



CORONERS ACT 1996 (WA) CORONIAL INVESTIGATIONS PROCESS



1. Reporting a death



**2. Scene attendance
and investigation**



**3. Post mortem examination
objection process**



**4. Forensic post mortem
examination process**



5. Inquiry and inquest

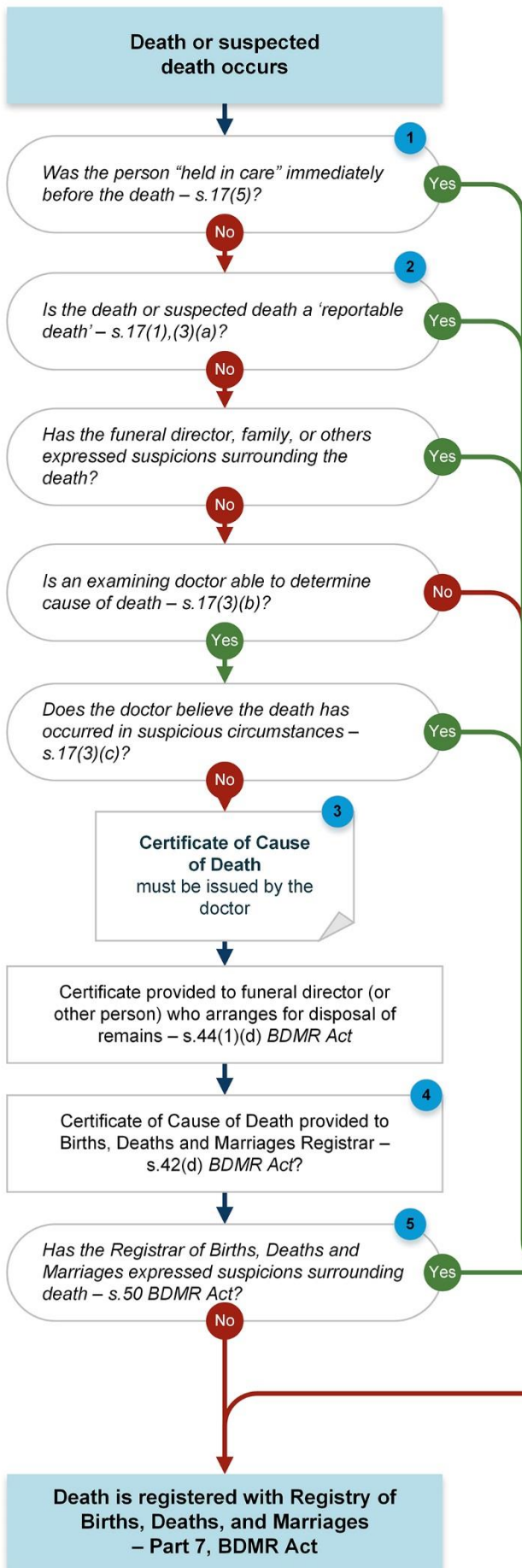


**6. Findings and
recommendations**



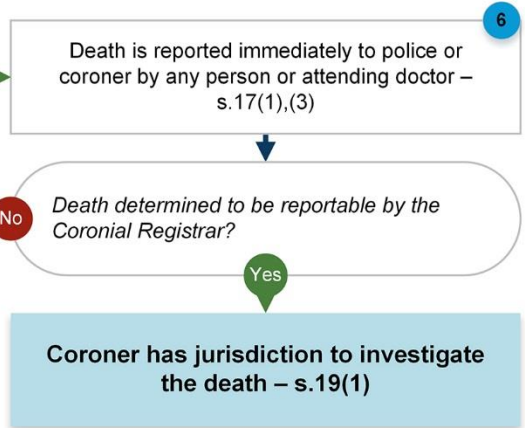


1. Reporting a death



Additional notes

- 1 A "person held in care" is defined within s.3
- 2 A "reportable death" is defined within s.3 as a death:
 - that is unexpected, unnatural, violent, or resulting from injury
 - that has occurred during or as an unexpected result of anaesthetic
 - of a person held in (involuntarily) care or custody
 - that appears to have been contributed to by a member of the Police Force
 - where the identity of the person is unknown
 - that has not been certified under the Births, Deaths, Marriages Registration Act 1998
 - that has occurred elsewhere, where the cause of death has not been certified
 - that has occurred under prescribed circumstance (currently none)
- 3 The doctor must certify the cause of death within 48 hours unless another doctor has issued the certificate, or if there are "reasonable grounds" for not complying – s.44 BDMR Act (Penalty: \$1,000)
- 4 Certificate of cause of death must be provided to the Births, Deaths and Marriages Registrar within 14 days of the death – s.42 BDMR Act (Penalty: \$1,000)
- 5 The coroner may order a body be exhumed if necessary for an investigation – s.38(1). The senior next of kin may apply to the Supreme Court for an order that the body not be exhumed – s.38(7).
- 6 Death must be reported immediately to a coroner unless there are "reasonable grounds" to believe the death has already been reported – s.17 (Penalty: \$1,000)





2. Scene attendance and investigation



Coroner has jurisdiction to investigate the death or suspected death – s.19

Body is under the control of the coroner – s.30(1)

Next of kin must be identified and provided information as soon as practicable – s.20(1)

“When a Person Dies Suddenly”
information must be provided in writing – s.20(2)

P99 – Certificate of Life Extinct
completed by doctor, nurse, paramedic or police (where obvious)

P98 – Mortuary Admission Form
completed by police

P92 - Identification of Deceased
completed by police with next of kin

Incident-specific forms

Police Attendance Report

Witness statements

Medical records

Post mortem and supplementary reports

Coroner or coroner's investigator may attend and restrict access to a place – s.32(1)

Form 7
A coroner must agree to a restriction – s.32(2)

Form 6
Notice of restriction may be placed – s.32(4)

Coroner may enter and inspect any place, copy documents and seize property necessary for the investigation – s.33(1)

A coroner's investigator may enter and inspect any place, and seize property relevant to the investigation – s.33(2a)

A coroner may authorise a coroner's investigator to enter and inspect a place, and copy documents or seize property – s.33(3)

Form 8
A copy of the authority must be provided to the owner or occupier

External investigation reports

Additional notes

7 A restriction imposed by a coroner's investigator otherwise ceases after 6 hours – s. 32(3)

8 A person must not enter or interfere with an area to which access is restricted – s.32(5) (Penalty: \$2,000)

Access to an area cannot be restricted for any longer than necessary – s.32(6)

Any aggrieved person may apply to the State Coroner for variation or removal of a restriction – s.32(7)

A person must not delay, obstruct or otherwise hinder a coroner or coroner's investigator – s.33(7) (Penalty: \$2,000)

9 Anything taken under section 33(1) or 33(3) may be released on an undertaking to comply with reasonable conditions – s.33(5),(6) (Penalty: \$2,000)

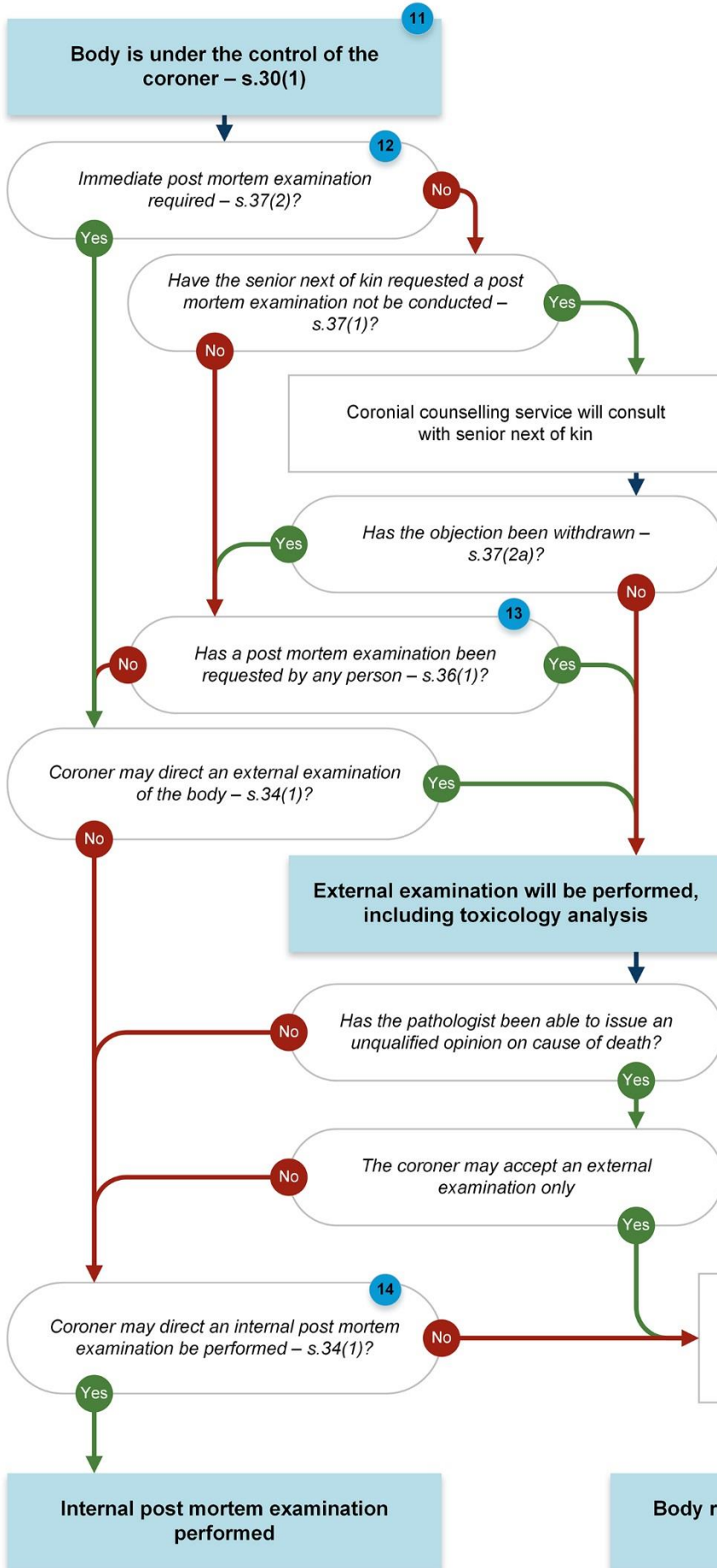
10 External investigations may include:

- WorkSafe (workplace deaths)
- EnergySafety (electricity or gas)
- Resources Safety (deaths on minesites)
- Ombudsman (children in care)
- Chief Psychiatrist (mental health facilities)
- Western Australian Review of Mortality (hospital deaths)
- Australian Transport Safety Bureau (aviation deaths)

P100 – Report of Death
Investigation report submitted to coroner



3. Post mortem examination objection process



Additional notes

11 Any of the deceased person's next of kin may view or touch the body unless the coroner determines it to be undesirable or dangerous - s.30(2)

12 An immediate post mortem may be required in case of:

- homicide
- suspicious death
- as directed by a coroner

16 Notice must be provided with reasons in writing to applicant and State Coroner if an application for post mortem examination has been refused - s.36(2)

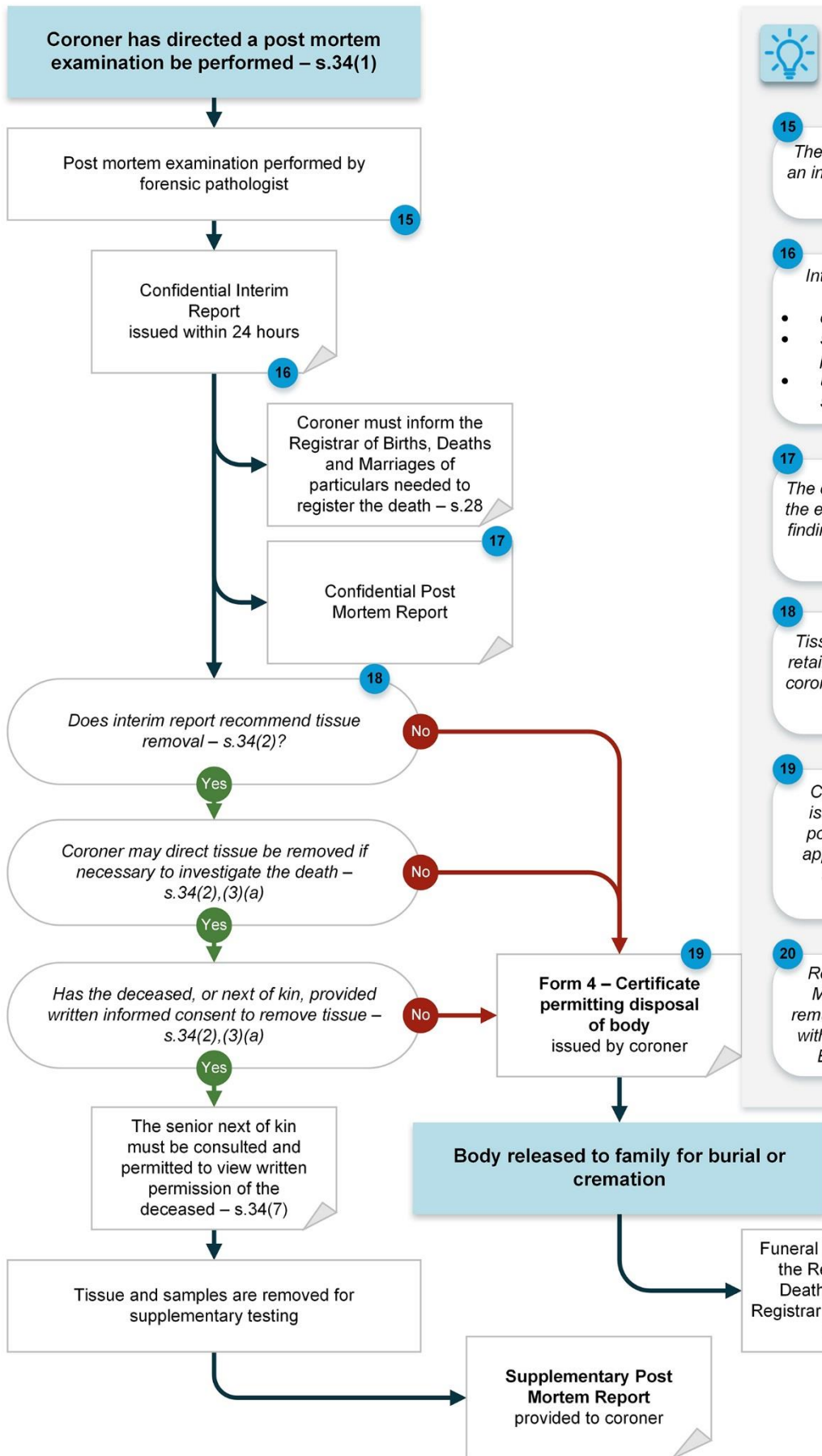
14 A post mortem examination may be ordered by a coroner if reasonably believed to be necessary for the investigation of the death - s.34(1) Before directing a pathologist to perform a post mortem examination, the coroner must consider all available medical information if relevant to the death - regulation 9

Notice must be provided in writing to senior next of kin and State Coroner if an objection has been overruled - s.37(1)

Aggrieved parties may apply to the Supreme Court within 2 days for an order with respect to a post mortem examination - s.36(3),(4) and s.37(3),(4)



4. Forensic post mortem examination process



Additional notes

15 The senior next of kin may request an independent doctor to be present at the post mortem – s.35

16 Interim post mortem report may contain:

- cause of death, if known
- suspected cause of death, pending confirmation
- undetermined cause of death, subject to further testing

17 The coroner must provide a report of the examination to the next of kin if a finding has not been made within 21 days – s.25(4)

18 Tissue samples may be taken and retained only in accordance with the coroner's directions and guidelines – s.34(6) (Penalty: \$10,000)

19 Certificate of disposal must be issued "as soon as reasonably possible" - s.29, subject to s.24 application for inquest or s.36(4) application for post mortem examination.

20 Registrar of Births, Deaths and Marriages must be informed if remains have not been disposed of within 30 days of the death – s.47 BDMR Act (Penalty: \$1,000)

20

Funeral director must notify the Registrar of Births, Deaths and Marriages Registrar within 7 days – s.45 BDMR Act



5. Inquiry and inquest



Coroner received investigation report

21 Is the death or suspected death subject to a mandatory inquest – s.22(1) or 23(2)?

Yes

No

Does the coroner believe an inquest is desirable – s.22(2)?

Yes

No

Has an inquest been requested by any person – s.24(1)?

No

Yes

Coroner decides to hold an inquest – s.24(1)(a)?

Yes

No

Supreme Court orders an inquest – s.24(3)?

Yes

No

Inquest

Notice of an inquest must be published at least 14 days prior to the inquest – s.39

An interested person may appear or be represented, and present submissions if an adverse finding is likely – s.44

25 The coroner may summon witnesses, retain evidence, compel answers, give directions and do anything else reasonably necessary – s.46(1)

The coroner may be assisted by counsel or any other person – s.46(2)

26 The coroner must ensure a record of evidence is kept – s.48



Additional notes

21

An inquest is mandatory if – s.22(1):
a. the person was held in care immediately before the death
b. the death may have been caused by a member of the police force
c. the death may have been caused while the person was held in care
d. directed by the Attorney General
e. directed by the State Coroner
f. the death occurred in prescribed circumstances, or the State Coroner has directed that the suspected death of a missing person be investigated – s.23(2)

22

Coroner must provide written notice of reasons for refusal – s.24(1)(b)

23

Upon application by any person, the Supreme Court may order an inquest be held if it is necessary or desirable in the interests of justice – s.24(3)

24

An inquest must not commence, or must be adjourned, until relevant criminal proceedings have concluded – s.53

25

A coroner is not bound by the rules of evidence and may conduct an inquest in any reasonable manner – s.41

26

The coroner must grant the senior next of kin access to evidence unless not desirable or practical to do so. – s.26A

27

The record of investigation following inquest must be open to public access unless the coroner orders otherwise – reg.19(2)
The record is not admissible as evidence in any court – s.26(2)

Inquiry

27 Form 3 - Record of Investigation into Death must be kept by the coroner or coroner's registrar – s.26(1)



6. Findings and recommendations



Record of findings and comments – s.26

The coroner may comment on any matter connected with the death, including public health or safety, or the administration of justice – s.25(2)

28

Death is of a person held in care (including custody)?

Yes

The coroner must comment on the quality of supervision, treatment and care of the person while in held in care – s.25(3)

No

The State Coroner may make recommendations to the Attorney General on any matter connected with the death – s.27(3)?

Yes

State Coroner submits recommendations to the Attorney General

29

No

Recommendations are relevant to the operations of a particular agency – s.27(4)?

Yes

State Coroner must inform the agency in writing of the recommendations

No

The coroner believes an indictable offence has been committed – s.27(5)(a)?

Yes

Coroner may report to the Director of Public Prosecutions

No

The coroner believes a simple offence has been committed – s.27(5)(b)?

Yes

Coroner may report to the Commissioner of Police

No

Evidence, information or matter touches on conduct of a person in their trade or profession – s.50(1)?

Yes

Coroner may refer any evidence, information or matter to a body having jurisdiction over the trade or profession

The record of investigation following an inquest must be open to public access unless the coroner orders otherwise – regulation 19(2)

30

The State Coroner must report annually to the Attorney General on the deaths which have been investigated – s.27(1)

31



Additional notes

28

A coroner must find, if possible – s.25(1):
a. the identity of the deceased
b. how the death occurred
c. cause of death
d. particulars needed to register the death under the Births, Deaths and Marriages Act 1998

A coroner must not frame a finding or comment in such a way that suggests or determines civil liability or guilt with respect to an offence – s.25(5)

Any person may apply to the Supreme Court for an order that the findings are void and the inquest be re-opened, or a new inquest be held – s.52

29

Recommendations may be made 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 – s.27(3)

30

The coroner may order that a report or evidence (or any part) must not be published if it would prejudice a fair trial or be contrary to the public interest – s.49

31

The annual report must include a specific report on the death of each person held in care – s.27(1)