# Under the Microscope: Reforming Western Australia's Coronial System

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In the past decade a number of Australian Coroners Acts have been reviewed and reformed, leaving Western Australia with the second oldest coronial legislation in the country. The Law Reform Commission of Western Australia's final report on its *Review of Coronial Practice in Western Australia* (the Review) is the culmination of three years' work and extensive consultation, both in Western Australia and elsewhere.[1] It recommends significant legislative amendments, as well as changes to policies and practices of the Office of the State Coroner, the Coroners Court and entities with responsibilities for delivering certain coronial services in Western Australia. This article discusses a number of the issues that emerged during the Commission's review and highlights some of the 113 recommendations made to improve Western Australia's coronial system for coming years.

## BACKGROUND

In Western Australia last year there were 13,001 deaths.[2] Of these, approximately 15% (1,996) were "reportable"[3] (unexpected) deaths and became coronial cases. Typically, around 70% of coronial deaths occur in the metropolitan area and are dealt with by the Office of the State Coroner in Perth, while the remaining 30% occur in regional Western Australia and are largely handled by regional magistrates acting ex officio as coroners.[4] Statistics over the past decade show that only around 2% of coronial cases are inquested each year with the remaining being dealt with as "administrative findings" (short-form findings on the papers). The number of coronial cases has risen by around 30% since 2000, while the number of inquests undertaken has dropped by around 45% over the same period. Presently, on average, 35 cases are inquested each year with approximately half of these being inquests that are mandated under the *Coroners Act 1996* (WA) (for example, deaths in custody and deaths of involuntary patients under the *Mental Health Act 1996* (WA)).[5]

In recent years, the coroners' jurisdiction in Western Australia has been plagued by problems of delay and mounting backlog in the system. The most current figures (30 June 2011) show that there are 2,315 pending coronial cases with a backlog of 916 cases that are over 12 months' old (536 of which have been fully investigated and are awaiting attention by a coroner) and 100 cases currently pending inquest.[6] An increase in funding and in staff numbers since 2009 has had some impact in reducing the backlog, but pending inquests have risen 25% in the last 12 months.[7] The average time for a death to reach inquest is currently estimated by the Office of the State Coroner to be approximately four years from the date of death.[8]

## THE NEED FOR SYSTEMIC REFORM

The Review identified a number of system-wide concerns with the coronial jurisdiction in Western Australia. Chief among them were problems with delay in delivery of coronial findings; lack of communication and cooperation between entities involved in coronial service delivery; and lack of information, guidance and training. These issues are discussed below with reference to some of the Commission's recommendations to assist the jurisdiction to overcome these problems.

### Delay

The primary concern of most people consulted by the Commission (and particularly members of the public) was delay. Delays of around two to three years between death and coronial conclusion are typical, while even longer delays can be expected if a case is scheduled for inquest. It is important to note that delays impact across the entire system and are not always within the control of the Office of the State Coroner. Delays are regularly experienced in receiving final cause of death determinations from forensic pathologists and in the process of investigation by police. The Commission has made a number of recommendations to assist in reducing delays in the coronial system. An important recommendation provides for coroners to authorise a doctor to issue a death certificate without a post-mortem examination in cases where the cause of death is sufficiently certain and the coroner is satisfied no further investigation of the death is warranted.[9] A typical case that would fall within such a provision is where an elderly person has died from hospital-acquired pneumonia as a result of immobility from injury following a fall. Implementation of this recommendation will take considerable pressure off coronial police who would otherwise be required to fully investigate the death. Presently these uncontentious deaths are given the lowest priority by police and, as a result, very simple cases can often languish in the coronial system for many years.

Obviously undue delay in the coronial process can be extremely distressing for families in a time of grief. Many families expressed the need to achieve 'closure' in respect of the deaths of their loved ones and felt this was not possible with a coronial investigation ongoing. In addition, some families made strong submissions that delays in the coronial process impacted negatively on their financial wellbeing because insurers and superannuation companies were deferring payment until the coronial process was complete. To assist families in this situation, the Commission has recommended that coroners provide the Registry of Births, Deaths and Marriages with interim coronial findings featuring sufficient information to issue a death certificate for insurers' purposes in cases where no final determination has been made within three months from the date of death and further delay is expected.[10] In addition, the Commission has recommended that the *Coroners Act* empower coroners to discontinue a coronial investigation in certain cases where a forensic pathologist has expressed an opinion that the death was consistent with natural causes and the coroner determines that, apart from the fact that the death was unexpected, it is not otherwise a reportable death.[11] In such cases, the information required to register the death and issue a death certificate may be immediately reported to the Registry of Births, Deaths and Marriages.

## Lack of Communication and Cooperation

The Review found that there was ineffective communication and cooperation between the Office of the State Coroner and other entities involved either intimately or peripherally in the delivery of coronial services, including police, PathWest, body transport contractors and regional coroners. This was perhaps most evident where specialist bodies were also investigating a death the subject of a coronial investigation. Bodies such as WorkSafe and the Department of Mines and Petroleum are obliged to investigate deaths falling within their own governing legislation and the coronial investigation runs parallel to the investigation undertaken by these bodies. The Commission found that cooperation and communication between workplace safety inspectors and coronial police could be improved and that, in the interests of avoiding unnecessary duplication of investigations and to expedite coronial findings where appropriate, legislative measures were required to enhance information sharing (from both sides) between specialist investigations bodies and the Office of the State Coroner.[12]

A principal reason for the inclusion of next of kin information provisions in the *Coroners Act 1996* was inadequate communication between the Coroners Court and the families of deceased.[13] However, the Review found that this problem still existed 15 years later. Almost three-quarters of those who responded to the Commission's public survey said they did not feel adequately informed about the progress of the deceased's case throughout the coronial process. Families expressed frustration that during the period between death and a coronial finding there was very little communication initiated by the Coroners Court and the onus was placed on families to continue calling the court for information.[14] In some cases, the Commission heard that families had received as few as two court-initiated communications in a period of several years. In the context of the current substantial delays between death and coronial findings, some family members have become distressed and angry and this has placed considerable pressure on reception and counselling staff. The Commission has recommended that the Office of the State Coroner investigate the provision of a secure online service for next of kin to notify them of the stage of the process that the deceased's case is at and the remaining stages to be completed.[15] The Commission suggested that such a service should anticipate the queries families might have by providing information about what happens at each stage in the coronial process, why it is necessary and how long it might be expected to take in a typical case. This simple solution will almost certainly have an immediate and significant positive impact on the already stretched human resources of the Office of the State Coroner and vastly improve the accessibility of information for families.

## Transparency of Coroners Court Procedures

From the earliest stages of the Review the Commission was made aware of problems faced by the legal profession practising in the coronial jurisdiction in Western Australia. There was apparent consensus among legal practitioners that Coroners Court procedures were not transparent and that practices of coroners were ad hoc and inconsistent across the jurisdiction. The Commission also heard complaints about insufficient notice of cases identified for inquest and of dates set down for hearings. The Commission has made a number of recommendations to address these concerns including legislating for notification and publication of hearing dates and providing for pre-inquest hearings for the purposes of deciding the issues to be investigated at the inquest, the evidence and witnesses required, length of the inquest and the dates for the hearing of the inquest.[16] In addition, the Commission has recommended that a full complement of coronial guidelines, forms and practice directions be developed and published by the State Coroner[17] and that education about the coronial system be offered to lawyers through the Continuing Professional Development program.[18]

A problem of particular concern was the late identification of witnesses against whom adverse findings might be made. The Commission heard that quite often witnesses at risk of adverse findings were only alerted to this risk by other parties' lawyers after they had given evidence (without the benefit of representation). The Review found that the Coroners Court was not always adequately discharging its duty under s44 of the *Coroners Act*, which requires a coroner to give an interested person the opportunity to present submissions against the making of an adverse finding. It noted that "it would be a rare occasion where counsel assisting, or the coroner, was not in a position to identify a *risk* of an adverse finding prior to an inquest".[19] The Commission recommended that reasonable efforts be made by the Coroners Court to identify and notify persons whose interests may be affected by the outcome of an inquest of the court's intention to hold an inquest *prior* to inquest hearing dates being set.[20]

## Inadequate Information, Guidance and Training

Information about the coronial system in Western Australia was found to be generally poor in comparison to other Australian jurisdictions. The paucity of information on the Coroners Court website seemed to place a significant amount of unnecessary pressure on court staff who are regularly engaged in communicating information that could be easily conveyed by a more informative web presence. An indication of the state of the website can be found on its inquest listings page which, at the date of writing, had not been updated since January 2010. In addition, coroners' findings, rulings and guidelines are not accessible on the website (or indeed in any other public forum). This not only affects the legal profession, but also regional magistrates who may require this information to perform their

role as coroners. The health care profession also requires more-accessible information about reportable deaths and death certification to discharge its own obligations under the *Coroners Act*. The Commission has recommended that the Coroners Court website be radically overhauled to provide, among other things, information sheets for families, health care professionals, witnesses, researchers and lawyers; copies of guidelines, practice directions and forms; regularly updated hearing lists including, where practicable, information about the matters to be investigated at the inquest; and copies of coronial findings, comments and recommendations.[21]

Training and guidance for those intimately involved in the delivery of coronial services in Western Australia was a significant concern. The Review found that despite regional magistrates being ex officio coroners, many had received little or no training in coronial matters. Regional magistrates often depended heavily upon their court clerks for support in coronial matters; however, they too had no formal training. It was also noted that despite numerous relevant changes to the jurisdiction, the State Coroner's guidelines had ostensibly not been updated since 1997 and that some of the people to whom they were directed had no knowledge of them. The Commission has made a number of recommendations to address known deficits in training and guidance for coroners, police, coronial contractors and court staff.[22]

## RESTRUCTURING THE CORONIAL JURISDICTION

### Repositioning the Coroners Court

The Coroners Court presently sits within the Specialist Courts and Tribunals Division of the Department of the Attorney-General with the State Coroner appointed for life (solely to the Coroners Court) and the Deputy State Coroner drawn from the magistracy and appointed on a periodic renewable contract. Concerns were expressed about the independence and status of the Coroners Court and the need for greater accountability of the court for its output. A major structural reform recommended by the Commission is the repositioning of the Coroners Court under the umbrella of the District Court to bring it more overtly within the judicial hierarchy of the state and to provide a clear line of accountability to a chief judicial officer.[23]

Many respondents to the Commission's consultations suggested that all coronial judicial positions, including that of State Coroner, should be of limited tenure. It was noted that in all other Australian jurisdictions with unified coronial systems, coroners are appointed for a finite term to avoid problems of "coronial burnout" and to enhance accountability. Under the Commission's recommendations, a State Coroner would be appointed from the District Court bench for a term not exceeding five years and be eligible for reappointment.[24] This limited tenure arrangement extends to all coroners under the Commission's recommendations and was strongly supported by submissions. The independence of coroners is protected by their contemporaneous appointment to a major state court: the District Court in the case of a State Coroner and the Magistrates Court for all other coroners including the Deputy State Coroner.[25]

### Dedicated Regional Coroners

The current *Coroners Act* sets up a semi-centralised coronial system with a State Coroner and Deputy State Coroner based in Perth dealing with metropolitan deaths and magistrates acting ex officio as coroners in regional areas. However, over the past decade only a handful of inquests have been undertaken by regional magistrates and this (in combination with the absence of training and guidance noted above) has caused magistrates to become deskilled in coronial matters.[26] Over the same period the coronial jurisdiction has become increasingly specialised, particularly in respect of the research and prevention role being embraced by dedicated coroners in many Australian jurisdictions.

While the inquest function has effectively been centralised to Perth, regional magistrates are still responsible for making coronial findings in matters that do not go to inquest. Generally, these are drafted by a court clerk and signed off by the magistrate. The Commission noted that because of the volume of Magistrates Court work and circuit travel, regional magistrates lacked the time and resources necessary to properly engage with the coronial jurisdiction and in particular to direct police coronial investigations. Regional police briefs have been found by the State Coroner to be substantially deficient and, as a result, some regional cases that should go to inquest may be overlooked.[27] Additionally, statutory services such as coronial counselling have long been neglected in regional areas, such that there is ostensibly no service available to regional Western Australians and no consideration of culturally appropriate coronial counselling or liaison services for Indigenous people.

The Review found that under the current model regional Western Australians do not have the same access to coronial services as their metropolitan counterparts. Several alternatives were considered by the Commission to improve outcomes for regional Western Australia, including complete centralisation of the coronial function to Perth so that all coronial cases would be dealt with by the Office of the State Coroner. Although potential economies were noted with this approach, the Commission determined that this would come "at the cost of less input from the regions; less familiarity with regional practices (including Indigenous cultural practices); less control over regional investigations; and less ongoing awareness of trends in deaths in regional areas".[28] The Commission ultimately recommended that coronial regions in the north and south of the state should be established and be serviced by dedicated regional coroners. The appointment of dedicated regional coroners (and regional registrars) will allow regional magistrates to be relieved of coronial duties but ensure that the regional focus to coronial service delivery is retained and strengthened. Dedicated regional coroners will be required to establish strong relations with the regions they serve and will be responsible for undertaking inquests and making administrative findings, directing police coronial investigations and supervising coronial services in their regions (including ensuring the establishment of networks for culturally appropriate coronial counselling for Indigenous people). Recognising that the northern region might currently lack sufficient coronial work to sustain a full-time coroner, it was suggested that the coroner appointed to that region might be based in Perth for the time being with the goal of moving to the region at an appropriate time.

## REFOCUSING THE CORONIAL JURISDICTION

The coroner's role in preventing future deaths in similar circumstances has gained significant traction over the past decade and coroners are now expected to contribute to death prevention strategies by making coronial recommendations and by providing data to research organisations. This "prevention role" has been embraced by the Commission's recommended reforms. It is reflected in the proposed objects clause for the *Coroners*

*Act*[29] and in the recommendation that a prevention team be established within the Office of the State Coroner to undertake analysis of coronial data to identify incipient trends in deaths and opportunities for targeted death prevention strategies.[30]

Noting that in the past coroners have made recommendations on matters that were only tenuously connected with the death under investigation, or in respect of matters for which very little evidence was adduced, the Commission recommended that the coronial recommendation function be confined to specific matters.[31] In addition, it has recommended that the prevention team be tasked with conducting research and stakeholder consultations to inform the proposed formulation of coronial recommendations.[32] The institution of pre-inquest hearings provides opportunities for coroners, in consultation with counsel, to determine what witnesses should be called to give evidence and to alert special interest advocacy bodies (whose evidence may inform the findings and recommendations of a coroner) of the intention to inquest.[33] Such bodies would have limited rights of appearance under the Commission's revised test for interested persons.[34]

The Review noted that "in all Australian jurisdictions, other than Western Australia and Tasmania, the requirement of certain parties to respond to coronial recommendations or reports is encapsulated in legislation or whole-of-government policy".[35] It recommended that public entities be required to respond to coronial recommendations within three months and that the findings, recommendations and responses be published on the Coroners Court website.[36] A common misconception of similar response systems operating successfully elsewhere in Australia is that the agency must *implement* the coronial recommendation. This is not the case. An agency may respond in any way it chooses, including by bringing attention to the fact that a recommendation may not feasibly be implemented. It is expected that the public nature of recommendations and responses will not only bring accountability to public agencies for their association with or involvement in a particular death, but also increase the quality of coronial recommendations by ensuring that they are as informed and as practical as possible.

## CONCLUSION

In light of the problems discussed in this article and the resource concerns consistently raised by the State Coroner,[37] the Coroners Court may appear to be an ailing institution with a questionable future. Indeed, one of the issues mooted by the Commission during its initial consultations was whether there was in fact a continuing role for the coroner in today's society. At first blush it might appear that death investigation could be better handled by specialist bodies with specific expertise in the area and, in many cases, the authority to immediately implement meaningful changes to prevent future deaths in similar circumstances. However, the strong views expressed during consultations coupled with its own extensive research convinced the Commission that the coroner continues to play a valuable role by ensuring that deaths that fall outside the remit of specialist bodies are not ignored, by enabling the independent exploration of unanswered questions about a death in a public forum and by raising public awareness about circumstances leading to particular deaths. The Commission's recommendations seek to assist the coronial jurisdiction to regain the public's confidence in its ability to effectively perform these important roles and, most importantly, to improve coronial outcomes for the Western Australian community.

## NOTES

1. Parts of this article are reproduced from the author's work on this review.
2. Registry of Births, Deaths and Marriages (WA). http://www.bdm.dotag.wa.gov.au/S/statistics.aspx?uid=5227-3572-2658-8961
3. "Reportable deaths" are any deaths that are unexpected, violent or which result directly or indirectly from injury. They include motor vehicle accidents, suicides, drowning, workplace deaths, unexplained deaths of infants, drug overdose deaths, unexpected deaths following medical treatment, homicides and deaths from natural causes where there is no medical history that would suggest the death was expected. Deaths of a person held in care (for example, deaths in custody or detention, police-related deaths and deaths of involuntary mental health patients) are also included in the definition of "reportable death".
4. LRCWA. *Review of Coronial Practice in Western Australia*, Discussion Paper, June 2011, App B, table 1. However, regional magistrates rarely conduct inquests.
5. These are deaths of a "person held in care" as defined in s3 of the *Coroners Act 1996* (WA). Other such deaths include police-related deaths, deaths of persons "admitted to a centre under the *Drug and Alcohol Authority Act 1974* (WA)" and deaths of children the subject of a care and protection order. Suspected deaths are also subject to mandatory inquest.
6. Manager, Office of the State Coroner, email, 18 January 2012.
7. As at 1 June 2010 there were 75 cases awaiting inquest: Western Australia, *Parliamentary Debates*, Legislative Assembly, 1 June 2010, 108c–125a (Mr CC Porter, Attorney-General).
8. Manager, Office of the State Coroner, email, 19 January 2012.
9. LRCWA. *Review of Coronial Practice in Western Australia*, Final Report, January 2012, recommendation 21.
10. *ibid.*, recommendation 26.
11. *ibid.*, recommendation 56.
12. *ibid.*, recommendations 36 & 37.
13. Western Australia, Parliamentary Debates, Legislative Assembly, 19 October 1995, 9498 (Mr Taylor).
14. LRCWA. *Review of Coronial Practice in Western Australia*, Discussion Paper, June 2011, 190–91.
15. LRCWA. *Review of Coronial Practice in Western Australia*, Final Report, January 2012, recommendation 94.
16. *ibid.*, recommendation 71.
17. *ibid.*, recommendations 19, 22, 27, 39, 46, 52, 75, 96, 97 & 98.
18. *ibid.*, recommendation 76.
19. *ibid.*, p 92.
20. *ibid.*, recommendation 73. It is also recommended that the Coroners Court identify and notify persons who may be required to appear as witnesses at an inquest.
21. *ibid.*, recommendation 96.
22. *ibid.*, recommendations 13, 19, 20, 22, 27, 39, 40, 46, 60, 61, 64, 75, 76, 88, 91 & 97.
23. *ibid.*, recommendation 6.
24. *ibid.*
25. *ibid.*, recommendations 7 & 8. Acting coroners may be appointed from outside the magistracy for a term not exceeding two years: recommendation 9.
26. Of the 422 inquests undertaken in the period 2000–2009, only 12 were regional inquests performed by a regional magistrate.
27. State Coroner. "Direction to Regional Magistrates: Quality of Police Briefs", 2 June 2010.
28. LRCWA. *Review of Coronial Practice in Western Australia*, Final Report, January 2012, 15.
29. *ibid.*, recommendation 1.
30. *ibid.*, recommendation 83.
31. *ibid.*, recommendation 84.
32. *ibid.*, recommendation 83.
33. *ibid.*, recommendation 71.
34. *ibid.*, recommendation 68.
35. *ibid.*, p 105.
36. *ibid.*, recommendations 82 & 87.
37. See, for example, Hope A. "Inside the Coroners Court", *Brief* 2010; 37(1)8.