Government of Western Australia
Department of Treasury

Improving the efficiency of coronial investigations

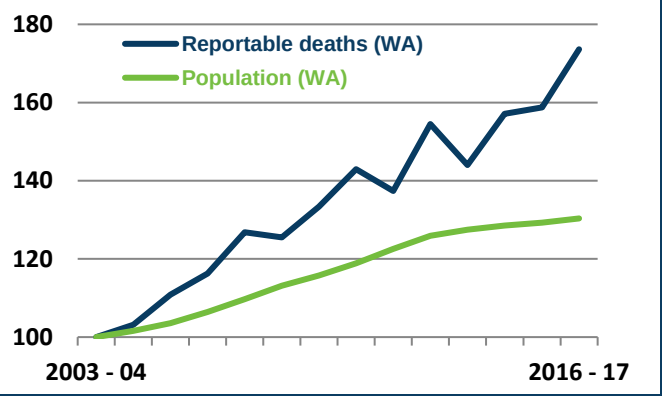
90-day Regulatory Mapping and Reform Project Series Report No.4

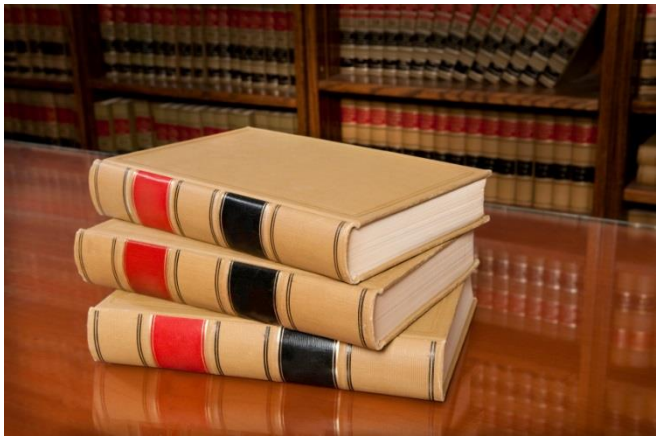
March 2018

Project background

The number of deaths reported to the coroner in Western Australia increased by 74 per cent in the period from 2003-04 to 2016-17, outpacing population growth by a substantial factor. The rapid increase in demand for coronial services within both practical and legislative constraints has led to increasing delays throughout the coronial system.

Index of annual deaths reported to the coroner and population in Western Australia, 2003-04 to 2016-17





Collaborative approach

This project has been implemented in consultation with principal stakeholders, including:

- ✓ The Office of the State Coroner;
- ✓ Western Australia Police Force;
- ✓ Department of Justice;
- ✓ Department of Health;
- ✓ PathWest Laboratory Medicine; and
- ✓ ChemCentre.

Contributions of other stakeholders, including interstate counterparts, were also invaluable.

Recommendations for reform

In consultation with stakeholders, the Department of Treasury has identified 19 priority recommendations for reform of coronial investigations in Western Australia. Many of these support existing initiatives being progressed within the Coroner's Court and other government agencies. Recommendations cover:

Efficiency reforms:

- ✓ **Acquisition of a CT scanner at the State Mortuary.**
- ✓ **Legislative amendments to facilitate the early resolution of natural cause death investigations under specific circumstances.**
- ✓ **Timely provision of medical records to the forensic pathologist, including access to electronic records.**
- ✓ **Implementation of a computer-based case management system within the Coroner's Court.**
- ✓ **Modified performance measures reflecting the integrated components of coronial investigations.**

Effectiveness reforms:

- ✓ **Mandating responses from Government agencies to coronial recommendations.**
- ✓ **Improved guidelines and legislative amendments for the return of seized property.**
- ✓ **Enhanced powers of the coroner to obtain information outside an inquest.**
- ✓ **Improving consistency of regional investigations and updating guidelines to police.**
- ✓ **Improving the provision of counselling services to regional areas and remote communities.**

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Implementation of priority reforms

During the project review period, the McGowan Government has progressed priority reforms to improve the efficient provision and finalisation of coronial investigations, including:

- *approving an allocation of $2.2 million in December 2017 to purchase, install and operate a dedicated CT scanner at the State Mortuary; and*
- *introducing the* Coroners Act Amendment Bill 2017 *to Parliament on 28 June 2017 to permit the coroner to discontinue an investigation into a natural cause death in specific circumstances and to issue non-narrative findings if there is no obligation to inquest the death and the coroner has determined there to be no public interest in a detailed narrative finding.*

These reforms, in addition to other measures proposed and being progressed within the Coroner's Court, will enhance the ability of the coroner to reduce unnecessary delays and facilitate a more timely response to families.

Project outputs and benefits

Consistent with the approved Terms of Reference, the project has produced:

1. **A map of the regulatory, physical and administrative processes** involved in the coronial investigation in Western Australia;
2. **Identification of impediments** to the efficient delivery of coronial outcomes for stakeholders, including next-of-kin, service providers and the Western Australian community; and
3. **Practical and achievable recommendations for reform**, developed in collaboration with principal stakeholders, and which are aligned with reform initiatives being progressed within the Coroner's Court.

Past reviews

The project draws upon and complements recommendations and reform priorities derived from several prior reviews of the coronial system in Western Australia, including:

- The Law Reform Commission of Western Australia Review of Coronial Practice, published in January 2012, including 113 recommendations for reform;
- The Strategic Review of the Office of the State Coroner, published in November 2012;
- The Legislative Project, formed by the Department of Justice to consider and progress the recommendations of the Law Reform Commission review.

About the project

The 90-day Regulatory Mapping and Reform Project series was launched in May 2016 to identify and deliver fast, practical reforms within a reform agenda that aims to reduce barriers to productivity, investment, employment and broader social goals by reducing regulatory burdens and improving government processes and administration.

The project mapped the coronial investigation process, identified key concerns and developed recommendations collaboratively with stakeholders.

This project is the fourth in the 90-day Regulatory Mapping and Reform series. Previous reports cover aquaculture, small business licencing, and eco and nature-based tourism.

Further information on the 90-day projects series is available at the Department of Treasury website: http://www.treasury.wa.gov.au/

Alternatively, please contact the 90-day projects team: 90dayprojects@treasury.wa.gov.au

Government of **Western Australia**
Department of **Treasury**

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

Death or suspected death occurs

1. *Was the person "held in care" immediately before the death – s.17(5)?*
   - Yes → 6
   - No ↓
2. *Is the death or suspected death a 'reportable death' – s.17(1),(3)(a)?*
   - Yes → 6
   - No ↓
3. *Has the funeral director, family, or others expressed suspicions surrounding the death?*
   - Yes → 6
   - No ↓
4. *Is an examining doctor able to determine cause of death – s.17(3)(b)?*
   - No → 6
   - Yes ↓
5. *Does the doctor believe the death has occurred in suspicious circumstances – s.17(3)(c)?*
   - Yes → 6
   - No ↓
6. **Certificate of Cause of Death** must be issued by the doctor

Certificate provided to funeral director (or other person) who arranges for disposal of remains – s.44(1)(d) *BDMR Act*

7. Certificate of Cause of Death provided to Births, Deaths and Marriages Registrar – s.42(d) *BDMR Act*?

8. *Has the Registrar of Births, Deaths and Marriages expressed suspicions surrounding death – s.50 BDMR Act?*
   - Yes → 6
   - No ↓

Death is registered with Registry of Births, Deaths, and Marriages – Part 7, BDMR Act

9. Death is reported immediately to police or coroner by any person or attending doctor – s.17(1),(3)

10. *Death determined to be reportable by the Coronial Registrar?*
    - No → **Death is registered with Registry of Births, Deaths, and Marriages – Part 7, BDMR Act**
    - Yes ↓

Coroner has jurisdiction to investigate the death – s.19(1)

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

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

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

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

9 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*

Police Attendance Report

Witness statements

Medical records

Post mortem and supplementary reports

10 *External investigation reports*

P100 – Report of Death *Investigation report submitted to coroner*

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)*

3. Post mortem examination objection process

Body is under the control of the coroner – s.30(1) [11]

Immediate post mortem examination required – s.37(2)? [12]

- No → *Have the senior next of kin requested a post mortem examination not be conducted – s.37(1)?*
  - Yes → Coronial counselling service will consult with senior next of kin → *Has the objection been withdrawn – s.37(2a)?*
    - Yes → *Has a post mortem examination been requested by any person – s.36(1)?* [13]
      - Yes → **External examination will be performed, including toxicology analysis**
      - No → *Coroner may direct an external examination of the body – s.34(1)?*
        - Yes → **External examination will be performed, including toxicology analysis**
        - No → *Has the pathologist been able to issue an unqualified opinion on cause of death?*
          - No → *The coroner may accept an external examination only*
            - No → *Coroner may direct an internal post mortem examination be performed – s.34(1)?* [14]
              - No → **Form 4 – Certificate permitting disposal of body** issued by coroner → **Body released to family for burial or cremation**
              - Yes → **Internal post mortem examination performed**
            - Yes → **Form 4 – Certificate permitting disposal of body** issued by coroner → **Body released to family for burial or cremation**
          - Yes → **Form 4 – Certificate permitting disposal of body** issued by coroner → **Body released to family for burial or cremation**
    - No → **External examination will be performed, including toxicology analysis**
- Yes → *Coroner may direct an external examination of the body – s.34(1)?*
  - Yes → **External examination will be performed, including toxicology analysis**
  - No → *Has the pathologist been able to issue an unqualified opinion on cause of death?*
    - No → *The coroner may accept an external examination only*
      - No → *Coroner may direct an internal post mortem examination be performed – s.34(1)?* [14]
        - No → **Form 4 – Certificate permitting disposal of body** issued by coroner → **Body released to family for burial or cremation**
        - Yes → **Internal post mortem examination performed**
      - Yes → **Form 4 – Certificate permitting disposal of body** issued by coroner → **Body released to family for burial or cremation**
    - Yes → **Form 4 – Certificate permitting disposal of body** issued by coroner → **Body released to family for burial or cremation**

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

Coroner has directed a post mortem examination be performed – s.34(1)

Post mortem examination performed by forensic pathologist [15]

Confidential Interim Report issued within 24 hours [16]

Coroner must inform the Registrar of Births, Deaths and Marriages of particulars needed to register the death – s.28

Confidential Post Mortem Report [17]

Does interim report recommend tissue removal – s.34(2)? [18]

- No → **Form 4 – Certificate permitting disposal of body** issued by coroner [19]
- Yes

Coroner may direct tissue be removed if necessary to investigate the death – s.34(2),(3)(a)

- No → **Form 4 – Certificate permitting disposal of body** issued by coroner [19]
- Yes

Has the deceased, or next of kin, provided written informed consent to remove tissue – s.34(2),(3)(a)

- No → **Form 4 – Certificate permitting disposal of body** issued by coroner [19]
- Yes

The senior next of kin must be consulted and permitted to view written permission of the deceased – s.34(7)

Tissue and samples are removed for supplementary testing

Supplementary Post Mortem Report provided to coroner

Form 4 – Certificate permitting disposal of body issued by coroner [19]

Body released to family for burial or cremation

Funeral director must notify the Registrar of Births, Deaths and Marriages Registrar within 7 days – s.45 BDMR Act [20]

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*

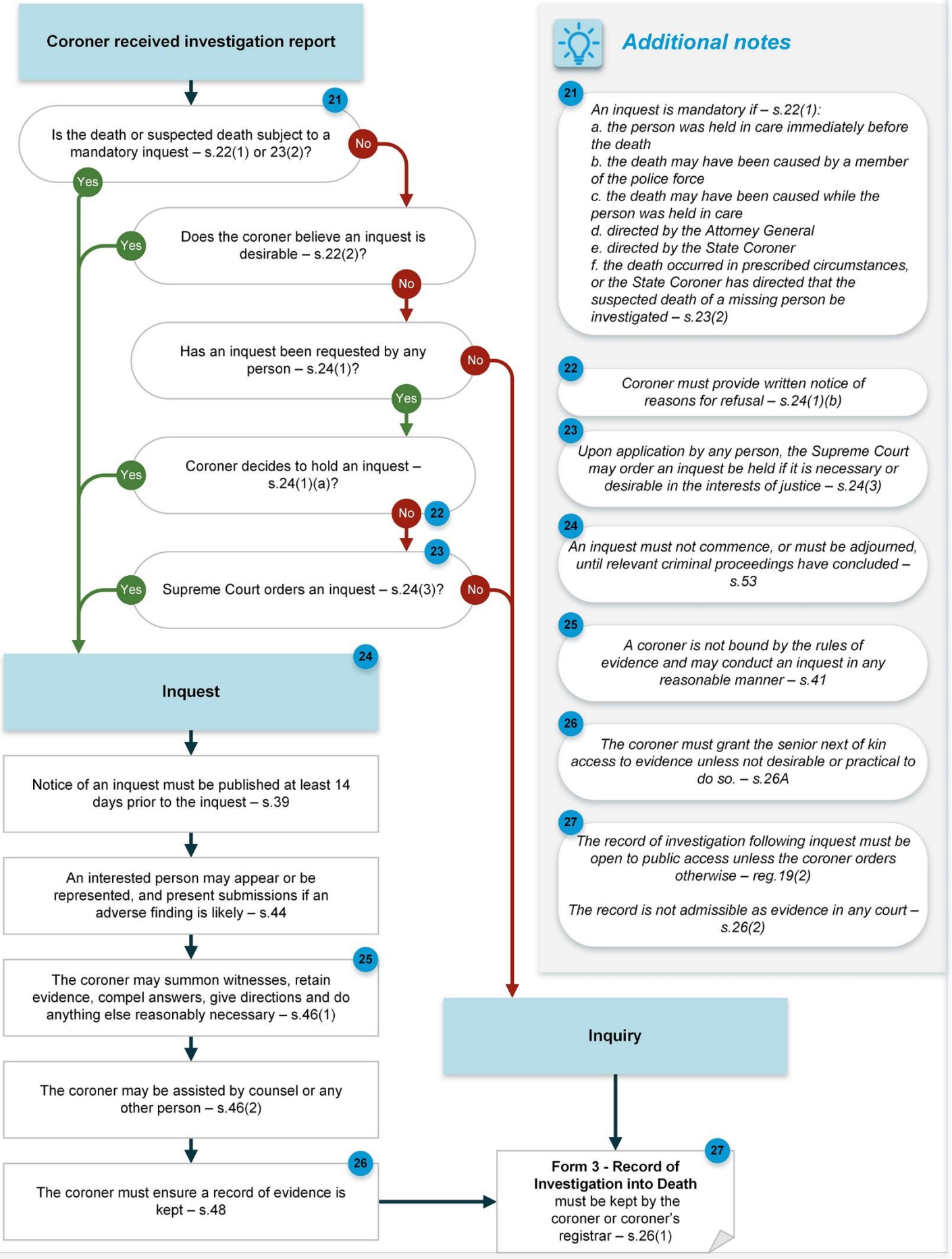
[17] *The coroner must provide a report of the examination to the next of kin if a finding has not been made within 21 days – s.25(4)*

[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)*

5. Inquiry and inquest



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)

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)*