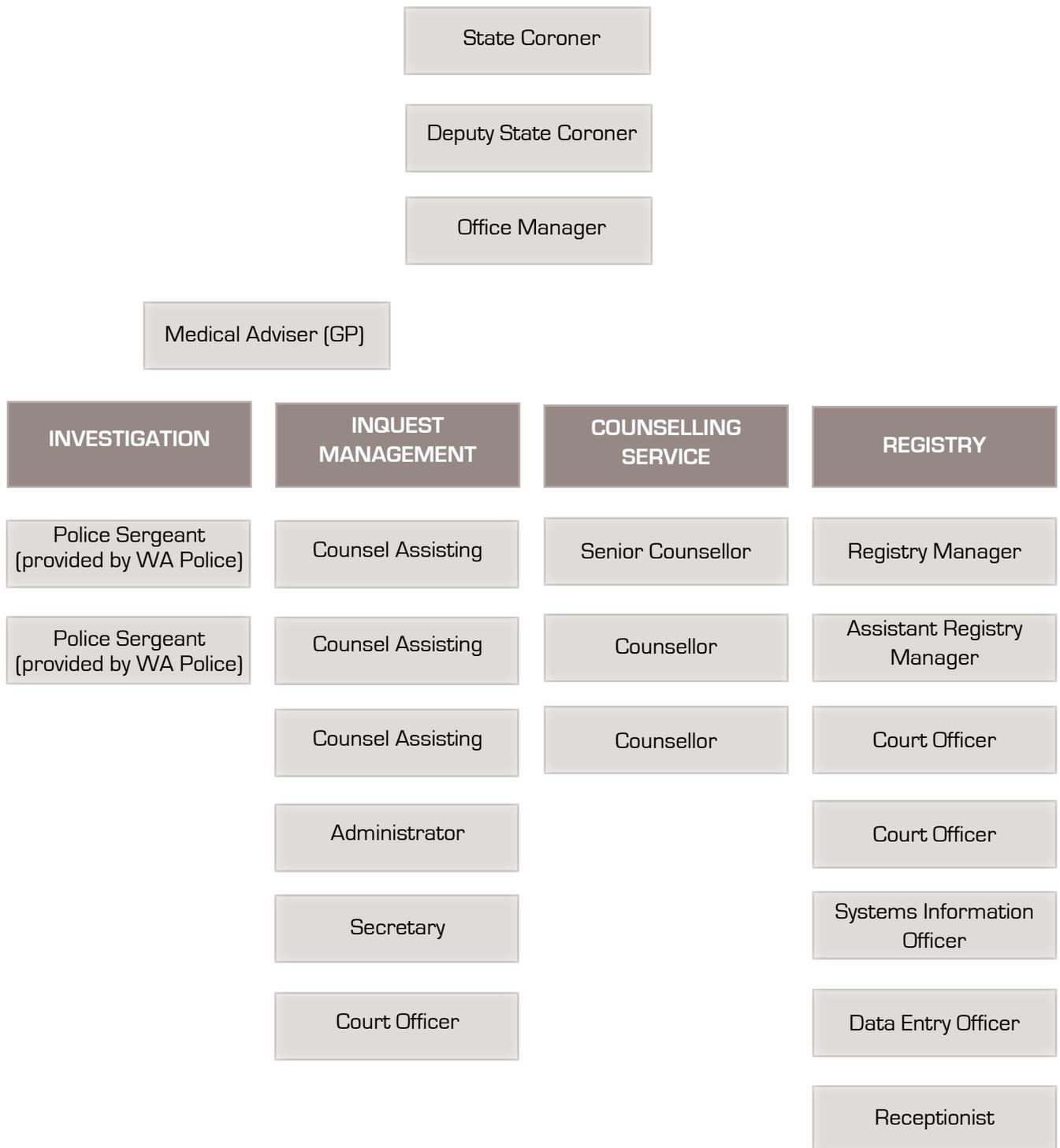
25. For example, in cases where the cause of death may have genetic implications for surviving family members or where the cause of death has been returned as 'unascertainable' after months of investigation: Kristine Trevaskis, Senior Counsellor, Office of the State Coroner, email (16 July 2010).

26. In addition to the letter sent by the Coroner specifying the results of the post mortem examination.

27. The Coronial Counselling Service won an Australian Safer Communities Award in 2006 for its team training and family support program which provides an immediate response in the event of a multiple-fatality incident.

28. Since January 2010 a number of presentations on the coronial system have been undertaken by the coronial counselling service, including a community briefing in Bunbury and a presentation to the Australian Funeral Directors' Association: Kristine Trevaskis, Senior Counsellor, Office of the State Coroner, email (15 July 2010).

OFFICE OF THE STATE CORONER – STRUCTURE



Chapter Three

Statistical Overview of the Colonial Jurisdiction in Western Australia

Contents

Statistical overview	31
A note about data	31
Coronial cases in Western Australia	32
Inquests in Western Australia	33
Mandated inquests	34
Type of coronial case going to inquest	34
Coroners' inquest workload	35
Representation at inquests	35
Indigenous coronial data	36
Coronial recommendations	37
Backlog in the coronial jurisdiction	38

Statistical overview

A NOTE ABOUT DATA

One of the defining features of the coronial jurisdiction both in Western Australia and elsewhere has been the paucity of data and statistical analysis of coronial cases. However, the opportunity to collect and analyse coronial data has improved significantly in the past decade with the introduction of the National Coroners Information System (NCIS) in 2000.¹ NCIS is a national database which ostensibly records every case that has come before an Australian coroner in the past decade.² It is not publicly accessible but is available for use by coroners and approved researchers on a subscription basis.³ Its primary function is 'to assist coroners in their role as death investigators by providing them with the ability to review previous coronial cases that may be similar in nature to current investigations, enhancing their ability to identify and address systematic hazards within the community'.⁴

Data is uploaded daily to NCIS by the Office of the State Coroner in Western Australia and is randomly audited by the NCIS quality assurance team, which is based at the Victorian Institute of Forensic Medicine in Melbourne. However, certain factors appear to have impacted upon data reliability for Western Australia.⁵ These include that, for an extended

period, the Coroners Court of Western Australia did not have a computer file management system to enable reliable data upload onto the NCIS⁶ or sufficient resources to provide for trained staff to input Western Australian coronial data.⁷ The Commission was also advised that the Office of the State Coroner had lost approximately six months' data when it moved locations and changed servers.⁸

To ensure the reliability of Western Australian data discussed in this Chapter, the Commission undertook the exercise of distilling relevant data from every inquest performed by Western Australian coroners over the 10-year period from 2000 to 2009. The Office of the State Coroner helpfully provided the Commission with copies of all inquest findings undertaken by Western Australian coroners since the passage of the *Coroners Act 1996*.⁹ Data that was undiscoverable from the face of the findings (eg, the deceased's aboriginality) was sourced from NCIS and any anomalies were checked against records held by NCIS and the Office of the State Coroner.¹⁰ The data presented below is, unless otherwise noted, the result of the Commission's study.

1. See the discussion of use of coronial data below, Chapter Four, 'Systemic Issues: Communication and Cooperation – Researchers and Special Interest Advocacy Groups'.
2. Coronial cases after 1 July 2000 from all Australian jurisdictions are recorded on NCIS (after 1 January 2001 for Queensland coronial cases). Recently New Zealand data has been added to NCIS.
3. Access to and use of Western Australian coronial data from NCIS must be approved by the Victorian Department of Justice Human Research Ethics Committee as well as the Coronial Ethics Committee of the Office of the State Coroner in Western Australia. At the outset of this project the Commission applied for and received approval to have Level 1 national access to coronial cases recorded on NCIS.
4. See < <http://www.ncis.org.au/index.htm> >.
5. For example, the Commission found 61 Western Australian cases in the 10-year period 2000–2009 where the 'inquest held' field had been erroneously marked 'yes'. The Commission is advised that NCIS' quality assurance process does not currently check the 'inquest held' field: Jessica Pearse, Manager NCIS, email (6 July 2010).

6. In his 2006–2007 Annual Report the State Coroner noted that the 'Coroners Court is the only court in Western Australia which does not have access to a comprehensive computer system for file management': Office of the State Coroner (WA), *Annual Report 2006–2007* (2008) 9.
7. A temporary budget increase to the court in 2009–2010 has enabled the employment of staff to, among other things, assist the court with data entry: Gary Cooper, Manager Coroner's Office (WA), consultation (18 June 2010).
8. The Commission is advised that the Office of the State Coroner has now restored this data to NCIS.
9. The Commission thanks Dawn Wright, Administrator of the Office of the State Coroner (WA) and Gary Cooper, Manager of the Office of the State Coroner (WA) for their assistance in providing requested information to the Commission.
10. Following a full interrogation of NCIS, the Commission discovered a further 12 inquests performed by regional coroners, which did not appear in the inquest files provided by the Office of the State Coroner. These findings have been included in the Commission's data study.

CORONIAL CASES IN WESTERN AUSTRALIA

Table 1: Coronial cases 2000–2009¹¹

	2000 ¹²	2001	2002	2003	2004	2005	2006	2007	2008	2009
Perth	1,084	1,090	1,009	1,000	1,015	1,063	1,104	1,263	1,291	1,305
Regions	442	415	394	427	382	412	456	521	506	522
Total coronial cases	1,526	1,505	1,403	1,427	1,397	1,475	1,560	1,784	1,797	1,827

Table 2: Coronial cases as percentage of total Western Australian deaths 2000–2009

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Total deaths ¹³	10,858	10,751	11,711	11,520	11,437	11,504	11,821	12,581	13,011	12,855
Total coronial cases	1,526	1,505	1,403	1,427	1,397	1,475	1,560	1,784	1,797	1,827
Percentage of total deaths ¹⁴	14%	14%	12%	12%	12%	13%	13%	14%	14%	14%

In Western Australia each year there are around 12,500 deaths.¹⁵ Approximately 70% of deaths occur in the metropolitan area, with the remaining 30% occurring in regional areas of Western Australia.¹⁶ This 70:30 split matches population patterns for Western Australia.¹⁷ Indigenous deaths represent approximately 4% of all Western Australian deaths,¹⁸ again closely mirroring population data.¹⁹

Of all Western Australian deaths, approximately 2,300 deaths are reported to the coroner each year.²⁰ As mentioned earlier, where a death certificate is issued by a doctor within a short time of reporting the case, the coronial case will fall away. Table 1 shows the number of deaths accepted as coronial cases for the past ten years.

As can be seen from Table 1, the percentage of accepted coronial cases appears to match general death (and population) patterns in Western Australia with just over 70% being metropolitan deaths and close to 30% being regional deaths.²¹ The number of coronial cases has increased by approximately 20% over the past decade.

Table 2 shows accepted coronial cases as a percentage of total Western Australian deaths over the same period. The percentage appears to be relatively stable with coronial cases representing approximately 14% of total Western Australian deaths over the past ten years.

11. Data supplied by the Coroners Court of Western Australia (18 June 2010).
12. Coronial case data for the calendar year 2000 has been estimated by the Coroners Court based on data from the 1999/2000 and 2000/2001 financial years. Gary Cooper, Manager Coroner's Office (WA), email (7 July 2010).
13. Registry of Births, Deaths and Marriages (WA), <<http://www.bdm.dotag.wa.gov.au/S/statistics.aspx?uid=5227-3572-2658-8961>> (viewed 18 June 2010).
14. Percentages of 0.5 and above are rounded up to the nearest full per cent.
15. Registry of Births, Deaths and Marriages (WA), <<http://www.bdm.dotag.wa.gov.au/S/statistics.aspx?uid=5227-3572-2658-8961>> (viewed 18 June 2010). See Table 2 below.
16. Australian Bureau of Statistics (ABS), 'Deaths, Summary, Statistical Divisions – 2000 to 2005' (2006) and 'Deaths, Summary, Statistical Divisions – 2003 to 2008' (2009).
17. ABS, 'Western Australian Statistical Indicators – Population', cat no. 1367.5 (2010).
18. ABS, 'Deaths, Indigenous Status – Australia, States and Territories – 1991 to 2008' (released 25 Nov 2009), Table 1 Western Australia.
19. As at Census date 30 June 2006 the estimated Indigenous population of Western Australia was 3.8% of the total Western Australian population: ABS, 'Population Distribution, Aboriginal and Torres Strait Islander Australians, 2006' cat no. 4705.0 (2007).

20. For the financial year 2006–2007 a total of 2,341 cases were referred to the coroner with 717 death certificates issued after the case was reported to the coroner: Office of the State Coroner (WA), *Annual Report 2006–2007* (2007) 34.
21. With minor yearly variations.

INQUESTS IN WESTERN AUSTRALIA

Table 3: Number of Inquests 2000–2009²²

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Perth inquests	45	32	32	30	35	30	26	24	29	20
Regional inquests	15	8	11	7	14	8	20	15	8	13
Total Inquests	60	40	43	37	49	38	46	39	37	33

Table 4: Regional inquests as percentage of total inquests

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Total Inquests	60	40	43	37	49	38	46	39	37	33
Regional inquests	15	8	11	7	14	9	20	15	8	13
Percentage of total inquests ²³	25%	20%	26%	19%	29%	24%	43%	38%	22%	39%

Table 5: Regional inquests by regional coroner

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Regional inquests	15	8	11	7	14	9	20	15	8	13
Regional inquests by regional coroner	1	0	1	0	1	2	3	1	0	3

Table 3 shows the number of inquests undertaken by Western Australian coroners during the past ten years.²⁴ As noted earlier, the majority of coronial cases are dealt with by administrative finding with inquests representing only a small percentage of total coronial cases.

As Table 3 shows, the number of coronial cases going to inquest has fallen in the past 10 years,²⁵ while the total number of coronial cases (see Table 1) has

increased by almost 20% over the same period. Over the ten-year period a total of 422 cases have gone to inquest in Western Australia, with 303 inquests in the Perth metropolitan area and 119 inquests in regional areas of Western Australia.

Table 4 shows regional inquests as a percentage of total Western Australian inquests. Generally, it can be seen that an increasing percentage of all inquests are being undertaken in regional areas. With the exception of 2008, in the past five years this table shows that, as a percentage of total inquests and taking into account the population and coronial case data discussed above, regional Western Australia is quite well represented. However, as shown in Table 5, only a very small number of regional inquests are being performed by regional coroners, with most of the regional inquest work being undertaken by the State Coroner and Deputy State Coroner who are based in Perth.

22. This table represents inquests begun in the calendar year. It is noted that a small number of inquests can span a calendar year.

23. Percentages of 0.5 and above are rounded up to the nearest full per cent.

24. The Commission has relied upon the Office of the State Coroner (WA) to provide copies of findings from inquests undertaken by all Western Australian coroners. Inquest numbers and names have been checked independently against lists also provided by the Office of the State Coroner and against NCIS records. It should be noted that some inquests involve investigation of more than one death.

25. There is a 45% difference between the number of inquests undertaken in 2000 (60 inquests) and 2009 (33 inquests).

Table 6: Number of mandated inquests as a percentage of total inquests 2000–2009

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Total inquests	60	40	43	37	49	38	46	39	37	33
Mandated inquests	21	18	18	18	21	16	17	17	19	17
Percentage of total inquests ²⁶	35%	45%	42%	49%	43%	42%	37%	44%	51%	52%

Mandated inquests

As discussed earlier, certain inquests undertaken in Western Australia are mandated by the *Coroners Act*. What this means is that where a death has certain features, the coroner *must* conduct a public inquest into the death. Deaths where inquests are mandated in Western Australia include suspected deaths, deaths of persons in custody or certain forms of state care (eg, wards of the state), cases where the death may have been caused or contributed to by police, deaths of persons on community treatment orders under the *Mental Health Act 1996* (WA) and deaths of involuntary inpatients in mental health facilities.²⁷ Table 6 shows the number of mandated inquests over the 10-year period 2000 to 2009.

As can be seen from Table 6, the percentage of total inquests that are mandated by the *Coroners Act* has increased over the past decade. This increase appears to be due more to the declining number of inquests being performed each year than to the number of deaths requiring a mandatory inquest. The latter figure has remained relatively steady over the past decade with small peaks in 2000 and 2004.

Type of coronial case going to inquest

Table 7 shows the number of inquests undertaken in Western Australia over the past decade categorised by type of inquest. It is important to note that the type of inquest categories below are representative of the main features of the inquest²⁸ and are not always indicative of the finding. For example, many death in custody inquests have a finding of ‘suicide’, while some medical care inquests have a finding of ‘natural causes’.

Table 7 reveals that the most inquested deaths in Western Australia are deaths in prison custody;

however, it is pertinent to note that this type of death falls into the mandated category in which a coroner must hold a public inquest. Of the discretionary category of inquests, the most inquested deaths are medical care deaths, the majority of which relate to deaths in hospital or of persons recently discharged from medical care. This is followed by motor vehicle deaths [discretionary] and suspected deaths [mandated].

Table 7: Number of inquests by type of inquest 2000–2009

Type of inquest / death	Total
Mandated	
Death of an involuntary psychiatric patient	30
Death in custody (prison)	69
Death of person held in care (eg, ward of state)	9
Death apparently caused or contributed to by police	35
Suspected death	38
Reopened inquest (by order of Supreme Court)	1
Discretionary	
Motor vehicle deaths	42
Mental health care	9
Medical care	50
Accident	23
Workplace/industrial/mining	20
Maritime	11
Drug death	16
Homicide (suspicion of)	11
Natural causes	3
Suicide	29
Aviation	14
Fire	3
Other – Miscellaneous	8
Unknown	1
Total	422

26. Percentages of 0.5 and above are rounded up to the nearest full per cent.

27. See *Coroners Act 1996* (WA) ss 22 & 23.

28. As categorised by the Law Reform Commission of Western Australia.

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	Total
State Coroner	36	13	19	19	27	6	17	23	19	18	197
Deputy Coroner	15	24	22	18	20	29	26	14	18	12	198
Other Coroner	9	3	2	0	2	3	3	2	0	3	27

	2000 ²⁹	2001	2002	2003	2004	2005	2006	2007	2008	2009
State Coroner	123	58	79	48	88	56	57	78	49	48
Deputy Coroner	19	50	49	50	40	65	56	60	59	29
Other Coroner	18	8	4	0	5	6	9	4	0	5
Total sitting days	160	116	132	98	133	127	122	142	108	82

Coroners' inquest workload

Although under the *Coroners Act* every regional magistrate is contemporaneously a coroner, it is apparent that the coronial inquest function has effectively been centralised to Perth with the State Coroner and Deputy State Coroner performing the majority of the state's inquest work in the past decade. As discussed above, where an inquest is held in a regional area, it is generally performed by the State or Deputy State Coroner. In fact, only 12 of the 27 inquests performed by a coroner other than the State or Deputy State Coroner in the past 10 years have been performed by a regional-based coroner in his or her local area.³⁰

Table 9 shows the number of sitting days (ie, the number of days in court on an inquest) per coroner, per year.³¹ Taken over the decade, it can be seen that the State Coroner sits an average of 68 days per year while the Deputy State Coroner sits an average of 47 days per year.³² However, the figures

for the past year, 2009, show that each coroner has sat approximately 20 days less than the average. Certain factors may impact upon the number of sitting days per year, such as coroners taking accrued leave and interruptions to the operation of the court consequent upon relocation.³³

Representation at inquests

Section 44 of the *Coroners Act 1996* permits an 'interested person' to appear or be represented by legal counsel at an inquest and to examine or cross-examine witnesses. Regulation 17 of the *Coroners Regulations 1997* (WA) provides that:

The following persons are interested persons for the purposes of section 44(3) of the Act –

- (a) a spouse, de facto partner, child, parent or other personal representative of the deceased person;
- (b) any of the deceased person's next of kin under section 37(5) of the Act;
- (c) a beneficiary under a policy of insurance issued on the life of the deceased person;
- (d) an insurer who issued such a policy of insurance;
- (e) a person whose act or omission, or the act or omission of an agent or servant of that person,

that year. If the average for each is taken over the nine years from 2001–2009, the State Coroner sits an average of 62 days per year while the Deputy State Coroner sits an average of 51 days per year.

- 33. For example, the Commission has been told that after moving to the Central Law Courts in late 2008, the Coroners Court was unable to secure a dedicated courtroom in its new location until relatively recently due to ongoing renovation of the Central Law Courts building: Gary Cooper, Manager Coroner's Office (WA), email (12 July 2010).

29. The Deputy State Coroner was appointed on 12 July 2000. This accounts for the low number of sitting days for Deputy State Coroner Vicker in this period.

30. A number of the inquests undertaken by other coroners have been undertaken in Perth. It is probable that this activity has occurred when one or other of the State or Deputy State Coroner has taken leave.

31. In some cases, more than one inquest is undertaken in a sitting day. For example, cases of uncontentious natural causes deaths in custody or care are subject to mandatory inquest, and several of these may be dealt with in a single sitting day.

32. The year 2000 appears to be an anomalous year. The Deputy State Coroner was only appointed on 12 July 2000 and so performed substantially less inquests than the State Coroner

Table 10: Legal Representation in Western Australian Inquests 2000–2009³⁴

	2000	2001	2002 ³⁵	2003 ³⁶	2004 ³⁷	2005 ³⁸	2006 ³⁹	2007	2008	2009 ⁴⁰
Total Inquests	60	40	43	37	49	38	46	39	37	33
Inquests with counsel ⁴¹	40	26	35	25	35	17	31	29	22	21
Inquests with counsel representing the deceased's family	20	11	11	7	8	7	13	15	6	6

may in the opinion of the coroner have caused, or contributed to, the death of the deceased person;

(f) a person appointed by an organization of employees to which the deceased person belonged at the time of death, if the death of the deceased person may have been caused by an injury received in the course of employment or by an industrial disease;

(g) the Commissioner of Police appointed under the *Police Act 1892*.

Table 10 shows the incidence of legal representation at Western Australian inquests for the period 2000 to 2009.⁴² An examination of inquest records shows that most counsel appear for parties described in paragraphs (e), (f) and (g) of reg 17. Probably the most represented persons at inquests are nurses, doctors and police officers called as witnesses. In many cases, counsel will be provided by or paid for by the relevant workers' union.

Unlike other interested persons, there is a relatively low incidence of lawyers appearing for the family of a deceased at inquest, as evidenced in the data above. This may be a reflection of the lack of legal aid funding for families of a deceased at coronial inquests,⁴³ or alternatively, it may be a mark of general satisfaction with how the Office of the State Coroner in Western Australia is representing the interests of families at inquests. Currently the Office of the State Coroner has three legal counsel and two police sergeants to assist the coroner at all inquests. As well as presenting evidence and examining witnesses,

34. Data supplied by the Coroners Court of Western Australia (18 June 2010).

35. Number of counsel is unknown in 1 case in 2002.

36. Number of counsel is unknown in 2 cases in 2003.

37. Number of counsel is unknown in 4 cases in 2004.

38. Number of counsel is unknown in 18 cases in 2005.

39. Number of counsel is unknown in 7 cases in 2006.

40. Number of counsel is unknown in 1 case in 2009.

41. Number includes family representative but not counsel assisting the coroner.

42. Unfortunately records have not always been reliably kept of counsel appearing at inquests and it is only in recent years that counsel have been listed on the face of the inquest finding. Those cases where records do not indicate one way or another whether counsel for an interested party appeared at inquest are noted by year in nn 35–40 above.

43. See Gibson F, 'Legal Aid for Coroners' Inquests' (2008) 15 *Journal of Law and Medicine* 587.

these counsel will generally assist the family of the deceased by exploring relevant issues raised by the family in the inquest forum.

INDIGENOUS CORONIAL DATA

Table 11 shows the number of coronial cases involving Indigenous deceased for the years 2001–2009.⁴⁴ It can be seen that the percentage of total coronial cases involving Indigenous deceased has hovered between 9% and 11% from 2001 to 2008 before dropping to 7% in 2009. It appears that while Indigenous deaths are relatively proportionate to general population figures, a higher proportion of those deaths are reportable deaths under the *Coroners Act*.⁴⁵

Table 12 shows the number of inquests involving one or more Indigenous deceased undertaken in Western Australia since 2000. Taking into account the information in Table 11, it can be seen from Table 12 that Indigenous deaths are adequately represented as a percentage of total inquests.

CORONIAL RECOMMENDATIONS

As discussed earlier, recommendations addressing the prevention of future deaths in similar circumstances are a feature of the modern inquest. Under s 27 of the Coroners Act the State Coroner may make recommendations in respect of any death that a coroner has investigated (including non-inquested deaths)⁴⁶ on any matter connected with the death, 'including public health or safety, the death of a person held in care or the administration

44. Data for the year 2000 on this field is incomplete and unable to be relied upon.

45. As mentioned earlier, ABS figures show that Indigenous deaths represent approximately 4% of all Western Australian deaths, while the Indigenous population of Western Australia sits at around 3.8% of the total Western Australian population.

46. The Commission's inquiries of the NCIS database in February 2009 have found that recommendations made outside of inquests are infrequent in Western Australia, with only seven such incidences discovered, all of which were inquiries undertaken by regional coroners.

	2001	2002	2003	2004	2005	2006	2007	2008	2009
Total coronial cases	1,505	1,403	1,427	1,397	1,475	1,560	1,784	1,797	1,827
Coronial cases – indigenous ⁴⁷	159	134	131	134	136	171	178	195	130
Percentage of total coronial cases ⁴⁸	11%	10%	9%	10%	9%	11%	10%	11%	7%

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Total Inquests	60	40	43	37	49	38	46	39	37	33
No. of inquests with Indigenous deceased ⁴⁹	5	6	7	8	13	5	4	10	6	5
Percentage of total inquests ⁵⁰	8%	15%	16%	21%	27%	13%	9%	26%	16%	15%

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Total Inquests	60	40	43	37	49	38	46	39	37	33
Inquests with recommendations	18	13	19	17	25	14	14	22	17	14
Percentage of total inquests ⁵¹	30%	33%	44%	46%	51%	37%	39%	56%	46%	42%

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Inquests with recommendations	18	13	19	17	25	14	14	22	17	14
Total recommendations made	38	25	62	61	89	52	39	88	54	57

of justice'. Table 13 shows the incidence of coronial recommendations in Western Australian inquests.

As can be seen from Table 13, coronial recommendations are made in between one-third and one-half of inquests each year in Western Australia.

47. In any given year there are a number of deceased whose aboriginality remains unknown.

48. Percentages of 0.5 and above are rounded up to the nearest full per cent.

49. Following examination of all inquest findings, enquiries of the NCIS were made to attempt to ascertain the aboriginality of deceased persons whose case had gone to inquest. However, the aboriginality of the deceased was unascertainable for 37 inquests in 2000, 14 inquests for 2001, 8 inquests for 2002, 2 inquests for 2003, 4 inquests for 2004, 1 inquest for 2005 and 2 inquests for 2007.

Taken over the full decade, recommendations featured in 173 inquests (41%).

Table 14 shows the number of coronial recommendations made per year over the past decade. In total, 565 recommendations were made by Western Australian coroners during the period 2000 to 2009. Where recommendations are made in an inquest it is usual that between one and four recommendations will be made. However, some very

50. Percentages of 0.5 and above are rounded up to the nearest full per cent.

51. Percentages of 0.5 and above are rounded up to the nearest full per cent.

public inquests have resulted in a large number of recommendations and these inquests account for the spikes in the number of recommendations in 2004 and 2007.⁵²

BACKLOG IN THE CORONIAL JURISDICTION

It is well accepted that there are significant delays in the coronial jurisdiction in Western Australia.⁵³ These delays have been defended as a result of ongoing under-resourcing of the Office of the State Coroner.⁵⁴ However, there are other factors that can impact upon the timely delivery of findings in coronial cases. These include the time taken by police and other investigatory bodies (eg, WorkSafe) to complete investigations into the death, the time taken for specialty testing in the post mortem examination process, and the time taken to prepare the brief for the inquest (including, in some cases, opinions from independent medical specialists). In traditional court jurisdictions these procedural or preparatory matters are generally finalised prior to the case coming to the court, whereas in the coronial jurisdiction the matter is taken by the court as soon as it is notified of the death. Therefore, it is a somewhat futile exercise to compare case delay data across Western Australian courts.

A clearer picture of the enormity of the problem of delay in the Western Australian coronial jurisdiction can be obtained by comparison of case clearance rates in coroners' courts across Australian jurisdictions. This exercise was performed by the Productivity Commission as part of its 2009 Report on Government Services with Western Australia recording a 92.8% clearance rate for coronial cases in 2007–2008.⁵⁵ The only jurisdiction with a lower

clearance rate was Victoria, which had a significantly lower rate of 78.7%.⁵⁶

Table 15: Completed cases timeliness – Western Australia 2006–2009⁵⁷

No. of months	2006	2007	2008	2009
< 3	115	174	105	296
3–6	494	482	515	399
6–12	376	476	510	366
12–18	191	229	298	301
18–24	90	153	168	125
24–30	38	58	89	51
30–36	26	47	51	34
36 or more	45	54	80	44
Total	1,375	1,673	1,816	1,616

Table 15 contains data from the Coroners Court of Western Australia as to completed case timeliness (or clearance rate). A completed case is one where a determination has been made by a coroner and the time to finalise a case is based on the number of months elapsed between the date of notification and the date of the death certificate.

The Commission is advised that the case clearance rate has recently been increased as a result of temporary funding allocated to the court in August 2009.⁵⁸ This funding enabled the Coroners Court to employ an additional coroner for a period of three months (to sign off administrative findings) and an experienced court officer for a period of five months (to draft administrative findings). These two additional staff have also enabled a concomitant reduction in the number of cases pending determinations, and as at 27 May 2010 the number of pending coronial cases was 1,893.⁵⁹

Coroners' courts in all Australian jurisdictions have some backlog of coronial cases.⁶⁰ This is a natural consequence of the fact that the date of lodgement of

52. For example, the 2007 joint inquest into the deaths of 22 Aboriginal people in the Kimberley featured a total of 27 coronial recommendations, while the 2004 joint inquest into the deaths of two women in a bushfire resulted in a total of 17 coronial recommendations.

53. The significant extent of the delays has been publicly acknowledged by both the State Coroner and the Attorney General: see Western Australia, *Parliamentary Debates*, Legislative Assembly, 1 June 2010, 108c-125a (Mr CC Porter, Attorney General); Office of the State Coroner (WA), *Annual Report 2006–2007* (2007) 3.

54. *Ibid.*

55. The clearance rate shows whether the volume of finalisation matched the volume of lodgements in the same reporting period. The Productivity Commission advises that a 'figure of less than 100% indicates that, during the reporting period, the court finalised fewer cases than were lodged, and the pending caseload should have increased.' South Australia had the next highest clearance rate after Western Australia with 93.5%; Queensland and Tasmania had clearance rates of above 100%; Productivity Commission, *Report on Government Services 2009* (January 2009) Table 7.16.

56. *Ibid.*

57. Data provided by the Office of the State Coroner (WA).

58. Gary Cooper, Manager Coroner's Office (WA), email (18 June 2010).

59. Western Australia, *Parliamentary Debates*, Legislative Assembly, 16 June 2010, 3983d (Mr CC Porter, Attorney General).

60. Productivity Commission, *Report on Government Services 2009* (January 2009), Table 7.11.

a coronial case in the court is the time of notification of the death; that is, prior to the case being investigated and prepared for a court finding (whether by inquest or by administrative determination). The data for pending caseload timeliness for the Western Australian Coroners Court from 2006–2009 is contained in Table 16, below. Pending caseload is the number of cases that have not been finalised as at the last day of the reported month.

The number of cases pending that are more than 12 months old is considered a key indicator in the coronial jurisdiction.⁶³ The above table shows that as at the end of 2009 there were 791 such cases in Western Australia.⁶⁴ As at 27 May 2010 that number had been reduced to 702 cases, according to data given by the Attorney General in Parliament.⁶⁵

Table 16: Pending caseload timeliness – metropolitan and regional Western Australia 2006–2009⁶¹

Months Pending ⁶²	2006	2007	2008	2009
Metro				
< 3	265	307	305	353
3–6	205	205	236	270
6–12	279	306	302	287
12–18	177	182	143	270
18–24	89	80	75	89
24–30	69	60	36	61
30–36	29	43	24	38
36 or more	113	139	137	149
Metro pending cases	1,226	1,322	1,258	1,517
Regional				
< 3	120	112	146	142
3–6	83	97	77	69
6–12	103	98	113	70
12–18	50	40	58	57
18–24	32	38	47	34
24–30	12	25	11	20
30–36	14	15	10	24
36 or more	39	43	51	49
Regional pending cases	453	468	513	465
Total pending cases	1,679	1,790	1,771	1,982

61. Data provided by the Office of the State Coroner (WA).

62. Months pending is the number of months from the date of notification to the last date of the month for each pending case.

63. Western Australia, *Parliamentary Debates*, Legislative Assembly, 1 June 2010, 108c-125a (Mr CC Porter, Attorney General).

64. Showing a split of 607 cases pending in the metropolitan area and 184 cases pending in regional areas.

65. Western Australia, *Parliamentary Debates*, Legislative Assembly, 16 June 2010, 3983d (Mr CC Porter, Attorney General).

Chapter Four

Issues with the Coronial Process: Results of Consultations

Contents

Issues with the coronial process	43
Role of the coroner	44
Prevention of deaths in similar circumstances	44
Purpose and scope of inquests	45
Coronial recommendations	45
Systemic issues	47
Delay	47
Communication and cooperation	48
External 'service providers'	48
Legal profession	48
Researchers and special interest advocacy groups	49
Information, guidance and training	50
Investigations, offences and penalties	52
Deaths in police presence and prison custody	52
Deaths in hospitals	52
Deaths in mental health facilities	53
Workplace deaths	53
Investigators' powers	53
Forensic medicine investigations	53
Offences and penalties	54
Role, rights and support of the family	55
Legal representation at inquest	55
Coronial counselling	55
External post mortem	55
Release of bodies	56
Transport of bodies	56
Condition of bodies following post mortem	56
Condition of state mortuary	57
Indigenous and other cultural concerns	57

Issues with the coronial process

As noted in the Introduction to this Paper, the Commission has engaged in extensive consultations with people involved in the coronial system. In the metropolitan area, consultations have been held with the State and Deputy State Coroners, staff of the Office of the State Coroner, police, judges, lawyers, forensic pathologists and coronial counsellors. The Commission has also consulted with individuals, agencies and organisations that regularly deal with the coronial system including doctors, hospitals, mortuary attendants, funeral directors, the Chief Psychiatrist, the Registry of Births, Deaths and Marriages, the Health Department, the Department of Corrective Services, the Inspector of Custodial Services, WorkSafe, the Department of Petroleum and Mines, the Ministerial Taskforce for Suicide Prevention, and members of support organisations (such as SIDS and Kids, ARBOR, Angelhands and the Victims of Crime Reference Group). Regional consultations in Western Australia have included magistrates,¹ regional court registrars, police, coronial body transport contractors, Aboriginal Legal Service and Legal Aid lawyers, and the Kimberley Aboriginal Medical Services Council. The Commission has also consulted with representatives of the National Coronial Information System and the Victorian Institute of Forensic Medicine.²

At these consultations concerns were raised about many aspects of coronial practice and procedure in Western Australia and about the operation of the *Coroners Act 1996* (WA). It is impossible in this context to address all issues raised with the Commission as requiring reform. The discussion below is therefore themed to capture what the Commission sees as being the most important broad issues for reform.

1. All magistrates are contemporaneously coroners under the *Coroners Act 1996* (WA) s 11(1).
2. A list of people consulted for this reference may be found at Appendix A to this paper.

Role of the coroner

During consultations the issue was mooted as to whether there was in fact a continuing role for a coroner in today's society. One of the arguments against the need for a coroner was that there were many existing specialist bodies that investigated fatalities in their area of expertise, many of which have power to impose penalties, make recommendations and institute meaningful changes to prevent deaths in similar circumstances. For example, WorkSafe is a body that investigates industrial and workplace fatalities. As discussed earlier, it has the power to prosecute employers for breaches of workplace safety requirements under the *Occupational Safety and Health Act 1984* (WA). WorkSafe's preventative activities include the issuing of health and safety alerts; publishing codes of practices for different industries; conducting targeted industry-specific interventions to address systemic problems; conducting education and awareness campaigns; and inspecting workplaces to ensure compliance with industry and safety standards. Similar independent specialist investigators exist in relation to mining deaths, aviation deaths, maritime deaths and rail deaths.¹ Specialist death investigation teams also conduct rigorous examinations of deaths in hospitals and mental health facilities and these have an important role in recommending and implementing system improvements to prevent future deaths in similar circumstances.² Police also have specialist death investigation teams (eg, for traffic fatalities and homicides), though their mandate is skewed more toward detection of criminality than prevention of deaths.

Although there appears to be an abundance of specialist investigation bodies, and of course the potential to create more, respondents to the Commission's consultations still saw an ongoing role for the coroner. In particular, there was a sense that the coronial process (or at least the inquest process) had some therapeutic validity for families by enabling the exploration of unanswered questions about the

1. See above Chapter Two, 'Investigation by non-police entities'.
2. Through the Western Australian Review of Mortality (and Sentinel Event reporting) process discussed briefly above in Chapter Two.

circumstances of the death of their loved one in a public forum. The potential for raising awareness about circumstances leading to particular deaths and encouraging consideration of action required to prevent future deaths in those circumstances was also an important factor in people's perception of the coroner.

PREVENTION OF DEATHS IN SIMILAR CIRCUMSTANCES

Western Australia was one of the first Australian jurisdictions to legislatively embrace a role for its coroner that is wider than simply finding the cause and immediate circumstances of a death. The *Coroners Act 1996* (WA) hints, in s 25, at a broader coronial objective in the authority to make comments 'on any matter connected with the death including public safety or the administration of justice'.³ It also includes, as discussed earlier, the ability for the State Coroner to make recommendations to the Attorney General on 'any matter connected with a death which a coroner has investigated'.⁴

As discussed earlier, coroners in Western Australia often use the recommendation function to make recommendations aimed at preventing deaths in similar circumstances in the future. This 'prevention role' is one with which many of those consulted for this reference (including the coroners) saw as being an appropriate role for the modern day coroner and it is one that has been explicitly embraced in legislation in Queensland, Victoria, South Australia and New Zealand.⁵ A number of respondents believed that for the coroner to be effective in such a role, it is necessary that the Office of the State Coroner be active in providing assistance, via data collection and dissemination, to research bodies and relevant government agencies. This would enable such bodies to more reliably identify trends in deaths (eg, trends in

3. In relation to deaths in custody or care the coroner is required to make comments on the 'quality of the supervision, treatment and care of the person'. This requirement was legislated in response to recommendations 12 and 13 of the Royal Commission into Aboriginal Deaths in Custody.
4. *Coroners Act 1996* (WA) s 27.
5. See *Coroners Act 2008* (Vic) s 1; *Coroners Act 2003* (Qld) s 3; *Coroners Act 2003* (SA) s 25; *Coroners Act 2006* (NZ) ss 3, 4 & 57.

suicide or drug deaths in particular areas or among particular defined groups in the community) and to focus public resources into meaningful and targeted death prevention strategies.

PURPOSE AND SCOPE OF INQUESTS

Although there was clear support for a prevention role for the coroner, consultations revealed some considerable concern about the scope of inquests being undertaken in Western Australia. Respondents from both within the Office of the State Coroner and external to it commented on the fact that inquests were becoming more wide-ranging, and there was a concern that recommendations arising from inquests were too broad and only tenuously connected to the death or deaths being investigated.

An example widely cited by respondents as going beyond the 'acceptable' scope of an inquest was the 'Kimberley Inquest'⁶ into the deaths of 22 Aboriginal people in the Kimberley region in which drug and alcohol abuse or self-harm was a factor. Recommendations arising from that inquest included that school football programs be expanded, that a swimming pool be constructed in Fitzroy Crossing, that a whole-of-government approach to addressing truancy be implemented, and that a system of compulsory income management be introduced for Western Australia.⁷ While most respondents appreciated the important media focus that the Kimberley Inquest brought to exposing the extent of disadvantage experienced by Aboriginal communities in the region, many argued that the coroner in that case had gone beyond his legislative mandate by making some recommendations that were insufficiently connected with the deaths being investigated. Important questions were raised about whether a coroner's inquest was the appropriate forum to investigate the social problems the subject of the recommendations and whether there was sufficient, evenly balanced and tested evidence

6. Inquest No 37/07.

7. There were 27 recommendations made by the coroner in this case with many broadly addressing the infrastructure, funding and human resources needs in the Kimberley and encouraging a whole of government approach to problems of underlying Indigenous disadvantage. The inquest received such media attention that the Minister for Indigenous Affairs established a Director General's group to formulate a government response to the coroner's recommendations. However, the Commission notes that most of the initiatives cited by the government in apparent response to the coroner's recommendations involved programs, policies and capital works that were already in place or planned prior to the inquest. Further, many of these initiatives were in fact established in response to previous specialist reports and evaluations commissioned by government. See 'WA State Government Response to the Hope Report' (7 April 2008) <www.dia.wa.gov.au/Publications>.

presented at the inquest to support the making of informed recommendations about such broad social policy matters.

Respondents also identified a more general danger in coroners who had no specialist training in the area under investigation (eg, medical, mining engineering etc) extrapolating from the circumstances of an individual death to arrive at recommendations about a process or procedure which may have much wider application than the circumstances of the death the subject of the coronial investigation. The Commission was urged to consider reforms to the coronial system to clearly define the purpose and scope of inquests,⁸ to enable experts to sit with the coroner in complex inquests, to encourage greater consultation with experts and agencies in the formulation of recommendations, and to limit the making of comments and recommendations to matters directly arising from the death. These matters will be explored in detail in the Commission's Discussion Paper.

CORONIAL RECOMMENDATIONS

As well as the concerns cited above in respect of the utility of some coronial recommendations, comments were also made by respondents that recommendations had no legal force and that agencies or individuals the subject of coronial recommendations were not required to respond to them. As discussed in Chapter Two, the Commission's review of responses and implementation of coronial recommendations for 2007 found that the more targeted and specific a recommendation was, the higher the likelihood of response and implementation.⁹

During consultations the Commission canvassed the potential for a legislative requirement of mandatory response to coronial recommendations. This system was instituted recently in Victoria, which under s 72 of the *Coroners Act 2008* (Vic) obliges any public entity in receipt of coronial recommendations to provide a written response to the coroner within three months. The response must specify a statement of action (if any) to be undertaken in relation to the recommendation.¹⁰ All recommendations and responses are published on the internet.¹¹

8. Including the legislative direction in regard to factors that coroners should consider when making a determination whether or not to go to inquest in respect of a particular death.

9. See above Chapter Two, 'Recommendations'.

10. *Coroners Act 2008* (Vic) s 72(4).

11. *Coroners Act 2008* (Vic) s 72(5)(a).

Strong support for such mandatory responses to coronial recommendations was received from respondents, with some suggesting it should also extend to private interests (such as nursing homes). The concept of publishing coronial findings, recommendations and responses on the internet also received strong support. The potential for enhanced transparency of the coronial process and improved accountability of agencies and individuals the subject of coronial recommendations were cited as important benefits of such reforms.

Systemic issues

During consultations for this reference, there were three issues frequently raised by respondents as being indicators of the immediate need for reform. These were undue delay in delivery of coronial findings; a general lack of communication and cooperation between the Office of the State Coroner and the entities or individuals responsible for coronial (and related) service delivery or otherwise having an interest in the coronial process; and lack of information, guidance or training. These issues appeared to the Commission to impact the coronial jurisdiction in a systemic way in that almost all areas of coronial practice were somewhat affected by them. These issues are briefly discussed below.

DELAY

The primary concern of most people consulted for this reference was the length of time between the date of death and the date of finding in a coronial case. Consultations confirmed that delays existed in most areas of coronial practice and that these had a compounding effect that could result in families waiting a significant length of time for a coronial finding in respect of their deceased relative. Delays are regularly experienced at the forensic medicine examination stage (with significant delays noted in the areas of neuropathology and, to a lesser extent, toxicology),¹ at the investigation stage (with lengthy completion times for police reports² and for reports from other investigatory bodies such as WorkSafe), and at the coronial finding stage.

In regard to the latter, there was a strong perception of undue delay in bringing cases to inquest.³ Currently the delay between date of death and date of inquest appears to run between two and three years (occasionally longer) and approximately 75 cases

are awaiting inquest.⁴ Considering the number of inquests conducted in recent years, it appears this backlog could take at least two years to clear.⁵ In these circumstances, it is important to note that as time passes the perceived public benefits in holding an inquest may substantially diminish, particularly in cases to be inquested for the purpose of identifying and bringing attention to system failures. For example, hospital and workplace deaths are subject to internal and/or independent review immediately following the death and these generally result in reforms to practices and procedures to prevent similar occurrences in the future. By the time of inquest the circumstances that contributed to the death in a particular case may therefore have long been addressed.

Clearly there are a number of factors that may impact upon the timely delivery of coronial findings, not all of which are within the direct control of the Office of the State Coroner. For example, the State Coroner has no control over delays caused by pending prosecutions and his capacity to expedite necessary investigations (in particular forensic medicine investigations) is limited. On the other hand, it is understood that the Office of the State Coroner has a substantial number of files awaiting administrative findings where investigations are complete and no prosecution or inquest is pending. A number of these files are more than three years old and some outstanding files concern relatively simple natural causes deaths.⁶

Obviously any delay in closure of a coronial case can be extremely distressing for families and should be avoided as much as possible. However, a family's emotional wellbeing is not the only thing affected by delays in the delivery of coronial findings: such delays also have the capacity to impact negatively on a family's financial wellbeing. During consultations the Commission was advised that insurance companies will not always pay out on an insurance policy on

1. Both of which can hold up the forensic pathologist's report identifying cause of death.
2. In particular in relation to traffic fatalities: Gary Cooper, Manager Coroner's Office (WA), consultation (18 June 2010).
3. The State Coroner has advised that delay in bringing cases to inquest can sometimes be beneficial, in particular where family members require time to deal with their grief 'prior to their being able to address the detail of the circumstances of a death and to make relevant decisions' as would be required in an inquest forum: Hope A, State Coroner of Western Australia, correspondence (7 January 2010) 9.

4. Western Australia, *Parliamentary Debates*, Legislative Assembly, 1 June 2010, 108c-125a (Mr CC Porter, Attorney General).
5. See above, Chapter Three, Table 3.
6. As noted earlier, a recent injection of human resources is assisting to reduce this backlog.

the basis of an interim finding as to cause of death, but rather wait until the coronial investigation is complete.⁷ In these circumstances there is an added impetus for reducing, so far as possible, delays in the coronial process.

COMMUNICATION AND COOPERATION

External 'service providers'

Another concern cited frequently during the Commission's consultations was an apparent lack of effective communication and cooperation between entities involved in coronial service delivery. The Office of the State Coroner relies on a number of external entities to successfully deliver coronial services to the Western Australian community. Some of these entities work under contract to the coroner (eg, body transport contractors), some are statutory authorities that provide essential services to the coroner (eg, Western Australia Police, PathWest and ChemCentre), and others are completely independent of the coronial system but are relied upon to a certain extent in the effective delivery of coronial services (eg, WorkSafe, ATSB and NCIS). The Office of the State Coroner also relies upon magistrates and court staff in regional Western Australia to deliver certain coronial services in their respective areas.

Ineffective communication (on all sides) between the Office of the State Coroner and its external service providers would appear to contribute to some of the administrative inefficiencies that cause delay in the coronial jurisdiction.⁸ It also impacts upon service delivery in related areas, in particular, the Registry of Births, Deaths and Marriages and the Health Department. Many of those consulted by the Commission stressed the importance of open communication with the Office of the State Coroner and the need for clear memoranda of understanding

7. The Commission was told that the forensic pathologist's interim findings of cause of death appear to be less definitive than they once were and are often expressed to be subject to results such as toxicology, which could affect an insurance claim.
8. For example, if police investigating a death on behalf of the coroner are not given clear directions from the outset as to what is required of their reports in a particular type of coronial case, it can cause significant delay when coroners return the files for further investigation. If a period of time has passed since the officer made his or her initial investigation there may also be some difficulty locating witnesses for further questioning. At the other extreme, coronial cases involving industrial or workplace deaths are often unnecessarily delayed because decisions by WorkSafe whether or not to prosecute are either not taken or are not communicated to the coroner at a sufficiently early stage.

regarding the sharing of information that is crucial to their respective functions. Others (in particular coronial investigators and people involved in regional coronial service delivery) noted that more direction or guidance was required from the State Coroner in order for them to contribute more effectively to the coronial system. A lack of training across all facets of the coronial system in Western Australia was strongly evident from the Commission's consultations.

Legal profession

The Commission was told by counsel (both in private practice and in government) that the Coroner's Court regularly failed to notify representatives of interested persons appearing at inquest about important events in the inquest process. Of particular concern was the extremely late notification firstly, of cases identified for inquest and secondly, of the dates set down for inquest. In many cases it was apparent that counsel only learned that a case was proceeding to inquest a matter of weeks before the listing date. The Commission notes that in cases such as hospital deaths, traffic deaths, deaths in custody and deaths in care it is relatively clear from the outset who would qualify as an interested person under reg 17 of the *Coroners Regulations 1997* (WA). These people should be identified at the earliest opportunity and kept informed of any potential inquest proceedings. In particular, persons who may be in some way implicated in the death have interests to protect, both in respect of potential disciplinary proceedings or criminal charges that may follow from an inquest. Counsel for interested persons need sufficient time to prepare their case, to examine the coroner's inquest file, and to seek their own independent expert reports. Often the need to file supplementary statements arises when the coroner's file is inspected and expert reports are reviewed. Failure to provide a reasonable time to prepare for inquest places procedural fairness at risk, in particular where an interested person is one against whom an adverse finding may be made.

Another complaint from counsel was that in many cases there was no effort made by the court to cooperate with counsel to identify key dates for inquest. In Western Australia very few counsel appear regularly in the Coroners Court and, because of its inquisitorial nature, it is considered a reasonably specialised jurisdiction. Apart from having a very limited time to prepare a case, it is possible that experienced counsel will not be available when given

such short notice of a listing. A similar criticism has been made in respect of key witnesses, such as doctors, who often have surgery schedules booked more than three weeks in advance.

Procedural and administrative concerns raised by the legal profession included failure of the Coroners Court to provide a settled 'inquest brief' to counsel; difficulty accessing evidence or expert reports relied upon by the coroner; refusal by the Office of the State Coroner to disclose certain expert reports; additions to inquest files made between the time of file viewing by counsel and inquest without advice to counsel; fragmentation of inquest hearings; non-disclosure of witness lists or issues to be examined in advance of inquest; the calling of expert witnesses by the coroner without prior notice to parties (who may have already given evidence and have not had the opportunity to consider and comment on the expert's report); and the need for enhanced court transcription services. It is the Commission's view that many of the issues discussed in this section can be addressed by relatively simple changes to court practice and procedure and these will be taken up in the Commission's Discussion Paper.

Researchers and special interest advocacy groups

If the coroner is to effectively discharge a death prevention role then it is clear that there needs to be a high degree of cooperation between the Office of the State Coroner and legitimate researchers and special interest advocacy groups within the community and government. Although in the past a small number of groups⁹ have been given supervised local access to closed case¹⁰ coronial data to focus their research and awareness raising activities, presently there appears to be very little direct information sharing. A very small cohort of Western Australian research organisations now access coronial data directly through the National Coroners Information System (NCIS).¹¹ These include the Royal Lifesaving Association (WA Branch) and the Western Australian Alcohol and Drug Authority, both of which are authorised to access national coronial data, including limited open case data.¹²

9. Such as the Ministerial Council for Suicide Prevention, SIDS and Kids and the Royal Lifesaving Association. Researchers applying for access to coronial data are vetted by the Coronial Ethics Committee of the Office of the State Coroner.

10. That is, cases that have been finalised by a coroner.

11. See discussion above, Chapter Three, 'A note about data',.

12. The only other authorised Western Australian user of Level 1 NCIS data is the Law Reform Commission of Western Australia. The Department of Health had access to NCIS

Because of the length of time between the date of death and finalisation of a case by the coroner, closed case data would appear to be a somewhat ineffective means of informing death prevention strategies. Open case data available through NCIS is similarly ineffective because users are not authorised to access text reports, which provide information necessary for early identification of particular trends in deaths.¹³ The Office of the State Coroner, on the other hand, has immediate access to information about the circumstances and place of death and priority access to interim post mortem findings as to cause of death.¹⁴ This information may be searched for broad terms such as 'hanging' or 'drowning' to enable identification of emerging trends (eg, suicide clusters in rural areas), which can inform targeted prevention strategies. The information available to the coroner can also be searched for specific drug or product names to confirm the existence of trends that have been anecdotally identified and to inform consumer awareness campaigns, product recalls or health and safety policies.

While the Office of the State Coroner has clearly suffered from considerable under-resourcing over the past decade in relation to computerisation,¹⁵ it now has adequate technological resources to enable reliable data collection.¹⁶ However, the analysis of data to identify trends in sudden, unexpected deaths, to support the needs of external researchers or to assist in informing government policy is beyond the current human resource capacity of the Office of the State Coroner.¹⁷ The Commission's consultations

from 2002 to 2005, at which time it declined to renew its access. Two projects being undertaken by PhD researchers at Curtin University currently have limited access to NCIS for de-identified closed case data from Western Australia only. This research is focused on fatalities in the mining and construction industries: Joanna Kotsonis, Access Liaison Officer, National Coroners Information System, consultation (17 August 2010).

13. Ibid.

14. For example, the P98 mortuary admission form provides a basic narrative as to circumstances of death, while toxicology and post mortem examination reports provide information on drugs in the deceased's system and cause of death. The P98 and interim post mortem examination findings are available within days of the death being recorded on NCIS, while the toxicology and full post mortem examination reports are attached to the NCIS file when they become available.

15. See, eg, comments of State Coroner Hope in Office of the State Coroner (WA), *Annual Report 2006-2007* (2008) 9.

16. However, the Commission is advised that the Office of the State Coroner's human resources are such that it can only keep up with daily data upload (from both the metropolitan and regional areas) and finds it difficult to respond to external requests that require research and/or analysis: Sue Sansalone, Systems Information Officer, Office of the State Coroner, consultation (16 August 2010).

17. Analysis of open case data would need to be performed within the Office of the State Coroner by a suitably qualified researcher because these are cases that have not yet been put before a coroner. In order to perform such a role the Office of the State Coroner would require further human resources in the form of a dedicated research and analysis

revealed a strong case for extending the current role of systems information within the Office of the State Coroner to include detailed data analysis, trend identification and timely dissemination of coronial information to relevant groups. This would constitute an important contribution to death prevention in Western Australia and the Commission will consider how best to facilitate this aspect of the coronial role in its Discussion Paper.

INFORMATION, GUIDANCE AND TRAINING

With the exception of Western Australia, coroners court websites in every Australian jurisdiction provide electronic links to coronial inquest findings and associated recommendations. In Queensland, South Australia, Northern Territory, Tasmania and Victoria all findings¹⁸ are publicly available on the coroners court website, while in New South Wales and the Australian Capital Territory a selection of coronial findings is featured. While Western Australia has a dedicated webpage for inquest findings, this page has been 'under construction' for some years.¹⁹ The Commission was advised in August 2008 that there were plans to provide a summary of findings with the ability to apply to the coroner for a full copy of an inquest finding; however, there appears to have been no action on this plan to date.

The lack of accessibility of coronial findings and guidelines has been raised before by this Commission in the context of its Aboriginal customary laws reference.²⁰ In response to the Commission's Discussion Paper for that reference the State Coroner submitted that these deficiencies in the Coroners Court website would be addressed 'in the near future'.²¹ That submission was made in March 2006 and no action appears to have been taken

officer. Media organisations and government agencies also regularly approach the Office of the State Coroner to provide specified data; however, the ability of the Office to provide data in answer to such requests is reportedly also limited by inadequate human resources: *ibid*.

18. With the possible exception of any findings where the relevant State Coroner has deemed the availability of findings not to be in the public interest.
19. It appears that inquest findings that were once available on the Coroners Court website were removed after the court received complaints from families of deceased. Although there may be a need to anonymise or otherwise withhold a small number of coronial findings to protect privacy (eg, of families and witnesses) in some instances, there appears to be a greater need to encourage understanding of the coronial system.
20. LRCWA, *Aboriginal Customary Laws: The interaction of Western Australian law with Aboriginal law and culture*, Project No 94, Final Report (September 2006) 255-6.
21. Alastair Hope, State Coroner of Western Australia, submission to Aboriginal customary laws Discussion Paper (7 March 2006) 5. See also discussion in the Commission's final report, *ibid*.

to address the concerns of the Commission in the intervening period. Consultations also suggested that the Coroners Court website was not an effective public interface for users of the court, including families and persons with an interest in certain coronial cases or coronial outcomes generally. In particular, the website appears to be updated only very infrequently. When viewed in mid-August 2010, the court listing page featured inquest dates for January and February 2010 only.²²

The Commission heard from Western Australian coroners that the legal profession, including the judiciary, did not sufficiently understand the coronial role or jurisdiction and did not appear to appreciate the differences between legal practice in the 'traditional adversarial system' and the inquisitorial system practised in the Coroners Court. This is a position with which some in the legal profession agreed, noting that the coronial system was an area that was neglected in general legal education. However, comments were made by members of the legal profession that the coronial jurisdiction was not transparent and that inquest practice was not consistent; further, counsel found it difficult to access information about Western Australian coronial practices and procedures. The Commission noted that there was little guidance offered to counsel, both by way of practice directions from the State Coroner or in the form of appellate law. The availability of findings online would enable analysis of coronial reasoning, promote a better understanding of coronial outcomes and, as noted earlier, may assist in encouraging implementation of recommendations. The public interest in the availability of inquest findings and transparency of coronial investigations of deaths in Western Australian hospitals and healthcare facilities is a priority for the Office of Safety and Quality in the Department of Health, which publishes all relevant inquest findings on its own website.²³

As well as the need for guidance from the State Coroner to Western Australia's legal profession, guidance was also sought from others involved in the coronial process. The Commission's consultations with police, both in Perth and in regional areas, suggested the need for clearer directions from the State Coroner in respect of the standards expected of coronial investigation reports. Police indicated that they would welcome more direct guidance and

22. <http://www.coronerscourt.wa.gov.au/C/court_lists.aspx> (accessed 13 August 2010).
23. <http://www.safetyandquality.health.wa.gov.au/mortality/inquest_finding.cfm> (accessed 14 August 2010).

feedback from coroners during the initial investigation stage. Consultations with regional magistrates and regional court registrars also revealed a need for greater communication and guidance in all areas of coronial practice, including the need for file checklists, precedents for drafting of administrative findings and information about the administrative needs of the Office of the State Coroner. Given that the inquest function had effectively been centralised to Perth, regional staff felt there was a greater need for guidance from the Office of the State Coroner about deaths that should be immediately identified for inquest in order to reduce delays experienced by families. Overall there was a sense of remoteness from the Office of the State Coroner in Perth which could be improved by regular newsletters in relation to coronial business or by establishing coronial regions with dedicated coroners in the north and the south of the state.²⁴

As noted earlier, training was a concern across the coronial jurisdiction with little or no coronial training offered to police, regional coroner's clerks, magistrates (who are required to exercise the coronial jurisdiction in regional areas) or coronial contractors (such as body transporters). Most parties consulted by the Commission said they were required to 'learn on the job' and would welcome more formalised training in coronial matters related to their work. Although the Coroners Court fulfils an important educational function by providing presentations to certain community groups including hospitals, funeral directors and others, there is clearly a need to extend this educational role to those more closely involved in the delivery of coronial services on behalf of the court.

24. The establishment of a northern and southern coroner for Western Australia was mooted with most people consulted for this reference. It received significant support and will be discussed in detail in the Commission's Discussion Paper.

Investigations, offences and penalties

The Commission's consultations revealed a number of issues impacting on coronial investigations which need to be addressed to eliminate, so far as possible, the delays in coronial findings and to ensure the integrity of investigations. Some of these issues are highlighted below.

DEATHS IN POLICE PRESENCE AND PRISON CUSTODY

A concern of a number of respondents was the concept of police investigating deaths that may have been caused or contributed to by police.¹ As noted in Chapter Two, deaths in police presence are subject to mandatory inquest and are investigated by the Major Crime Squad with oversight or joint investigation by Internal Affairs.² There was some criticism by counsel that the focus of police investigations in these cases was too narrowly confined to criminal responsibility and that certain issues that should be canvassed in a coroners brief were left wanting. Similar issues were raised by those consulted in respect of death in custody investigations.

The Commission notes that these concerns were raised during the passage of the *Coroners Act 1996* (WA) and that s 14, which allows the appointment of independent coroner's investigators, was intended to address this issue.³ However, to the Commission's knowledge the independent investigator powers in s 14 have never been used. Some police consulted felt that there was scope for 'on the scene' oversight of police investigations by an experienced investigator from an independent body such as the Corruption and Crime Commission to ensure that the integrity of a death in police presence investigation was

maintained. In respect of deaths in prison custody the Commission was invited to examine the investigations model of the Prison and Probation Ombudsman in England, with the potential for the Inspector of Custodial Services to be given extended powers to perform a similar role in Western Australia. These ideas each have merit and will be examined in detail in the Commission's Discussion Paper.

DEATHS IN HOSPITALS

According to police, approximately 20% of coronial cases examined by the Coronal Investigation Unit are hospital deaths. During consultations police confided some concerns about their capacity to investigate deaths in medical settings effectively. Presently police attend at the hospital to identify witnesses and seize patient records, but reports and statements are often sought a significant time later and are generally provided through the hospital or through a doctor's counsel rather than gathered through questioning by police immediately following the death. Unlike most other death investigations, which are conducted by bodies independent of the institution in which the death occurred, this practice tends to internalise investigations to the hospital and may give an appearance of bias. A particular concern is that statements may not address the questions required by the coroner because the coroner's investigator is not leading the investigation. This is further exacerbated by the fact that statements are given without knowledge of any expert evidence the coroner may have sought and without a full appreciation of the issues that the coroner seeks to explore at inquest. This can create the false perception that the witness is avoiding questions of concern to the court. Further, because of the delay between the death and the provision of a statement, there may be issues with the recollection by medical staff of the event.

There was strong support for the establishment of a specialist medical investigation unit among those consulted. A number of possible locations for such a unit were mooted during consultations, including a team within the police Coronal Investigations Unit

1. The issue of police investigating police has been the subject of a recent article in Western Australia: see Allingham K & Collins P, 'Coronial Reform in Western Australia' (2008) 12 (SE2) *Australian Indigenous Law Review* 90, 90.
2. This arrangement appears to effectively implement recommendations 33 and 34 of the Royal Commission into Aboriginal Deaths in Custody with Major Crime Squad investigators being the most experienced death investigators on the Western Australia police force and with senior oversight by Internal Affairs.
3. See Western Australia, *Parliamentary Debates*, Legislative Assembly, 22 June 1995, 5705 (Ms C Edwardes, Attorney General); Western Australia, *Parliamentary Debates*, Legislative Assembly, 18 October 1995, 9378 (Mr Reibeling).

with access to medical specialists; a team within the Office of the State Coroner and utilising the coroner's own medical adviser; and a team within the Health Department.

DEATHS IN MENTAL HEALTH FACILITIES

Investigations into deaths in mental health facilities are conducted by local police, or officers from the Coronial Investigation Unit or Major Crime Squad, depending on the circumstances. The Commission heard that there were instances where insufficient regard was given to the special nature of the environment where the death occurred. In its Discussion Paper the Commission will consider whether there is a need for a protocol between police and the Office of the Chief Psychiatrist to ensure that police investigators are conscious that vulnerable patients may be unduly distressed by interruptions to institutional routines caused by an investigation and to determine ways of diminishing patient distress.

WORKPLACE DEATHS

The Commission was made aware of considerable delay in relation to coronial findings where deaths were subject to a WorkSafe investigation. Under s 53 of the *Coroners Act* the coroner must adjourn a coronial inquest where criminal proceedings are instituted. Section 52(3) of the *Occupational Health and Safety Act 1984* (WA) gives WorkSafe investigators three years to determine whether charges should be preferred in respect of a workplace death. This means that matters are not generally finalised by the coroner until after WorkSafe have made a determination whether or not to charge in respect of a workplace death. The Commission notes that there is nothing in the *Coroners Act* to prevent a coroner from making an early administrative finding in relation to a workplace death in cases where an inquest is unlikely to be held, thereby eliminating unnecessary delay. However, it appears that coronial determinations often rely more on the findings of WorkSafe investigations, than the investigations concurrently conducted by police (which may, in turn, seek to rely on WorkSafe findings in relation to certain aspects of the investigation). The State Coroner and WorkSafe have recently negotiated a protocol for coronial access to privileged investigation documents to enable a faster coronial response to workplace deaths.

INVESTIGATORS' POWERS

Police⁴ investigating deaths in Western Australia have certain powers under the *Coroners Act* at their disposal. Chief among these is the power to restrict access to premises (s 32) and to enter, search and seize any material relevant to a coronial investigation (s 33). The power to restrict access to premises is valid for six hours unless the coroner gives notice in writing of an extension. Police also have the option to apply for search and seize warrants and for entry and restriction of access to premises under the *Criminal Investigation Act 2006* (WA); however, it was argued that it is sometimes difficult to judge, within six hours, whether there is any criminality involved in a death to justify the seeking of a warrant.⁵ Metropolitan-based police consulted for the reference suggested that the time period of six hours should be extended to permit proper forensic processing of a scene (which can take up to 72 hours) and to enable them to determine whether a warrant under the *Criminal Investigation Act* is necessary. Regional police consulted for the reference did not share these concerns and appeared to prefer to utilise the powers under the *Criminal Investigation Act*. There is a tension here between the powers immediately at the disposal of police officers investigating a death under the *Coroners Act* and those that must be sought by warrant under the *Criminal Investigation Act*. The Commission will explore coronial investigations powers in more detail in its Discussion Paper and review comparable powers available to police in other Australian jurisdictions.

FORENSIC MEDICINE INVESTIGATIONS

Western Australia's forensic pathology team at PathWest is highly regarded both in Western Australia and internationally, with members closely involved in disaster victim identification in incidents such as the 2002 Bali bombings. As discussed in Chapter Two, this team works closely with external specialists in areas such as neuropathology and toxicology to support the coronial function in determining cause of death. However, as noted earlier, there are aspects of the forensic medicine investigation process which can cause significant delays in coronial determinations. In addition a 2006 report by the Auditor General for Western Australia

4. And 'coroner's investigators' appointed under s 14.

5. The primary reason given was the fact that it can take several hours to get a police forensic unit to the scene of a death.

found that there was a need for greater integration of forensic services with better allocation and utilisation of resources and improved information sharing.⁶ During consultations the Commission discussed with key stakeholders whether there was a need to establish a centre for forensic medicine to enable more streamlined responses to coronial and justice needs and to assist, among other things, in the identification of trends in deaths. Similar centres exist elsewhere in Australia, most notably the Victorian Institute of Forensic Medicine, which is co-located with the Victorian Coroners Court. Consultations revealed a mix of views about the idea of a dedicated centre for forensic medicine. While some respondents saw merit in the idea, those closely involved in the system indicated that the existing relationship between forensic medicine services and the Coroners Court was satisfactory. In particular, forensic pathologists emphasised the benefits of their current co-location with a hospital and stressed the need to maintain close professional relations with their clinical colleagues.

OFFENCES AND PENALTIES

Police, coroners and others consulted drew the Commission's attention to the very low level of penalties attaching to sometimes quite serious offences in the *Coroners Act*. The Commission has noted that penalties are somewhat out of step with those in comparable jurisdictions. For example, unlawful access to premises on which a restriction is placed (as described above) is subject to a fine of only \$1,000 in Western Australia, whereas in Victoria the penalty is \$7,167 or imprisonment for a period of six months. The Commission's Discussion Paper will review offences and penalties within the *Coroners Act* to assess whether the level of penalty is appropriate and whether there is a need for the creation of further offences to assist coroners and coroners' investigators to discharge their statutory functions.

6. Auditor General (WA), *Behind the Evidence: Forensic Services* (May 2006) 5-6.

Role, rights and support of the family

Though it was clear from consultations with Coroners Court staff that families were the first priority of the office, overall there was a sense from consultations that more could be done to support families in the broader coronial process. Below are just a few of the issues raised with the Commission that require consideration in its Discussion Paper.

LEGAL REPRESENTATION AT INQUEST

As shown in Chapter Three, there is a relatively low incidence of families being represented at coronial inquests in Western Australia. The Commission was told anecdotally that this is not the case in other Australian jurisdictions, which apparently had a much higher proportion of families legally represented. Questions were raised as to whether legal aid funding needed to be improved to enable families to be represented at inquests, should they request it. The need for legally aided representation for families at coronial inquests was a recommendation of the Royal Commission into Aboriginal Deaths in Custody.¹

CORONIAL COUNSELLING

As discussed in Chapter Two,² the coronial counselling service is an important means of providing families with necessary information about the coronial process. It plays a very short-term grief counselling role with longer term counselling needs being supplied by support services such as Arbor and SIDS and Kids or by community psychologists.³ People consulted for this reference were complimentary of the counsellors and the service they provided, while recognising that the service had significant resource limitations that impacted upon the extent of the work they were able to undertake. Of particular concern was the realisation that coronial counselling was not being effectively offered to people in regional areas of

Western Australia.⁴ This was an issue identified and addressed by the Commission in its 2006 report on Aboriginal customary laws.⁵ Further, there was concern in some consultations that Indigenous people and others were reluctant to use the service when referred by coroners court clerks, police or others because of the association of the term 'counselling' with 'mental health'. The term 'coronial liaison' was widely preferred and indeed may be more descriptive of the services provided by the counsellors. There was also a need identified for greater involvement of coronial counsellors when conducting viewings at the State Mortuary.

EXTERNAL POST MORTEM

The process for objecting to post mortem examination is discussed in detail in Chapter Two. During consultations the question was raised whether internal post mortem examination was required in every case given the trend toward less invasive post mortem examination procedures in other jurisdictions.⁶ This was also a matter highlighted by the Barnes report, which recommended that the *Coroners Act* be amended to provide for an external autopsy in all cases with family members being able to object only to an internal post mortem examination.⁷ External, or partial, post mortem examination might include the use of imaging technology (such as CT scans), the taking of blood, urine and other bodily fluids (such as spinal fluids), and the taking of small tissue samples by fine needle aspiration biopsy.

Many of those consulted supported the idea of legislating for a first instance external post mortem examination, with an internal post mortem

1. Recommendation 23.
2. See above, Chapter Two, 'Inside the Office of the State Coroner: Coronial Counsellors'.
3. Some services indicated the need for greater communication by coronial counsellors of services available to families within the community.

4. Coronial counselling in the regions is primarily delivered through provision of a freecall number to the coronial counselling service in Perth; however, the success of this service in regional areas is unclear.
5. LRCWA, *Aboriginal Customary Laws: The interaction of Western Australian law with Aboriginal law and culture*, Project No 94, Final Report (September 2006) 256. The Commission's recommendation 77 that a full-time Indigenous coronial counsellor/educator be employed and that resourcing for the expansion of coronial counselling services to rural areas be investigated has not yet been implemented, reportedly due to lack of resources.
6. Most notably Queensland and New South Wales.
7. Barnes M, *Review of the Coroners Act 1996 (WA)* (August 2008) 25.

examination to be directed by the coroner only if the external post mortem examination revealed a need. However, concerns were raised by forensic pathologists that external post mortem examination would not always be able to satisfactorily identify a cause of death and that it may, in certain circumstances, take longer than an internal autopsy and delay release of bodies for burial or cremation.

RELEASE OF BODIES

Although there is nothing in the *Coroners Act* governing the release of bodies under control of the coroner to a particular party, it often falls to the coroner to arbitrate disputes regarding the release of a body where family members disagree. The coroner cannot make a legally binding determination in this respect but does provide assistance to families to reach a mediated outcome through the coronial counselling service. Where intervention by the coroner is unsuccessful the family may apply to the Supreme Court for an order as to whom the body should be released.

The Commission has examined this issue in its Aboriginal customary laws reference, which dealt with concerns that Aboriginal customary law in Western Australia was generally at odds with Australian common law in relation to who should have the right to dispose of a deceased's body.⁸ In relation to that reference, consultations revealed that the current court process needed to be more accessible in the event that a mediated resolution could not be reached.⁹ The Commission made a series of recommendations regarding the observation of burial instructions of a deceased and the proper forum for determining burial disputes.¹⁰ In its Discussion Paper, the Commission will examine the issue again in this broader context to determine whether a greater role should be played by the coroner in the first instance in deciding to whom a body should be released and whether any legislative reform is required to support such a role.¹¹

8. LRCWA, *Aboriginal Customary Laws: The interaction of Western Australian law with Aboriginal law and culture*, Project No 94, Final Report (September 2006) 257–64.

9. *Ibid* 263.

10. See *ibid*, recommendations 78 and 79.

11. A related issue to be examined in the Commission's Discussion Paper is the claim that people are not always made aware that they must appoint a funeral director in order to apply for release of the deceased's body from the State Mortuary in Perth following a post mortem examination. This is particularly problematic in regional areas where bodies are transferred by a body transport contractor, but cannot be returned to the regional morgue without a specific request for release by a funeral director. The Commission is aware that there are a number of unclaimed bodies at the State Mortuary, some of

TRANSPORT OF BODIES

As noted earlier, the Office of the State Coroner relies on external contractors to transport bodies to the State Mortuary in Perth for post mortem examination. In regional areas the recovery and transport of bodies can be especially challenging, in particular where bodies are located in remote locations some distance from an airport. The Commission is aware of problems experienced in the north-east of Western Australia where bodies have been transported by unrefrigerated vehicles in extremely hot conditions over long distances.¹² The Commission was advised by police of one case of homicide where the body arrived in Perth in a significantly deteriorated state.¹³ While transport in refrigerated vehicles is not currently a requirement of the coronial transport contract, there is clearly a need to slow the inevitable deterioration of bodies in these circumstances to ensure that useful and reliable findings can be obtained at post mortem examination.

CONDITION OF BODIES FOLLOWING POST MORTEM

The Commission heard complaints from people involved in the funeral industry about the condition of bodies on release from the State Mortuary in Perth following a post mortem examination. In Perth, funeral industry representatives noted that bodies returned from post mortem examination were required to be reopened and packed to eliminate seepage and that where brains had been retained for testing often no effort was made by mortuary technicians to refix the skullcap. In regional areas, funeral directors called attention to the fact that many regional morgues do not have body wash down facilities, making it extremely difficult for them to prepare bodies for viewings and funerals on return from post mortem.¹⁴ In particular, it was noted that

which are from regional areas. See 'Unclaimed bodies in Perth morgues', ABC news (19 November 2009) <www.abc.net.au/news/stories/2009/11/19/274715.htm> (accessed 17 August 2010).

12. This issue has also been ventilated in the media: see 'Funeral Director Defends Using Ice Packs, Hire Cars', *The West Australian* (4 February 2010).

13. The Commission was also told by police in one regional area that body bags were not sealed by police to prevent the possibility of tampering with the body (or physical evidence attached to the body) during transport to the State Mortuary in Perth. It is noted that a body may go through a number of hands on its journey to Perth from regional Western Australia. Where no attempt is made by police to preserve the chain of evidence, particularly in cases of suspicious deaths, questions may arise as to the admissibility of evidence found at post mortem examination.

14. Unlike funeral directors in Perth, very few funeral directors in regional areas have premises with body storage and

bodies were not washed down following post mortem examination and arrived at the regional morgue unwrapped (that is, with no means of soaking up body fluids released during transportation). In comparison, the Commission was told that bodies that had undergone post mortem examination in Darwin arrived in excellent condition, having been washed and wrapped for transportation.

CONDITION OF STATE MORTUARY

As part of its initial research for this reference, the Commission viewed the facilities of the State Mortuary in Perth and hospital morgues in Perth and in regional areas. Criticisms of the poor conditions of the State Mortuary at the QEII Medical Centre in Perth by those consulted for the reference were confirmed on viewing by the Commission. There appeared to be no designated parking for families attending to view their deceased relative and access to the viewing area of the morgue was via the main driveway to the body drop-off and collection port. This driveway also contained bins for industrial and hospital waste from the Sir Charles Gairdner hospital next door. The mortuary waiting area consisted of some chairs in a hallway which was used for deliveries to the main scientific area of PathWest. There were no rooms to enable counselling of families prior to viewing the body and only a very small area for viewing and identification of a deceased. The décor was dated and institutional, and the smell and sounds of mortuary operations penetrated the area making the experience extremely counter-therapeutic.

In contrast the morgue at Royal Perth Hospital was light, spacious and featured a well-appointed viewing room. It had two comfortable waiting areas with sofas, coffee-making facilities, toilets and a telephone. Even morgue viewing facilities in some regional hospitals were substantially better than those in the State Mortuary in Perth. For example, the facilities at Broome Regional Hospital were modern with a comfortable indoor waiting area, toilet facilities and a dedicated outdoor undercover courtyard. The viewing room was sufficiently large with windows to enable remote viewing if necessary in cases where touching of the body was not permitted.¹⁵

preparation facilities. In most cases, the Commission understands, bodies are prepared for viewing and funeral in the local hospital morgue.

15. For example, in cases of infectious disease or suspicious deaths where the coroner has made an order under s 30(2) of the *Coroners Act 1996* (WA).

INDIGENOUS AND OTHER CULTURAL CONCERNS

A number of Indigenous cultural concerns were raised with the Commission regarding the coronial process. These included the reluctance of Aboriginal people to utilise coronial counselling services (discussed above); the formality of inquest proceedings and the court environment; the lack of Aboriginal staff or cultural liaison within the Office of the State Coroner; the lack of understanding of Aboriginal kinship systems and their impact on family decisions relating to coronial matters; misunderstanding about Aboriginal burial practices; the communication of family rights in the coronial process, such as objection to post mortem; and cultural concerns about naming of an Aboriginal deceased at inquest.

Just as there is a need for attention to culturally appropriate delivery of coronial information to Indigenous people there are opportunities for reform to reflect similar needs in relation to other culturally and linguistically diverse groups within the Western Australian community. Possible reforms might include the provision of coroners brochures in different languages and the provision of interpreters to explain the rights of the family where necessary.¹⁶

16. For example, the Commission heard from police about cases of deaths of foreign nationals where difficulties were experienced in advising families of their rights in the coronial process.

Appendices

Contents

Appendix A:	List of people consulted	61
Appendix B:	When a person dies suddenly (Reproduction of the Coroners Court brochure)	65

List of people consulted

The Commission thanks the following people for their input during the consultation stage of this reference:

Alan Goodger, Detective, Western Australia Police, Kununurra
Alastair Hope, State Coroner of Western Australia
Amanda Banks, Journalist, The West Australian
Andrew Lewis, Librarian, Parliament of Western Australia
Anita Rudeforth, Senior Policy Officer, Strategic Development, Department of Mines and Petroleum (WA)
Ann O'Neill, Angelhands
Ben White, Solicitor, Aboriginal Legal Service, Broome
Bernadine Brierty, Bowra & O'Dea
Brett Burns, Registrar, Registry of Births Deaths & Marriages (WA)
Brianna Lonnie, Solicitor in Charge, Legal Aid, Kununurra
Brian Begg, Seasons Funerals
Brian Bradley, Partner, Bradley Bayly Legal
Brian Powell, Detective Inspector, Internal Affairs Unit, Western Australia Police
Caroline Thatcher, State Solicitor's Office (WA)
Casey Prins, Detective Inspector, Special Crime Squad, Western Australia Police
Catherine Elphick, Senior Associate, DLA Phillips Fox
Charendev Singh, Australian Inquest Alliance
Chief Justice Wayne Martin, Supreme Court of Western Australia
Chief Stipendiary Magistrate Stephen Heath, Magistrates Court of Western Australia
Claudia Chipper, Medical Scientist and Quality & Project Support Officer, PathWest
Cleo Taylor, Senior Practice Development Officer, Department of Child Protection, Broome
Dave Dent, Registry Manager, Office of the State Coroner (WA)
Dave McCann, former Perth Coroner (ret.)
Dave Taylor, Operations Manager, PathWest
Dawn Wright, Administrator, Office of the State Coroner (WA)
Dell Collins RN, Community Nurse, Kununurra
Dianne Scaddan, Senior Solicitor, Legal Services Unit, Western Australia Police
Dominic Bourke, Partner, Clayton Utz
Dominic McKenna, Lawyer, Legal Aid Western Australia
Dominic Mulligan, Barrister, John Toohey Chambers
Dr Alanah Buck, Forensic Anthropologist/Quality Officer, PathWest

Dr Andy Robertson, Chief Health Officer Division Director, Health Protection Group, Department of Health

Dr Clive Cooke, Chief Forensic Pathologist, PathWest

Dr David Ranson, Deputy Director, Victorian Institute of Forensic Medicine

Dr Gavin Turbett, Director Forensic DNA, PathWest

Dr Ian Freckelton, Barrister, Owen Dixon Chambers, Melbourne

Dr Jacqueline Scurlock, Consultant Paediatrician, SIDS and Kids

Dr Jodi White, Forensic Pathologist, PathWest

Dr Karin Margolis, Forensic Pathologist, PathWest

Dr Paul Caterina, Principal Scientist, Division of Tissue Pathology, PathWest

Dr Robert Turnbull, Medical Adviser, Office of the State Coroner (WA)

Dr Rowan Davidson, Chief Psychiatrist Western Australia

Dr Steven Patchett, Director, Office of Mental Health (WA)

Dr Tom Hitchcock, Office of Safety and Quality, Health Department of Western Australia

Evelyn Vicker, Deputy State Coroner (WA)

Faye Zavazal, Okuri Funeral Services, Broome

Felicity Zempilas, Counsel Assisting, Office of the State Coroner (WA)

Fred Zagami, Detective Superintendent, Deaths in Custody Investigations, Western Australia Police

Gary Cooper, Manager, Office of the State Coroner (WA)

Genevieve Cleary, Lawyer, Legal Aid Western Australia

Geoff Bourhill, Partner, Lavan Legal

Geoff Sorrell, Sergeant, Office of the State Coroner (WA)

Graeme Slattery, Senior Associate, Minter Ellison

Graham Sears, Senior Sergeant, Western Australia Police, Kununurra

Grant Donaldson SC, Barrister, Francis Burt Chambers

James Woodford, Associate to Justice Templeman, Supreme Court of Western Australia

Janet Peacock, Manager, Office of Chief Psychiatrist (WA)

Janet Roy, Secretary, Office of the State Coroner (WA)

Jeff Byleveld, Detective Superintendent, Major Crime Division, Western Australia Police

Jennifer Searcy, Victims Advocate and Researcher, Murdoch University

Jenny Scott, Coroners Clerk, Hobart (Tas)

Jessica Pearse, Manager, National Coroners Information System

Joanna Cotsonis, Access Liaison Officer, National Coroners Information System

John Banfield, Mortuary Manager, Royal Perth Hospital

John Hammond, Partner, Hammond Legal

John O'Sullivan, Senior Solicitor, State Solicitors Office WA)

Judge Neil MacLean, Chief Coroner, New Zealand

Judy McCreath, Forensic Pathologist, PathWest

Katherine Hams, Manager, Kimberley Aboriginal Medical Services Council, Broome
Kathryn Dowling, Team Leader, Duty Intake, Department of Child Protection, Broome
Kelly Taylor, Constable, Western Australia Police, Broome
Kris Trevaskis, Senior Counsellor, Office of the State Coroner (WA)
Leanne Daking, Quality Manager, National Coroners Information System
Lois Henderson, Coroners Court, Wellington (NZ)
Magistrate Catherine Crawford, Kununurra Magistrates Court
Magistrate Colin Roberts, Broome Magistrates Court
Magistrate Elizabeth Hamilton, Albany Magistrates Court
Magistrate Felicity Zempilas, Kalgoorlie Magistrates Court (formerly counsel assisting the State Coroner)
Magistrate Gregory Benn, Kalgoorlie Magistrates Court
Magistrate Kelvin Fisher, Bunbury Magistrates Court
Magistrate Michelle Pontifex, Bunbury Magistrates Court
Magistrate Paul Roth, South Hedland Magistrates Court
Magistrate Stephen Sharratt, Geraldton Magistrates Court
Magistrate Steve Wilson, Northam Magistrates Court
Magistrate Tanya Watt, Kalgoorlie Magistrates Court
Magistrate Vivien Edwards, Bunbury Magistrates Court
Marde Hoy, Access Liaison Officer, National Coroners Information System
Mark Bordin, Detective Inspector, Coronial investigation Unit, Western Australia Police
Mark Williams, Partner, DLA Phillips Fox
Martin Knee, Director of State Mining Branch, Department of Mines and Petroleum
Michael Barnes, State Coroner, Queensland
Michelle Kosky, Executive Director, Health Consumers' Council (WA)
Nina Lyhne, Commissioner & Executive Director, Worksafe Western Australia
Owen Deas, Registrar, Kununurra Magistrates Court
Owen Starling, Regional Manager, Kimberley/Pilbara Courts, Broome Magistrates Court
Paul Greenshaw, A/Detective Superintendent, Major Crime Squad, Western Australia Police
Peter Collins, Director Legal, Aboriginal Legal Service of Western Australia
Peter Harbison, Sergeant, Office of the State Coroner (WA)
Peter Quinlan, Barrister, Francis Burt Chambers
Professor Neil Morgan, Inspector of Custodial Services (WA)
Professor Richard Harding, former Inspector of Custodial Services (WA)
Professor Sven Silburn, Ministerial Council for Suicide Prevention (WA)
Rohan Quinn, Registry Manager, Registry of Births, Deaths and Marriages (WA)
Sam Nunn, Solicitor, WorkSafe
Shauna Gaebler, CEO, SIDS and Kids

Simon Walker, Victim Support Services, [former counsellor, Office of the State Coroner]
Steven Begg, Senior Solicitor, Aboriginal Legal Service, Broome
Steve Potter, Senior Sergeant, Coronial Investigations Unit, Western Australia Police
Sue Holt, Manager Critical Review, Department of Corrective Services
Sue Sansalone, Systems Information Manager, Office of the State Coroner (WA)
Taimil Taylor, Solicitor, Aboriginal Legal Service, Broome
Ted Wilkinson, Solicitor in Charge, Legal Aid, Broome
Tim Lethorn, Archives Officer, State Records Office of Western Australia
Tony White, Mortuary Supervisor, PathWest
Vivienne Chinnery, Manager Customer Services, Registry of Births Deaths & Marriages (WA)



NEED ASSISTANCE?

Coronial counselling services

The Coroner's Office has a free counselling service available for families and friends of a deceased person.

Counsellors can help with:

- explaining what happens when you object to a post-mortem examination
- understanding what the Coroner does
- making arrangements to see the deceased person
- counselling on issues of trauma and loss.

A duty counsellor is available daily between 7am-6pm. During business hours call 9425 2900.

Country callers call 1800 671 994.

On weekends and public holidays call 0419 904 476.

Senior next of kin

The senior next of kin is the first person who is available, from the following people:

- a person who, immediately before the death, was living with the person and was either:
 - i. legally married to the person
 - ii. aged 18 years or over and in a marriage-like relationship with the person
- a son or daughter, who is 18 years or over
- a parent of the person
- a brother or sister, who is 18 or over
- an executor named in the will of the deceased or a person who, immediately before the death, was a personal representative of the deceased
- any person nominated by the person to be contacted in an emergency.

When A Person Dies Suddenly

Information for families

CONTACT

Coroner's Court of Western Australia Department of the Attorney General

Central Law Courts
Level 10, 501 Hay Street
PERTH WVA 6000

Office hours 8.30am - 4.30pm, Monday - Friday
Phone (08) 9425 2900
Fax (08) 9425 2901
Country callers 1800 671 994
Website www.coronerscourt.wa.gov.au

Coronial Investigation Unit

Phone (all hours) (08) 9420 5200

Victims of Crime

Website www.victimsofcrime.wa.gov.au

Department of the Attorney General

Phone 13 67 57
Website www.dotag.wa.gov.au

Who is the Coroner?

The Coroner is a judicial officer who must be advised when a person dies apparently from unnatural causes or where the cause of death is not known.

Once a report of death is received, usually from police, doctors or hospital authorities, the Coroner has legal control over the body of the deceased person, and must establish the:

- circumstances surrounding the death
- cause of death
- particulars needed to register the death
- identity of the deceased.

Can I see the deceased?

Yes, arrangements will be made for the deceased person to be taken to a mortuary where they may be viewed by the next of kin.

The body may be touched unless the Coroner directs otherwise.

In Perth, arrangements can be made by contacting the State Mortuary on 9346 2533 or after hours on 9346 2536.

In country areas, contact the local police station or the Coroner's Court on 9425 2900.

What is a post-mortem examination?

A post-mortem examination is the only certain method of determining and recording the cause of death.

It involves an external and internal examination of the deceased. Some tissue and blood samples are usually retained for laboratory analysis.

After the post-mortem, care is taken to return the body as close as possible to its original condition.

In most cases, the body is released for burial or cremation immediately after the examination. In some cases, it may be necessary for organs to be retained for further examination. This may need to be taken into account when deciding on a funeral date.

Information regarding organ retention following the post-mortem is available from the Coronial Counselling Service. The senior next of kin* may request that a doctor of their choice be present at the examination.

If the Coroner has not directed that a postmortem examination be held, the senior next of kin may request that one be held.

What are my rights?

Unless the Coroner decides that a post-mortem examination must be held immediately, the senior next of kin may object to a post-mortem examination.

As there are practical reasons for holding post-mortem examinations as soon as possible, any objection should be lodged by the next of kin within 24 hours of receiving this brochure.

An objection received after 24 hours will be acted upon if possible, but the post-mortem examination may have already commenced.

To make an objection, phone the Coroner's Office on 9425 2900 during office hours or the WA Police Coronial Investigation Unit after hours on 9420 5200.

Before deciding to object to a post-mortem examination, it is important to consider whether there are any concerns about the circumstances of the death. If a post-mortem examination is not held, vital information may be lost.

If you wish to object to a post-mortem examination do not set a date for the funeral, as the objection process may take some time.

Coroner's report

The Coroner will write to the next of kin with the results of the post-mortem examination. The family will also be advised of the outcome of the Coroner's investigation.

Organ and tissue donation

The senior next of kin may give consent for organ and tissue donation, if the deceased person did not indicate a wish not to be a donor.

You may be contacted by a donor coordinator from Donate West to discuss the possibility of organ and tissue donation. Please let police or coronial staff know if you do not wish to be contacted by a donor coordinator:

If you wish to discuss organ and tissue donation you can contact the donor co-ordinator on 9346 3333.

*definition on reverse of brochure.