

Review of Coronial Practice in Western Australia

DISCUSSION PAPER

Project No 100

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Law Reform
Commission of
Western Australia

The Law Reform Commission of Western Australia

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Foreword

In 1999 the Law Reform Commission of Western Australia published its final report on the criminal and civil justice system in Western Australia. One area that was not examined at that time was the jurisdiction of the coroner. The investigation of unexpected deaths is a vitally important function in society and it was therefore fitting that the Commission was asked to examine whether reforms were needed as part of a separate and broad ranging reference.

The Commission has made every effort to consult extensively during its Review of Coronial Practice in Western Australia. We met with over 180 professionals who are either intimately or peripherally involved with the coronial jurisdiction and have been contacted by 113 members of the public since the release of our Background Paper in September 2010.

The coronial system is not easily accessible to, nor well understood by, many Western Australians. As a result the Commission decided to publish a Background Paper on the coronial jurisdiction in order to assist the public to understand both the legislative and practical operations of the jurisdiction. The Commission also travelled to regional areas of Western Australia in order to ensure that proposals for reform took into account their particular needs and issues.

Throughout the consultation process several themes continued to emerge. Overwhelmingly there was support for the office of the coroner and the important function of making recommendations aimed at avoiding preventable deaths. However, it became apparent that the current legislative framework does not adequately reflect the preventative role of the modern coroner. Many commented upon the lack of any statutory obligation on agencies or organisations to consider or respond to coronial recommendations that are directed to them. Concerns were also raised about an apparent

inequality of service to the regional areas of Western Australia.

The Commission sought out the views of family members of deceased who have been the subject of coronial investigations. Key themes that emerged from families were issues of delay and the need to improve communication of information to families and cooperation among the various entities involved in coronial service delivery. These same issues were foreshadowed in the Commission's Background Paper and appear to impact on almost all areas of coronial practice.

In informing its proposals for reform the Commission had regard to the following key objectives:

- to strengthen and support the prevention role of the coroner;
- to improve communication and cooperation between individuals and entities involved in the coronial process;
- to reduce delay in the coronial process;
- to promote public confidence in the coronial system;
- to improve reporting of deaths, recording of coronial data and identification of trends;
- to facilitate informed recommendations and encourage meaningful responses;
- to enhance the role and support of families in the coronial process; and finally
- to promote equality of access to coronial services for regional Western Australians.

Concerns relating to the resourcing of the Coroners Court were raised throughout consultations. Clearly some of the Commission's proposals will have funding implications. The Commission has made it clear throughout its consultation process that detailed operational

funding and staffing numbers are matters that are beyond the scope of this reference.

The Commission would like to acknowledge and thank all those who voluntarily provided their time and expertise during the consultations for this report. Special mention must be made of the State Coroner, the Deputy State Coroner and their administrative staff. They have willingly provided us with invaluable information to assist in the development of the proposals we trust will improve the efficiency and effectiveness of the Coroners Court. It cannot be overstated that the subject matter of this reference is emotionally devastating for the families involved and for those that work with them. We are grateful for their support and look forward to a continued working relationship as we head towards the next stage of the review, presenting our final recommendations to Parliament.

Executive Officer Heather Kay and Project Manager Sharne Cranston have provided the Commissioners with outstanding support and assistance throughout this lengthy reference. They have dealt with enquiries and taken information from family members and friends of individuals who have died unexpectedly or tragically and are to be commended upon handling these contacts with understanding and respect for the dignity of the individuals involved. Thanks also to Cheryl MacFarlane who continues to provide excellent technical editing support to ensure the Commission's reports are correctly formatted and ready for publication.

Finally, my fellow Commissioners and I would like to especially acknowledge the principal researcher and author of this report, Dr Tatum Hands, for taking over the project midway through our review and for producing a thoroughly researched, excellent and comprehensive report. The Commission is indebted to her for her commitment to the reference.

Mary Anne Kenny
Chair

Chapter One

The Commission's Approach

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Introduction

TERMS OF REFERENCE

In 2008 the Law Reform Commission of Western Australia ('the Commission') was asked by the former 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 was 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.

Scope of the reference

As can be seen from the above terms, the Commission's reference is intended as a comprehensive review of the operation of the coronial jurisdiction and of the *Coroners Act 1996* (WA) ('the Coroners Act'). However, **it is important to note that while the Commission has broadly considered the structure of the Office of the State Coroner and its human resources, detailed budget and staffing allocations are beyond the scope of the Commission's reference.**¹

1. The Commission has maintained throughout this reference that details such as the number of FTEs and the budget allocation the Coroners Court may require as a result of the Commission's proposals or to overcome the backlog in the current system are not matters with which the Commission would ordinarily deal or have the capacity to address: LRCWA, letter to Attorney General (29 January 2009) and LRCWA, letter to Attorney General (24 August 2009).

As discussed in the Commission's Background Paper,² an operational review³ of the Coroners Act was conducted in 2008 by Queensland State Coroner Michael Barnes with the knowledge that the Commission had been given a contemporaneous reference to undertake a wider review of the coronial jurisdiction.⁴ Coroner 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 he considered to be beyond the scope of his operational review.⁵ Coroner Barnes made a series of recommendations about such matters as resourcing of the Coroners Court, budgetary allocations, administrative issues and staffing levels within the Office of the State Coroner. The Commission understands that the recommendations of the Barnes Report have informed temporary funding (and staffing) increases to the Office of the State Coroner over the past three budget cycles and have appropriately informed detailed business plans submitted by the Coroners Court to the Department of Treasury.

Coroner Barnes also referred a number of matters to the Commission for consideration and identified several opportunities for statutory amendment and other desirable reforms. These are considered within this Discussion Paper.

CONSULTATIONS AND BACKGROUND PAPER

The Commission began work on this reference by consulting extensively with recognised experts in coronial law both in Western Australia

2. LRCWA, *Review of Coronial Practice in Western Australia*, Background Paper (September 2010) 10–11.
3. Section 57 of the *Coroners Act 1996* (WA) provides for ongoing review of the operation of the Act 'as soon as practicable after every fifth anniversary of [its] commencement'. Although some 14 years have passed since commencement of the Act, only one review has ever been undertaken pursuant to this section.
4. Barnes M, *Review of the Coroners Act 1996 (WA)* (August 2008).
5. Ibid 1.

and elsewhere. It also consulted with those intimately involved with the delivery of coronial services in Western Australia. Consultations were held in Perth 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 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). Consultations have been held in regional Western Australia with regional magistrates,⁶ regional court registrars, police, coronial body transport contractors, Aboriginal Legal Service, Legal Aid lawyers, the Department for Child Protection and the Kimberley Aboriginal Medical Services Council. The Commission has also consulted with representatives of the National Coronial Information System, the Victorian Institute of Forensic Medicine and coroners offices in other jurisdictions.⁷

In September 2010 the Commission published a Background Paper which provided a legislative history of coronial law in Western Australia since settlement,⁸ explained the current coronial process and the operation of the Office of the State Coroner, gave a statistical overview of the jurisdiction in Western Australia, and set out the concerns about coronial practices and procedures raised in its initial consultations. The purpose of the Background Paper was to engage the public to ensure that proposed reforms to the coronial system take account of those who ultimately are the 'users' of the system; that is, the family and friends of a

6. All magistrates are contemporaneously coroners under the *Coroners Act 1996 (WA)* s 11(1).

7. A list of people consulted for this reference may be found at Appendix D to this Paper.

8. As discussed in the Commission's Aboriginal customary laws reference, inquiries or 'inquests' into the cause of death of a member of a group were also common in pre-settlement traditional Aboriginal societies: LRCWA, *Aboriginal Customary Laws*, Discussion Paper, Project 94 (December 2005) 300-1.

person whose death has been dealt with by the coroner. Through a series of advertisements in Western Australian newspapers and in the newsletters of appropriate counselling, support and research organisations the Commission invited members of the public to share their experiences of the coronial jurisdiction with the Commission. To assist people to focus their comments, the Commission published an online survey to guide people through each step of the coronial process relevant to their experience.

The Commission had an excellent response to its public appeal for comments with over 100 responses to its online survey. Some members of the public also contacted the Commission for face-to-face meetings or telephone consultations to discuss their experiences with the Coroners Court and the coronial investigation process in Western Australia. Others preferred to contact the Commission by email to provide in-depth detail and associated documents relating to their experiences. Members of the public who wished to be acknowledged for their contribution are listed in Appendix D to this reference; however, the majority of public respondents elected to remain anonymous.⁹

Initial responses to the public survey demonstrated a high interest in the project from people involved in the funeral industry. In response to this, and at the request of the Australian Funeral Directors Association (AFDA), the Commission quickly developed a separate online survey directed to funeral industry workers in Western Australia dealing with such matters as communication with the Coroners Court, body transport and condition of bodies following release from the State Mortuary after post mortem examination. The AFDA distributed the survey to its metropolitan and regional members in Western Australia.

ABOUT THIS DISCUSSION PAPER

This Discussion Paper draws upon the information presented in the Commission's Background Paper and should be read closely in conjunction with that paper. This Discussion Paper is divided into seven chapters:

9. The Commission's online survey gave respondents the option to provide their name for the purpose of inclusion in Appendix D or to remain anonymous.

Chapter One provides a brief snapshot of the coronial process¹⁰ and identifies eight objectives of reform which are informed by the Commission's consultations.

Chapter Two sets out the current Coroners Court model in Western Australia and introduces proposals for institutional and structural reform.

Chapter Three examines issues with the system of reporting and registration of deaths in Western Australia and proposes legislative and administrative reforms to overcome identified issues.

Chapter Four looks at the system of death investigation in Western Australia and examines concerns relating to specific types of investigation (eg, deaths in police presence and deaths in healthcare facilities), as well as problems identified with forensic investigation.

Chapter Five discusses coronial findings and inquests including the powers of the coroner at the hearing and determination stage.

Chapter Six examines the role of the coroner in preventing death and injury including the identification of trends in deaths and the role of coronial recommendations.

Chapter Seven discusses the role, rights and support of families in the coronial process including provision of information and counselling, cultural issues, and the rights and concerns of families in respect of post mortem examinations and release of bodies.

Terminology

While the proposals for legislative reform in this Paper are substantial, there are a number of miscellaneous provisions in the current Act that are not specifically considered by the Commission but which remain useful and necessary. The Commission considers that whether a new Coroners Act should be drafted to replace the current Act or, alternatively, whether the current Act should simply be amended, is

properly a decision for the Attorney General in consultation with parliamentary counsel. The proposals for reform throughout this Paper therefore use the generic term Coroners Act to encompass both the potential for a new enactment or for substantial amendment to the *Coroners Act 1996* (WA).

SUBMISSIONS

The Commission invites interested parties to make submissions on the reforms proposed in this Discussion Paper. Submissions will assist the Commission in formulating its final recommendations for reform of the law in this area. Submissions received by **24 August 2011** will be considered by the Commission in the preparation of its Final Report.

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.

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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 or confidential 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.

10. A detailed review of the coronial process in Western Australia is found in LRCWA, *Review of Coronial Practice in Western Australia*, Background Paper (September 2010) ch 2.

Coronial process snapshot

Each year in Western Australia there are around 12,500 deaths.¹ Approximately 70% of deaths occur in the metropolitan area, with the remaining 30% occurring in regional areas of Western Australia.² The relative proportions of metropolitan and regional deaths closely mirror the spread of the Western Australian population.³ Indigenous deaths represent approximately 4% of all Western Australian deaths,⁴ again closely mirroring population data.⁵

Approximately 2,300 deaths are reported to the coroner each year⁶ pursuant to s 17 of the *Coroners Act 1996* (WA) ('the Coroners Act'). Of those deaths reported, around 1,800 become accepted as coronial cases.⁷ This means approximately 14% of total deaths each year in Western Australia are investigated by a coroner.⁸ Typically a coroner's investigation will consist of an internal post mortem examination (including toxicology and testing of tissue samples) to determine a medical cause of death and a police investigation to determine the circumstances surrounding the death.⁹ In certain cases, an investigation by a specialist

body will run concurrently with the police investigation and may contribute to the coronial investigation by provision of specialist reports or advice. These include cases of workplace or industrial deaths (investigated by WorkSafe), mining deaths (investigated by the Department of Mines and Petroleum) and aviation deaths (investigated by the Australian Transport Safety Bureau).¹⁰

Reports produced by forensic pathologists, police and specialist investigators are provided to the coroner who then undertakes an internal review of reports¹¹ to determine whether an inquest (public hearing) should be held into the death. Under the Coroners Act certain deaths must (mandatorily) be the subject of a public inquest. These include deaths of a person in, escaping from or being transported to or from, custody or detention; deaths in police presence; deaths of involuntary mental health patients; and deaths of children in state care.¹²

In addition to the mandatory requirement to hold an inquest into particular specified deaths, a coroner may hold an inquest into a death if he or she believes it desirable to do so.¹³ Issues that may impact on a coroner's decision 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. 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.¹⁴ A feature of many coronial inquests in Western Australia and

1. Department of the Attorney General (WA), *Registry of Births, Deaths and Marriages* (2011) <<http://www.bdm.dotag.wa.gov.au/S/statistics.aspx?uid=5227-3572-2658-8961>> (accessed 18 June 2010).
2. Australian Bureau of Statistics (ABS), 'Deaths, Summary, Statistical Divisions – 2000 to 2005' (2006) and 'Deaths, Summary, Statistical Divisions – 2003 to 2008' (2009).
3. ABS, *Western Australian Statistical Indicators – Population* (cat no 1367.5, 2010).
4. ABS, 'Deaths, Indigenous Status – Australia, States and Territories – 1991 to 2008' (released 25 November 2009) table 1, Western Australia.
5. 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).
6. For the financial year 2006–2007 a total of 2341 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.
7. Where a death certificate is issued by a doctor and accepted by the coroner within a short time of reporting the case or where the coroner determines that the case is not reportable, the coronial case will fall away. There is, nevertheless, a degree of involvement from coronial staff to bring a reported case to this stage of finalisation.
8. 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: see table 2, Appendix B.
9. For detail of the post mortem examination and police investigation process, see Chapter Four.

10. For a detailed discussion, see Chapter Four, 'Specialist Investigators'.
11. The internal review may include a review of reports by the coroner's in-house medical adviser and requests for further specialist reports.
12. This list is not exhaustive. For a full discussion, see Chapter Four, 'Mandated Inquests'.
13. *Coroners Act 1996* (WA) s 22(2).
14. For examples, see LRCWA, *Review of Coronial Practice in Western Australia*, Background Paper (September 2010) 20.

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.¹⁵

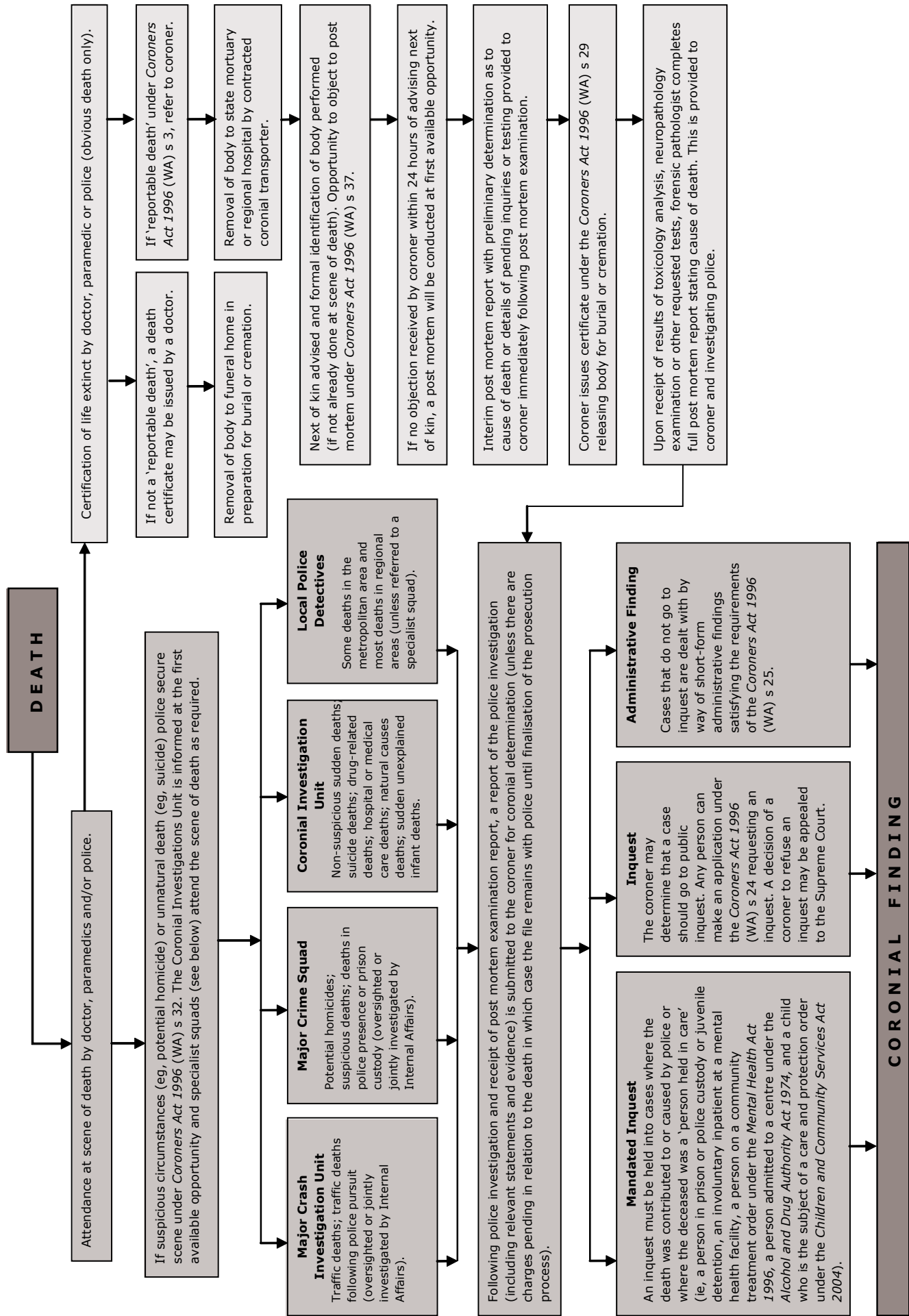
As shown in Chapter Three of the Commission's Background Paper, the number of coronial cases going to inquest has fallen in the past 10 years,¹⁶ while the total number of coronial cases has increased by almost 20% over the same period.¹⁷ In 2009 a total of 33 inquests were undertaken in Western Australia with 17 of those being inquests that were mandated under the Coroners Act.¹⁸ Thirteen of the 33 inquests held in 2009 were held in regional areas.¹⁹ These figures are reasonably representative of the past five years.²⁰

Those coronial cases that are not the subject of public inquest are dealt with 'on the papers' and are the subject of administrative findings. These findings are usually drafted by registry staff within the Office of the State Coroner or regional court and signed off by a coroner. They record the necessary particulars to register the death under the *Births, Deaths and Marriages Registration Act 1998* (WA) (eg, the identity of the deceased, a simple narrative of the circumstances of death and a finding as to cause of death).²¹

The Commission's Background Paper for this reference provides a step-by-step overview of the coronial investigation and determination

process and should be read in conjunction with this Discussion Paper. The chapters following will analyse specific parts of that process and discuss options for reform of legislation, practices and policies falling within the Commission's terms of reference. For present purposes, the following chart serves to illustrate the coronial investigation and determination process from death to coronial conclusion.

15. 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* (WA) 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 coroners system reforms.
16. There is a 45% difference between the number of inquests undertaken in 2000 (60 inquests) and 2009 (33 inquests): LRCWA, *Review of Coronial Practice in Western Australia*, Background Paper (September 2010) ch 3, table 3 (reproduced in Appendix B to this Discussion Paper).
17. Ibid, ch 3, table 1 (reproduced in Appendix B to this Discussion Paper).
18. Ibid, ch 3, tables 4 & 6 (reproduced in Appendix B to this Discussion Paper). Inquests which are mandated by the *Coroners Act 1996* (WA) include deaths in custody or care. For further discussion, see Chapter Five, 'Mandated Inquests'.
19. Ibid, ch 3, table 4 (reproduced in Appendix B to this Discussion Paper).
20. Taken over a five-year period (2005–2009) an average of 38 inquests has been undertaken each year in Western Australia with an average of 17 each year being mandated under the *Coroners Act 1996* (WA) and an average of 13 being held in regional Western Australia: *ibid*, tables 4 & 6 (reproduced in Appendix B to this Discussion Paper).
21. See *ibid* 20–1.



The Commission's approach

As noted in the Introduction, the Commission has undertaken extensive consultations with recognised experts in coronial law, with people who are intimately involved in the delivery of coronial services and with users of the coronial system. At these consultations the Commission heard a range of opinions and concerns about the coronial process in Western Australia and canvassed some potential reforms to the coronial system. The results of these consultations are summarised in the Commission's Background Paper where a number of apparently systemic problems with the current coronial process are also identified.¹ The Commission's consultations and research have informed the following (interrelated) objectives of reform, which serve to explain the Commission's approach to this reference.

OBJECTIVES OF REFORM

1 Strengthen and support the prevention role of the coroner

Historically in Western Australia, the role of coroners was confined to determining the identity of a deceased and how, when and where he or she died.² These elements make up the coroner's official 'findings' in a case. However, from 1960 a limited role for the coroner in making comments or recommendations designed to prevent future deaths in similar circumstances was recognised in Western Australian coronial legislation.³ This role has continued in the current *Coroners Act 1996* (WA) (the Coroners Act), which permits a coroner to make comments 'on any matter connected with the death including public safety or the administration of justice'⁴ and recommendations in relation

1. LRCWA, *Review of Coronial Practice in Western Australia*, Background Paper (September 2010) ch 4.
2. *Coroners Act 1920* (WA) s 11(3).
3. See *Coroners Act Amendment Act 1960* (WA) s 11(c).
4. *Coroners Act 1996* (WA) s 25. 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, *National Report* (1991) vol 5.

to 'any matter connected with a death which a coroner has investigated'.⁵ While not forming part of the official coronial findings, comments and recommendations can raise awareness about circumstances leading to particular deaths and encourage action to prevent future deaths in similar circumstances. Consultations revealed strong support for the prevention role of the coroner and for more explicit legislative recognition of this role in accord with recent reforms in comparable jurisdictions.⁶ Various proposals are made throughout this Discussion Paper to better facilitate the prevention role of the coroner.

2 Improve communication and cooperation between individuals and entities involved in the coronial process

As noted in the Commission's Background Paper, a general lack of communication and cooperation between key players in the coronial process emerged during consultations as a significant concern.⁷ Particular instances were highlighted, but it became apparent that communications between the Office of the State Coroner and the entities or individuals responsible for coronial (and related) service delivery⁸ or otherwise having an interest in

5. *Coroners Act 1996* (WA) s 27. The recommendation's power is limited under the Act to the State Coroner who must direct any recommendations to the Attorney General. However, in practice, it appears that recommendations are regularly made by any coroner in relation to any case and are directed to whomever the coroner thinks fit. For further discussion, see Chapter Six.
6. This 'prevention role' has been explicitly embraced in legislation in Queensland, Victoria, South Australia and New Zealand. 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.
7. LRCWA, *Review of Coronial Practice in Western Australia*, Background Paper (September 2010) 48–50.
8. Including entities or individuals that work under contract to the coroner (eg, body transport contractors); statutory authorities that provide essential investigative services to the coroner (eg, Western Australia Police, PathWest and ChemCentre); and independent agencies or bodies which are relied upon to a certain extent in the effective delivery of coronial services (eg, WorkSafe, Australian Transport Safety Bureau and the National Coroners Information System). 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.

the coronial process⁹ were not always effective and may, in some cases, be contributing to unnecessary delays or misunderstandings. The Commission makes a number of proposals for reform in this Paper to encourage improved cooperation and communication between individuals and entities involved in the coronial process.

3 Reduce delay in the coronial process

The primary issue of concern for 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),¹⁰ at the investigation stage (with lengthy completion times for police reports¹¹ and for the processes of other investigation and prosecuting authorities such as WorkSafe), and at the coronial inquest or finding stage.¹² In this Discussion Paper each stage of the coronial process has been examined with the objective of improving the efficiency of coronial service delivery in mind.

4 Promote public confidence in the coronial system

It has been stated that '[t]he most important measure of the performance of the court system is the extent to which the public have confidence in its independence, integrity and impartiality'.¹³ Essential preconditions for the maintenance of public confidence in the courts have been held to include impartiality, accountability, open justice, procedural fairness, independence and

competence.¹⁴ These attributes should apply equally to all courts in a democracy, including coroners courts.¹⁵ However, consideration of requirements of public confidence in a specific court must take into account the specific community or communities it serves.¹⁶ In relation to coroners' courts, 'whether coroners' processes are exercising a counter-therapeutic impact upon the vulnerable through a combination of delay, insensitivity, poor communication and inadequate funding and administration'¹⁷ are matters to consider in determining whether a court is adequately responsive to its public.

The Commission considers promoting and maintaining public confidence in the Coroners Court and coronial system to be key objectives of its proposed reforms.¹⁸ In addition to the issues of delay and poor communication (discussed above), matters raised in the Commission's consultations that may impact upon public confidence in the coronial system in Western Australia included that processes and procedures of the Coroners Court were not sufficiently transparent; that information about the jurisdiction was not readily accessible; that the findings and recommendations of coroners were not publicly available; that families were not adequately informed about essential aspects of a deceased's case; that regional coroners and their delegates were not adequately trained; and that the Coroners Court was not adequately resourced to fulfil its statutory functions. Other concerns impacting on public confidence in the coronial system were directed at investigation

9. Such as members of the legal profession, expert witnesses, researchers and special interest advocacy groups.
10. Both of which can delay the forensic pathologist's report identifying the cause of death.
11. In particular, in relation to traffic fatalities: Manager, Office of the State Coroner (WA), consultation (18 June 2010).
12. LRCWA, *Review of Coronial Practice in Western Australia*, Background Paper (September 2010) 47-8.
13. Gleeson AM, 'The State of the Judicature -1999' (2000) 74 *Australian Law Journal* 147, 153.

14. See, eg, *ibid*; Gleeson AM, 'Public Confidence in the Judiciary' (Paper delivered to the Judicial Confidence of Australia, Launceston, 27 April 2002); Brennan G, 'Courts for the People, Not People's Courts' (Inaugural Deakin Law School Oration, 26 July 1995) 20; Zdenkowski G, 'Magistrates Courts and Public Confidence' (Paper delivered to the Confidence in the Courts Conference, Canberra, 9-11 February 2007).
15. It is noted that public confidence was a key objective that underpinned the coronial system recommendations of the Royal Commission into Aboriginal Deaths in Custody (RCIADIC) in Australia and of the 'Luce Report', which investigated reforms to the death investigation and coronial system in England, Wales and Northern Ireland. See RCIADIC, *National Report* (1991) vol 1, ch 4; *Death Certification and Investigation in England, Wales and Northern Island: The report of a fundamental review* (2003) CM 5831 ('the Luce Report') ch 3.
16. Zdenkowski G, 'Magistrates Courts and Public Confidence' (Paper delivered to the Confidence in the Courts Conference, Canberra, 9-11 February 2007) 14.
17. Freckelton I, 'Reforming Coronership' (2008) 16 *Journal of Law and Medicine* 379, 391.
18. Indeed, it is noted that this was a key objective of previous reforms in coronial law in Western Australia, in particular in relation to the introduction of the *Coroners Act 1996* (WA): Western Australia, *Parliamentary Debates*, Legislative Assembly, 19 October 1995, 9494 (Ms Warnock).

procedures; in particular, the issue of police investigating deaths that may have been caused or contributed to by police officers.

5 Improve reporting of deaths, recording of coronial data and identification of trends

An effective coronial system relies upon relevant deaths being reported to the coroner in a timely fashion and reliable recording of data in respect of those deaths. The Commission's consultations 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 legitimate researchers and special interest advocacy groups.¹⁹ This would assist in informing consumer awareness campaigns, product recalls and health and safety policies, and constitute an important contribution to death prevention in Western Australia.

6 Facilitate informed recommendations and encourage meaningful responses

For coronial recommendations to be effective in helping to prevent future deaths in similar circumstances, they must be as informed as possible, be clear and sufficiently well directed, and be able to be practically implemented. During consultations questions were raised about the utility, feasibility and appropriateness of some coronial recommendations and the Commission was urged to consider reforms to improve this aspect of coronial decision-making. It was also recognised that coronial recommendations will be of little import if agencies or individuals the subject of recommendations are not obliged to take heed of them.²⁰ Legislative or policy reform has been taken in a number of states and territories to mandate responses to coronial recommendations.²¹ Facilitating the making of informed recommendations and encouraging

19. See discussion in LRCWA, *Review of Coronial Practice in Western Australia*, Background Paper (September 2010) 49–50.

20. However, the Health Department has, through the Office of Safety and Quality, released an Information Circular (IC0008/07) which requires a managed response to coronial recommendations and which applies to the whole of the public health system including mental health.

21. See, eg, *Coroners Act 2008* (Vic) ss 72 & 73; *Coroners Act* (NT) s 46B; Department of Premier and Cabinet (NSW), 'Responding

meaningful responses to and implementation of those recommendations are important objectives of coronial law reform and support the prevention role of the coroner.

7 Enhance the role and support of families in the coronial process

At the time of its enactment in 1996, the Coroners Act was the most advanced of Australian coronial legislation with regard to the rights and role of families in the coronial process. It entrenched the right of the senior next of kin to object to a post mortem examination, the right to have an independent doctor present at a post mortem examination, the right to the provision of certain information, and the right to appear at an inquest and question witnesses. A counselling service attached to the Coroners Court was also provided for in the Act. However, these rights are meaningless if they are not sufficiently supported and resourced in practice.

The primary complaint of people who responded to the Commission's public survey was that they did not feel adequately informed about what to expect from the coronial process or what their rights were in the process. Many responses indicated that communication between families and the Coroners Court was inadequate, with lack of information about the progress of a deceased's case being a major concern.

8 Promote equality of access to coronial services for regional Western Australians

The coronial process in Western Australia operates on a semi-centralised model. While coronial investigations are handled locally, almost all regional inquests (and some administrative findings)²² are handled by Perth-based coroners. Consultations have revealed concerns in regional areas in respect of availability of coronial counselling; difficulties getting essential information to families in regional areas; insufficient attention to cultural

to Coronial Recommendations', Policy Memorandum M2009-12.

22. Where files are sent by regional coroners to Perth for an opinion from the medical advisor or from the State Coroner they are usually finalised by Perth staff. The Office Manager estimates that one in five files dealt with in Perth is a regional file: Manager, Office of the State Coroner (WA), consultation (10 January 2011).

(in particular, Indigenous) concerns; lack of effective communication between the Office of the State Coroner and regional providers responsible for some coronial services; quality of coronial investigations; failure to identify trends in deaths in a timely manner; delay in holding inquests; inadequate training of regional coroners, registrars, investigators and contractors; body transport issues; and inadequate morgue facilities in some regional areas. The Commission believes that reforms to the coronial process should be informed by local conditions, including the demographic and geographic realities of particular regions. These matters have been taken into account when developing the proposals for reform in this Discussion Paper.

OBJECTS OF THE CORONERS ACT

The Commission's consultations overwhelmingly supported the view that the role of the coroner and the objectives of the coronial process need to be defined more clearly in legislation. The insertion of an objects clause into the Coroners Act was also a primary recommendation of Michael Barnes in his 2008 review of the Act.²³ Barnes noted that while the Act 'creates statutory offices, grants powers, imposes obligations and authorises and allocates various functions ... it does not articulate the overarching or underpinning purpose or objects of the regime it creates'.²⁴ He argued that an objects clause can:

- provide inspiration and direction to coroners and their staff;
- inform the public and consumers of coronial services of the underpinning policy objectives of the system generating a better understanding of the operation of the court, the coroners and the staff;
- assist coroners, other judicial officers and lawyers interpret the substantive provisions of the Act; and
- assist other disciplines that collaborate with coroners [to] appreciate the difference between the Coroners Court and other

23. Barnes M, *Review of the Coroners Act 1996 (WA)* (August 2008) recommendation 1. For a summary of this review undertaken pursuant to the *Coroners Act 1996 (WA)* s 57, see LRCWA, *Review of Coronial Practice in Western Australia*, Background Paper (September 2010) 10–11.

24. Barnes, *ibid* 4.

courts and the purposes for which their assistance is being sought.²⁵

Almost all Australian and New Zealand coronial legislation enacted during the past decade contain a purposes or objects clause.²⁶ These clauses set out the basic purposes of requiring reporting and investigation of particular deaths, but also refer explicitly to broader purposes such as the prevention role of the coroner and the place of family in the coronial process.²⁷

As discussed in the Commission's Background Paper, respondents to the Commission's consultations perceived the prevention of future deaths in similar circumstances to be a defining role for the Western Australian coroner.²⁸ While this prevention role is presently facilitated by provisions enabling coroners to make comments on matters connected with a death the subject of coronial investigation,²⁹ the Commission agrees with Barnes that the coronial jurisdiction would benefit from having this role clearly articulated as an object of the Coroners Act. Another important function recognised and facilitated by the Coroners Act is the provision of counselling services to 'any person coming into contact with the coronial system' and, particularly in the face of resource issues that have apparently constricted the availability of this service, the Commission considers that this should also be articulated as an object of the Act.

The subject matter of each of the objects contained in Proposal 1 is individually considered and supported by research and argument at relevant points in this Discussion Paper. However, the Commission takes this opportunity to articulate the defining aspects of the role of the coronial system by proposing that the Coroners Act include a clear statement of the primary objects of the Act.

25. *Ibid*.

26. *Coroners Act 2003 (Qld)* s 3; *Coroners Act 2006 (NZ)* s 3; *Coroners Act 2008 (Vic)* s 1 and pt 2; *Coroners Act 2009 (NSW)* s 3. Further, a 2009 review of the *Coroners Act 1997 (ACT)* recommended that the Act be amended to include a clear statement of the role and objectives of the coronial process, including a death prevention role for the coroner. South Australia's *Coroners Act 2003* is the only Coroners Act of the 2000s that does not include a purposes clause.

27. *Ibid*.

28. LRCWA, *Review of Coronial Practice in Western Australia*, Background Paper (September 2010) 44–5.

29. *Coroners Act 1996 (WA)* s 25(2).

PROPOSAL 1

Objects of the Coroners Act

That the Coroners Act feature a section which articulates the following primary objects of the Act:

- (a) to require the reporting of particular deaths;
- (b) to establish the procedures for investigations and inquests by coroners into reportable deaths;
- (c) to establish a coordinated coronial system for Western Australia with defined coronial regions and dedicated coroners including a State Coroner as head of jurisdiction;
- (d) to contribute to a reduction in the incidence of preventable deaths and injury by the findings and recommendations made by coroners and by the timely provision by coroners of relevant data to appropriate authorities and research bodies;
- (e) to facilitate the timely provision of relevant information to family members of a deceased person the subject of a coronial investigation; and
- (f) to provide a counselling service to family members, friends and others associated with a death the subject of a coronial investigation.

Chapter Two

The State Coroner's Office and the Coroners Court

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The current model

The *Coroners Act 1996* (WA) ('the Coroners Act') set up a semi-centralised coronial system constituted by a full-time State Coroner based in Perth and regional magistrates acting ex officio as coroners.¹ It established the Coroners Court as a court of record² with the State Coroner as head of jurisdiction with responsibility for overseeing and coordinating coronial services throughout Western Australia.³ In 2000 the Coroners Act was amended to provide for the appointment of a full-time Deputy State Coroner also based in Perth.⁴

CORONERS IN WESTERN AUSTRALIA

The State Coroner

The appointment of coroners in Western Australia is governed by Part 2, Division 2 of the Coroners Act. The State Coroner is appointed by the Governor on recommendation of the Attorney General and is entitled to the same salary and conditions as the Chief Stipendiary Magistrate and to hold office on the same terms as a magistrate.⁵ As such, there is no specified term of appointment, but the State Coroner must, like a magistrate, retire at age 65.⁶

The functions of the State Coroner are set out in s 8 of the Coroners Act and are as follows:

- (a) to ensure that a State coronial system is administered and operates efficiently;
- (b) to oversee and coordinate coronial services;
- (c) to ensure that all reportable deaths reported to a coroner are investigated;
- (d) to ensure that an inquest is held whenever there is a duty to do so under this Act or whenever it is desirable that an inquest be held;

1. *Coroners Act 1996* (WA) ss 6, 7 & 11.

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

3. *Coroners Act 1996* (WA) s 8.

4. *Coroners Act 1996* (WA) s 7.

5. *Coroners Act 1996* (WA) s 6(3) & (4).

6. See *Magistrates Court Act 2004* (WA) s 2(2). The State Coroner can also be suspended or removed from office under the terms of the *Magistrates Court Act*.

- (e) to issue guidelines in accordance with this Act;
- (f) such other functions as are conferred or imposed on the State Coroner under this Act.

The Deputy State Coroner

The Deputy State Coroner is appointed by the Attorney General on the recommendation of the State Coroner for such period as specified in the instrument of appointment (currently three years).⁷ The current Deputy State Coroner is a magistrate, although there is no requirement under the Coroners Act that such appointment be made from the magistracy.⁸ The functions of the Deputy State Coroner are not specified in the Coroners Act but the Deputy may act in the office of the State Coroner where the office is vacant or the incumbent is absent from duty.⁹

Other coroners

Under s 11(1) of the Coroners Act every magistrate is contemporaneously a coroner. It is this ex officio status that the Western Australian coronial system relies upon to deliver coronial services to the regions. The Attorney General may also (on the recommendation of the State Coroner) appoint coroners from outside the magistracy; however, the person must be a lawyer who is eligible for appointment as a magistrate.¹⁰ In 2010 a legal practitioner with considerable experience as counsel in coronial matters was appointed under this section as a temporary coroner to assist in clearing the backlog of coronial cases in Perth.

7. *Coroners Act 1996* (WA) s 7.

8. Section 7 of the *Coroners Act 1996* (WA) (which governs the appointment of the Deputy State Coroner) states that the position of Deputy State Coroner must be filled by a 'coroner'. As well as all magistrates (who are contemporaneously coroners), a person who is eligible for appointment as a magistrate may be appointed a coroner under s 11(2).

9. *Coroners Act 1996* (WA) s 7(3).

10. *Magistrates Court Act 2004* (WA) s 2 requires that the person have at least five years' experience in legal practice and be under 65 years of age.

THE OFFICE OF THE STATE CORONER

The Office of the State Coroner and the Coroners Court of Western Australia come within the Specialist Courts and Tribunals division of the Department of the Attorney General. Since December 2008 the Office of the State Coroner has been co-located with the Magistrates Court, occupying one floor of the Central Law Courts Building in Perth and with a dedicated courtroom. Until relatively recently the Office of the State Coroner was staffed by 11.8 FTE staff providing support to the State Coroner and Deputy State Coroner. The Commission heard many positive comments from people intimately involved with the coronial process about the dedication of staff at the Office of the State Coroner, with many observing that the staff were doing their best in a situation where resources (human and financial) were obviously lacking. The resourcing concerns of the Coroners Court were brought to public attention in 2008 with the State Coroner noting that the impact of 'inadequate resources' raised the possibility that he would be unable to effectively perform the functions of his office.¹¹

In response to these concerns, the Attorney General approved a temporary funding allocation in August 2009 (with an additional funding allocation made in 2010),¹² which enabled the creation of five new full-time contract positions¹³ and a part-time position of medical adviser to the coroner.¹⁴ A findings clerk and temporary coroner were also employed for a short period to assist in clearing the backlog of administrative findings.¹⁵ The Office of the State Coroner has also recently acquired a full-time findings clerk

to draft administrative findings for non-natural causes deaths.¹⁶

The Background Paper sets out the responsibilities of key staff within the Office of the State Coroner and provides a chart showing the structure of the office.¹⁷ For present purposes, it can be said that staff of the Office of the State Coroner fall roughly into four streams:

- **Investigation** comprising two police sergeants (attached to the Office of the State Coroner but funded separately by the Western Australia Police) and the State Coroner's part-time medical adviser (a general practitioner who interprets medical records, sources expert opinions and provides advice to coroners on the pre-death medical management of a deceased).
- **Inquest Management** comprising three legal counsel to assist the coroners with the preparation, management and conduct of inquest hearings; two administrative assistants serving the State and Deputy State Coroners; and a court officer.
- **Coronial Counselling Service** comprising two counsellors and a senior counsellor/manager who together provide clinical counselling services and coronial liaison, and have an education function.
- **Coroners Court Registry** comprising the registry manager (who, along with the Office Manager and the new findings clerk,¹⁸ drafts administrative findings for non-natural causes deaths), an assistant manager (who, along with some junior staff drafts administrative findings for natural causes deaths); two court officers, a systems information officer, a data entry officer and a receptionist.

Sitting above these four streams are the State Coroner, Deputy State Coroner and the Office

11. Office of the State Coroner (WA), *Annual Report 2006–2007* (2008) 3. For further discussion, see LRCWA, *Review of Coronial Practice in Western Australia*, Background Paper (September 2010) 24.

12. For more detail about this temporary budget increase, see LRCWA, *ibid.* The Commission is advised that an amount of \$641,000 was allocated to the Coroners Court by the Attorney General in 2010 to take the current staffing load through to 30 June 2011. In May 2011 this funding was extended for a further two years.

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. The Office of the State Coroner has submitted a business case for a further six staff (in addition to the six staff appointed on contract in 2009) and another coroner.

14. This two-and-a-half day a week position is now shared by two general practitioners.

15. The Commission has been advised that this has resulted in an increase in Western Australia's clearance rate in coroners cases: Cheryl Gwilliam, Director General, Department of the Attorney General, correspondence (7 December 2010).

16. This staff member has been redeployed by the Department of the Attorney General which will meet wages costs until such time as the Office's business case for further staff is approved: Manager, Office of the State Coroner (WA), consultation (10 January 2011).

17. LRCWA, *Review of Coronial Practice in Western Australia*, Background Paper (September 2010) 24–7.

18. It is expected that the recent allocation of funding for a full-time findings clerk will relieve the Office Manager of some responsibility for drafting non-natural causes findings: Manager, Office of the State Coroner (WA), consultation (10 January 2011).

Manager. The latter is akin to an executive officer and handles (among other things) procurement and budget development, management of staff and facilities, human resources, and implementation of organisational policies and procedures.

Regional Coroners Courts

Under s 11 of the Coroners Act each magistrate is contemporaneously a coroner. In practice, however, only regional magistrates exercise functions under the Coroners Act. Deaths outside the metropolitan area are reported to the relevant regional court whose registrar (or court clerk) logs the relevant information into a local computer system and undertakes the administrative duties pertaining to the coronial case (including liaising with families of a deceased and with police investigators).¹⁹ Bodies of deceased are transported to the State Mortuary in Perth for post mortem examination,²⁰ and regional police in the relevant area investigate the death²¹ and report to the regional coroner.

Regional courts do not have dedicated coronial staff: the registrar handles coronial work in addition to the general work of the court.²² Although practice varies in the regions, in most cases administrative findings for natural causes deaths are drafted by a registrar and findings for other deaths are prepared by the magistrate.²³ Coronial counselling (which is based in Perth) is generally only available to regional areas by telephone.²⁴ Because regional magistrates rarely undertake inquests, they have no need for in-house legal counsel assisting or other inquest management services.²⁵ In the rare case that an inquest is handled by a regional

magistrate a counsel assisting may be assigned by the Office of the State Coroner.

CONCERNS WITH THE CURRENT MODEL

As discussed in Chapter One, the Commission has engaged in extensive consultations with people involved in the coronial system and with members of the public who have come into contact with the coronial system. These consultations revealed a number of concerns about the current coronial system in Western Australia and a summary of those issues appears in Chapter Four of the Commission's Background Paper. Some of the most important concerns were systemic in nature, reflecting problems that impact across the coronial system and which may be exacerbated by the semi-centralised model set up by the Coroners Act. These include concerns about communication and cooperation between the Office of the State Coroner in Perth and regional magistrates, registrars, contractors and investigators; and limited guidance, information or training being provided to those responsible for the delivery of coronial services in the regions.

In his 2008 review Barnes set out a number of problems he perceived with the operation of the current semi-centralised coronial model.²⁶ He noted that regional magistrates have 'infrequent involvement in coronial work [leading] to some ... being unsure of how to proceed'.²⁷ He also noted the extent of delegation of coronial functions to sometimes 'inexperienced' regional registrars and the inconsistencies that can 'readily develop' in coronial practice as a result.²⁸ In particular, Barnes argued against the use of regional magistrates as ex officio coroners for the following reasons:

- the potential conflict that may arise where a magistrate acting as coroner receives information about a death that later becomes the subject of a criminal charge;

19. Regional coroners' registrars do not have access to the National Coroners Information System and all regional data is inputted on the system through the Office of the State Coroner in Perth.

20. The only exceptions are where an objection to post mortem examination is upheld by the coroner or in cases of natural causes deaths reported to the Albany courthouse. In the latter case a local doctor (trained in post mortem examination techniques) usually conducts the post mortem examination.

21. In some circumstances, a specialist metropolitan police team may be deployed to investigate a regional death.

22. See 'Coroners' Registrars', below.

23. Consultation with Regional Magistrates (9 November 2009).

24. On occasion a counsellor might travel to a regional area with the State Coroner or Deputy State Coroner to assist with an inquest.

25. Of the 120 regional inquests held over the past decade, only 12 have been undertaken by a regional coroner: see LRCWA, *Review of Coronial Practice in Western Australia*, Background Paper (September 2010) ch 3, table 5 (reproduced in Appendix B to this Discussion Paper).

26. Although it should be noted that State Coroner Barnes consulted with Perth-based personnel only in respect of this review, many of his observations about the problems that can beset a semi-centralised system using non-dedicated coroners were also brought to the attention of the Commission during its broader consultations.

27. Barnes M, *Review of the Coroners Act 1996 (WA)* (August 2008) 16.

28. *Ibid.*

- the fact that regional magistrates do not usually have the time available to individually manage coronial investigations (including directing police in their investigations) or to hold lengthy inquests; and
- the increasing specialisation of the coronial role, including the research and development of recommendations to prevent future deaths in similar circumstances, which is substantially 'different to the usual work of lawyers and magistrates and requires skills that are difficult to learn, particularly when infrequently utilised'.²⁹

These concerns were also reflected in the comments of regional magistrates with whom the Commission consulted.³⁰ On the whole, regional magistrates saw coronial work as a specialised area of practice that did not necessarily sit well with the general role of a magistrate.³¹ Some appeared apprehensive about undertaking inquests, while others expressed an interest in coronial work and conducting more inquests. However, all conceded that the volume of Magistrates Court work, insufficient administrative resources and the travel involved with circuit courts generally precluded them from devoting the time necessary to investigate, prepare and hold a coronial inquest.

The Commission's consultations with regional magistrates confirmed that the lack of uniformity in their approach to coronial investigations and findings, noted by the Ad Hoc Committee in 1989, still existed.³² Although the State Coroner

has issued a short 'guidelines' document for coroners (which briefly explains the jurisdiction and a coroner's powers), regional magistrates suggested that each court relied upon its own templates and precedents for coronial findings and that they were often quite dependent upon the experience of their registrar.³³ Other matters that appear to have impacted on the lack of uniformity of findings, investigations and coronial processes across Western Australia include a lack of training for new regional magistrates and coroner's registrars;³⁴ lack of access to the State Coroner's and Deputy State Coroner's findings and to the National Coroners Information System (NCIS) database;³⁵ the decreasing involvement of regional magistrates in inquest work; and the increasing incidence of delegation of coronial functions to court registrars. These matters can also contribute to delay in the coronial process, which was a significant concern of most people consulted by the Commission.³⁶

MODELS IN OTHER AUSTRALIAN JURISDICTIONS

The structure of the coronial jurisdiction varies greatly throughout Australia. The Northern Territory and New South Wales have coronial systems which are described as having 'administrative' rather than judicial status.³⁷ Although the State Coroner of New South Wales and the Territory Coroner of the Northern Territory must be appointed from the magistracy, there is no separately established Coroners Court³⁸ or specific coronial division of the Magistrates Court in those jurisdictions. Every other Australian jurisdiction has established a separately constituted Coroners Court, except Tasmania whose *Coroners Act 1995* (Tas) explicitly establishes a (judicial) coronial division within the Magistrates Court.³⁹

29. Ibid 17. The Ad Hoc Committee made similar observations to Barnes in its 1989 review of the *Coroners Act 1920*. The Committee noted the difference in approaches of regional magistrates to their duties as ex officio coroners, expressing concern at the lack of uniformity of findings, investigations and coronial processes and noting that regional magistrates were 'fully occupied dealing with their responsibilities in jurisdictions other than those arising under the Coroners Act': *Report of an Ad Hoc Committee for the Review of the Coroners Act* (August 1989) 6.

30. The Commission addressed the Regional Magistrates' Conference on 9 November 2009 and undertook a joint consultation with 10 regional magistrates on that day. The Commission further undertook separate consultations with a magistrate based in the south of Western Australia in August 2008, and with magistrates and coroner's registrars based in the north of Western Australia in July 2010.

31. One magistrate expressed the opinion that there was the potential for a perception of bias where witnesses and families involved in inquests are also dealt with by the magistrate in other matters (such as criminal, care and protection and family law). Another magistrate suggested that there may be difficulty in cases where police (with whom they deal on a daily basis) fall under some criticism in an inquest.

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

33. Regional Magistrates, consultation (9 November 2009).

34. See 'An Inquisitorial Jurisdiction', below and Proposal 12.

35. The Commission understands that some regional magistrates now have access to NCIS; however, registrars of regional magistrates courts (who are responsible for drafting most findings) still do not appear to have access.

36. See LRCWA, *Review of Coronial Practice in Western Australia*, Background Paper (September 2010) 47–8.

37. VPLRC, *Coroners Act 1985*, Final Report (2006) 586.

38. Despite this, the Coroner's Office in New South Wales is almost universally referred to as the Coroners Court, including in findings.

39. *Coroners Act 1995* (Tas) s 5.

In Tasmania the Chief Magistrate is responsible for administering the coronial jurisdiction which uses the services of magistrates as ex officio coroners and local court staff as coroners' clerks.⁴⁰ A similar operation is found in the Australian Capital Territory; however, in that jurisdiction a Coroners Court is established and the Chief Magistrate is, by virtue of that office, the Chief Coroner for the jurisdiction.⁴¹ Western Australia, New South Wales, Victoria and Queensland have semi-centralised systems with dedicated full-time state coroners who coordinate and oversee the state's coronial function. These jurisdictions have independent offices⁴² based in their respective capital cities housing coronial administrative staff, counselling or support staff and one or more full-time coroners.⁴³ They utilise regional magistrates and court registries (to varying degrees) for coronial cases outside the metropolitan area. In addition, Queensland has two full-time coroners based in regional centres to the north and south of the capital city.

The Northern Territory and South Australia are the only jurisdictions to completely centralise all coronial operations to their capital cities. The Northern Territory Coroner is appointed from the magistracy and oversees the coronial work of the territory. He conducts all inquests (including those held in regional and remote locations)⁴⁴ and also works as a general magistrate in Darwin. He has a deputy who is a full-time coroner based in Darwin who completes all administrative findings.⁴⁵ All magistrates are contemporaneously coroners under the *Coroners Act* (NT);⁴⁶ however, they are rarely required to act in this role. Investigations of coronial deaths are generally performed by three coroner's constables based in Darwin

and Alice Springs,⁴⁷ and an external counsel assisting is engaged for all inquests.⁴⁸

South Australia has a full-time State Coroner and Deputy State Coroner who together manage the coronial output for the entire state. The coronial function in South Australia is truly centralised: all deaths are reported to the Coroner's Office in Adelaide, investigations are managed from the Office and very few inquests are held in the regions.⁴⁹ The Coroner's Office in South Australia employs two counsel assisting and has an in-house coronial investigations team of nine, including two senior police officers, four detective investigators (who investigate complex cases and medical deaths) and three constables (who check coronial briefs on each death investigated by local police).⁵⁰

40. A dedicated clerk or clerks may also be assigned to the coronial jurisdiction.

41. *Coroners Act 1997* (ACT) ss 4 & 6.

42. With all but New South Wales having statutorily established coroners' courts.

43. Including the State Coroner, the following number of full-time coroners are employed in each jurisdiction: Western Australia (2); New South Wales (6); Victoria (9); Queensland (5). Queensland's full-time coroners include a northern and southern coroner based in the regions.

44. Unless there is some conflict or clash of schedules in which case a scheduled inquest will be held by another magistrate; however, this is apparently a rare event: Vicki Hall, Coronial Support Officer, Coroner's Office (NT), consultation (18 January 2011).

45. These are cases that do not go to inquest and are known as chambers findings in many jurisdictions.

46. *Coroners Act* (NT) s 4(3).

47. Unless some level of specialisation is required (eg, motor vehicle fatalities) or the death is very remote (in which case local community police will investigate).

48. Vicki Hall, Coronial Support Officer, Coroner's Office (NT), consultation (18 January 2011).

49. Michele Bayly-Jones, Manager Coroner's Office (SA), consultation (19 January 2011).

50. *Ibid.*

A new structure

IS CENTRALISATION THE ANSWER?

In his 2008 review of the *Coroners Act 1996* (WA) ('the Coroners Act'), Barnes recommended that the coroners and staff of the Office of the State Coroner in Perth should 'assume responsibility for all coronial investigations and inquests' in Western Australia.¹ The Commission has therefore considered whether centralisation of all coronial functions to Perth is appropriate for the state.

Significantly, the Commission notes that no jurisdiction that has been subject to recent system-wide reform has adopted a complete centralisation of the coronial function. Following reforms in 2008, Victoria adopted a semi-centralised system with substantial numbers of dedicated coroners and support staff in the capital city and magistrates (who hold an appointment as coroner) servicing the regional areas.² Comprehensive reforms undertaken in Queensland in 2003 have again resulted in a semi-centralised system with three full-time coroners in the capital city and magistrates servicing some regional areas. In addition, the more-populous regional centres of Cairns and Southport have dedicated full-time coroners. New Zealand, which underwent system-wide reform in 2006, implemented a yet more regionalised system. Headed by a Chief Coroner with a centrally based coronial services unit, the New Zealand system also features 14 legally trained³ dedicated coroners in nine locations undertaking inquest circuits in their regions.

The two Australian jurisdictions where the coronial function has moved to total centralisation—the Northern Territory and South Australia—are quite different to Western Australia, both geographically and demographically.

Western Australia occupies approximately a third of Australia's total landmass and has the fastest growing population.⁴ Outside the Perth metropolitan area the fastest growing regions are the Pilbara and the Eastern Goldfields.⁵ Growth in these areas is linked to increased resource sector development;⁶ however, population estimations do not take into account the significant amount of fly-in, fly-out workers who boost the residential population on a cyclical basis and may contribute to coronial deaths in the regions.⁷ Australian Bureau of Statistics' population projections predict that the Western Australian population will grow from its current estimate of 2.3 million to 3.25 million within the next 15 years with significant population influx to the regions.⁸

While the Northern Territory has a geographical footprint approximately half the size of Western Australia,⁹ its population is only 10 per cent of Western Australia's current population¹⁰ and this is reflected in the very small number of coronial cases.¹¹ South Australia's land mass is much smaller at just over one-third of the total land mass of Western Australia and it has just under three-quarters of the population of Western Australia.¹² South Australia's regional

1. Barnes M, *Review of the Coroners Act 1996 (WA)* (August 2008) recommendation 6.
2. New South Wales has a very similar system though it has not undergone substantial structural reform (as opposed to legislative reform) in recent years.
3. Many New Zealand coroners have joint qualifications in medicine (or related area) and law.

4. ABS, *Australian Demographic Statistics* (June quarter 2010).
5. ABS, *Regional Population Growth Australia 2008–2009 – Western Australia* (cat no 3218.0, 2010).
6. ABS, *Western Australia Statistical Indicators September 2009: Spotlight on the Pilbara* (cat no 1367.5, 2009).
7. For example, traffic deaths and workplace deaths.
8. ABS, *Population Projections, Australia* (cat. no. 3222.0, 2008).
9. The land area of the Northern Territory is 1,352,176 km² while Western Australian is 2,531,563 km²: ABS, *National Regional Profile 2005–2009*.
10. ABS, *Australian Demographic Statistics* (June quarter 2010). The Northern Territory's population is expected to increase by 100,000 in the next 15 years with the growth largely confined to the capital city: ABS, *Population Projections, Australia* (cat. no. 3222.0, 2008).
11. The Northern Territory Coroner handles approximately 350 cases and 15 inquests each year: Vicki Hall, Coronial Support Officer, Coroner's Office (NT), consultation (18 January 2011). In contrast Western Australia handles approximately 1800 cases and 35 inquests each year: see 'Coronial Process Snapshot', Chapter One above.
12. ABS, *National Regional Profile 2005–2009*; ABS, *Australian Demographic Statistics* (June quarter 2010). However, South Australia's coronial output is strikingly similar with approximately 1900 cases each year and between 30 and 40 inquests. This similarity cannot be attributed to coronial factors alone – the number of deaths per annum average

population is slowly declining¹³ and population growth projections are quite low.¹⁴

The Commission notes that the arguments raised by Barnes in support of his recommendation to centralise the coronial function in Western Australia relate almost exclusively to the use of regional magistrates as ex officio coroners. These arguments were supported during the Commission's consultations by most regional magistrates and by the State and Deputy State Coroners. The Commission agrees that the use of regional magistrates as ex officio coroners is not ideal in circumstances where magistrates have infrequent involvement in the coronial jurisdiction and where the jurisdiction is becoming increasingly specialised.¹⁵ The Commission also agrees that the coronial function does not necessarily sit well with the role of regional magistrate. It is not difficult to think of circumstances where such roles might conflict. An obvious example is where a traffic fatality is dealt with by a regional magistrate as coroner and where that same magistrate may be called upon to deal with the driver in circumstances where prosecution has been recommended as a result of the coronial investigation.¹⁶

The fact that regional courts are not appropriately resourced to perform the coronial function and the magistrates' already demanding workloads simply add to the argument that the coronial function should be removed from regional magistrates. On all of the evidence before it, the Commission is persuaded that this course is appropriate. However, it must be stressed that removing the coronial function from regional (and other) magistrates does not necessarily mean that the coronial function should be removed from the regions and

centralised to Perth. The Commission explores below the potential of an alternative model which maintains a regional coronial presence.

PROPOSAL 2

No ex officio coroners

That magistrates should no longer hold automatic contemporaneous ex officio appointments as coroners.

AN ALTERNATIVE MODEL

Having concluded that regional magistrates should be divorced from their coronial role, it remains necessary to consider whether the current semi-centralised system should be maintained in Western Australia or whether there is a better alternative.

While centralisation may have certain advantages in terms of potential economies of scale, it does 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.¹⁷ The Commission's consultations with regional magistrates, regional registry staff, Legal Aid and the Aboriginal Legal Service argued strongly for the retention of a regional coronial presence and saw merit in the establishment of coronial regions in the north and south of the state serviced by dedicated coroners. This model is currently operating in Queensland and, to a greater extent, in New Zealand.

As mentioned earlier, Queensland has dedicated coroners based in Cairns and Southport to service those regions. Each coroner is supported by a counsel assisting and three administrative officers. The Commission envisages that a similar model could be set up in Western Australia, but which includes coroners operating an inquest circuit like the New Zealand regional coroners. The State Coroner could continue to undertake those regional inquests that are particularly complex or politically sensitive.

17. Significantly, trends in regional deaths to date have really only come to the attention of the State Coroner via journalists and some magistrates who are interested in coronial work and significantly invest in their region.

around 12,500 for each state: ABS, *Deaths – Australia* (cat no 3302.0, 2009) tables 1.4 & 1.5.

13. ABS, *Regional Population Growth Australia 2008–2009 – South Australia* (cat no 3218.0, 2010).

14. In contrast to Western Australia, whose population is expected to increase by one million people in the next 15 years, South Australia's maximum estimated population growth over the same period is just 300,000: ABS, *Population Projections, Australia* (cat no 3222.0, 2008).

15. In particular, in terms of the research and prevention function being embraced by modern coroners: see LRCWA, *Review of Coronial Practice in Western Australia*, Background Paper (September 2010) 44–5.

16. Under the *Coroners Act 1996* (WA) s 27(5) a coroner may report his or her belief that an offence may have been committed in connection with a death to appropriate authorities. Conflict in these circumstances might be difficult to manage where there is only one magistrate serving a particular region.

In the Commission's view three coronial regions should be established:

- **the metropolitan region** (encompassing metropolitan Perth as defined by the electoral boundaries)¹⁸ and serviced by a State Coroner, a Deputy State Coroner and a principal registrar (discussed below);
- **the northern region** (encompassing the circuit regions covered by magistrates based in Broome, Kununurra, Carnarvon, Geraldton and South Hedland) serviced by a dedicated coroner based in a northern hub town; and
- **the southern region** (encompassing the circuit regions covered by magistrates based in Albany, Bunbury, Kalgoorlie and Northam) serviced by a dedicated coroner based in a southern hub town.

In Queensland, the northern and southern coroners deal with 17% and 15% respectively of the total number of reportable deaths in that state.¹⁹ This compares favourably to the proportion of total Western Australian deaths to be dealt with by the northern and southern coroners under the Commission's proposal, which is 12% and 17% respectively.²⁰ However, while the proportion of coronial cases is comparable, the number of cases in this state's northern and southern regions is approximately half that dealt with by their Queensland counterparts. While almost all those consulted on the dedicated regional coroner model agreed with the idea in principle, a number of people questioned whether there were enough deaths to justify a dedicated coroner based in the northern region.

Given the projected population growth for Western Australia of one million people over the next 15 years (a substantial proportion of which is expected to infiltrate the Pilbara and Goldfields regions²¹), the distances required

to be travelled for inquest circuits and the changes (discussed in Chapter Three), which will likely increase reportable deaths, the Commission believes that a dedicated regional coroner model can be justified. Although as a proportion of total inquests per year regional Western Australia appears reasonably well represented, the percentage of coronial deaths inquested in Western Australia is noted as being quite low when compared to some other Australian jurisdictions.²² Further, as discussed in the Background Paper, the delay in bringing matters to inquest is as long as three years and there is a substantial backlog of cases currently identified for inquest.²³ When consulted, both the State Coroner and Deputy State Coroner conceded that 'quite often' there were regional cases that they would have liked to have seen inquested or more thoroughly investigated, but by the time the file was submitted to Perth the usefulness of pursuing an investigation was questionable.²⁴

The Commission was told by the State Coroner and Deputy State Coroner that the Office of the State Coroner in Perth was handling an 'increasing proportion of country findings'.²⁵ In January 2011 the Office Manager estimated that one in every five administrative findings done in Perth was on a regional file.²⁶ Under the Commission's proposal, the regional coroners would manage all files of deaths in their regions,²⁷ which should significantly reduce the backlog of administrative findings and impact positively upon the delays currently experienced in the coronial system.

A particular problem that has been raised by regional magistrates and the dedicated coroners alike is the quality and timeliness of police investigation files in regional areas. This issue had become so acute that in June

18. Although not part of the metropolitan region, the Commission has determined that it is appropriate that Christmas Island and the Cocos Keeling Islands deaths be reported to the State Coroner in Perth, given that most deaths on Christmas Island will be politically sensitive because it is the location of the federal government's offshore refugee processing facility.

19. Based on figures for 2008–2009: State Coroner Queensland, *Annual Report 2008–2009* (2009) 14.

20. Based on a statistics average taken over four years from 2006–2009, the northern coroner would be dealing with approximately 205 deaths per year, while the southern coroner would be dealing with an average of 295 deaths per year.

21. ABS, *Regional Population Growth Australia 2008–2009 – Western Australia* (cat no 3218.0, 2010); see also discussion above.

22. For example, figures for 2008–2009 show that 3.5% of total coronial cases are being inquested in Victoria, 3.87% in New South Wales, while only 1.8% of cases were inquested in Western Australia. The Northern Territory coroner (who is not full-time) inquested 4.28% of coronial cases in the same period.

23. LRCWA, *Review of Coronial Practice in Western Australia*, Background Paper (September 2010) 47. At the time of writing that paper, there were approximately 75 cases awaiting inquest.

24. State Coroner and Deputy State Coroner, consultation (20 August 2008).

25. *Ibid.*

26. Manager, Office of the State Coroner (WA), consultation (11 January 2011).

27. With the exception only of files that the State Coroner wishes personally to manage to inquest.

2010 the State Coroner issued a direction to regional magistrates emphasising that substandard police investigation briefs should not be accepted by them, but should be sent back with directions for deficiencies to be addressed in a timely manner.²⁸ The Commission's consultations with regional police and magistrates in late July 2010 revealed that significant delays were still occurring and that some police investigation practices were likely to be considered substandard by a dedicated coroner. Of particular concern was the practice of police in one major regional centre to only request copies of patient records (rather than originals) and to permit a delay of up to a month to receive them. This not only enables potential corruption of files,²⁹ but may also impact upon the quality of the post mortem examination.³⁰

It is most likely a combination of lack of regional registry resources, lack of time on the part of regional magistrates and lack of adequate training of all parties involved in regional coronial service provision that has contributed to problems identified by the State Coroner in the investigation of some regional coronial deaths. It certainly appeared to the Commission that coronial matters were given a low priority by some police and, in some cases, it appeared that police were unsure of the coroner's requirements once it was clear that the death being investigated did not involve any overt criminal offence.³¹ It is the Commission's opinion that, by establishing networks within regional areas and by clearly communicating acceptable coronial investigation standards to senior district police, dedicated regional coroners will be able to deflect many of the problems currently being experienced in the regional coronial system. Many police commented to the Commission that they would welcome more direct guidance from coroners at the initial investigation stage, and this is another issue that could be usefully

addressed in a timely manner by dedicated regional coroners.³² The Commission does not believe that a centralised operation could build reliable and accountable networks or offer the same degree of attention to the investigation of regional deaths as could be provided by dedicated regional coroners.

In addition to these issues, under the Commission's proposed structure the dedicated regional coroners would be responsible for administering regional body transport contracts; reviewing and reporting on contractor facilities; and ensuring the smooth running of all matters coronial within their regions. Recent concerns surrounding the contractor responsible for the recovery and transport of bodies in the East Kimberley³³ have shown that attention does need to be paid to the activities of local contractors to ensure that bodies are treated with dignity and respect, and that they arrive at the state mortuary in as optimal a state as possible.³⁴ Management of these issues at the local level would increase accountability of regional contractors, and would significantly alleviate the pressures on the staff and coroners of the Office of the State Coroner in Perth.

In order for the Commission's model to work it requires sufficient resources to enable the coroners to be based within the regions to which they are assigned. Without sufficient resources there is a danger that these coroners will be subsumed within the Perth office and all benefits of the dedicated regional coroner system will be lost. For regional magistrates, this potential was particularly concerning with most stating that they would rather the system as it currently is (and with all its faults) rather than lose all local coronial contact with the regions. In the Commission's opinion a regional coroner would require a legal counsel assisting; a registrar who is capable of handling

28. State Coroner, 'Quality of Police Briefs' (2 June 2010).

29. For example, hospital records may potentially be altered or added to after the death. This has been an issue in some cases investigated by Western Australian coroners.

30. In hospital deaths it is important for the pathologist to have immediate access to the deceased's medical records in order to properly assess the potential for medical misadventure or error.

31. The Commission notes that the Coronial Investigation Unit in Perth is now working to overcome some of the shortfalls of officer training in the investigation of coronial deaths by assuming responsibility for the relevant training module at the police academy and by developing operational aides memoire to assist officers in the field: Inspector Mark Bordin, OIC Coronial Investigation Unit, consultation (11 March 2011).

32. The Commission notes the success of a recent initiative operating in Perth where the Deputy State Coroner attends at the Coronial Investigation Unit to discuss with officers the necessary investigation requirements for each coronial death occurring in the previous week. It is expected that a similar approach can be taken in the regions by dedicated regional coroners.

33. See discussion in LRCWA, *Review of Coronial Practice in Western Australia*, Background Paper (September 2010) 56. This issue has also been ventilated in the media: see 'Funeral Director Defends Using Ice Packs, Hire Cars', *The West Australian* (4 February 2010).

34. There is an obvious 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.

the administrative requirements of the office and of acting (when necessary) as coroner's associate; and a counsellor (or coronial liaison officer) who provides support to families during coronial inquests, conducts training and education sessions throughout the region and deals with all coronial family liaison. Although the Coroners Act requires that a counselling service be attached to the Coroners Court and be available to all who come in contact with the court,³⁵ regional Western Australia has been significantly neglected in this area. It will be incumbent upon the counsellor for each region to establish relationships and networks with appropriate people in each community to enable the culturally appropriate delivery of coronial information to family members of a deceased. This will be illuminated further in Chapter Seven of this Paper.

Although the proposed dedicated regional coroner model will require further and necessary resourcing of the coronial jurisdiction, there will be a positive impact on the resources of the Magistrates Court because regional magistrates and regional court clerks will no longer be required to perform coronial functions. In addition, the Commission's proposals (which require that dedicated coroners also be appointed as magistrates) would permit dedicated coroners to also sit in the Magistrates Court should the coronial work in the specified region not be of sufficient volume to justify the appointment of a full-time dedicated regional coroner.

PROPOSAL 3

Establish coronial regions

That three coronial regions be established being the metropolitan region (encompassing metropolitan Perth as defined by the electoral boundaries), the northern region (encompassing the circuit regions covered by magistrates based in Broome, Kununurra, Carnarvon, Geraldton and South Hedland) and the southern region (encompassing the circuit regions covered by magistrates based in Albany, Bunbury, Kalgoorlie and Northam).

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

PROPOSAL 4

Dedicated regional coroners

That sufficient resources be assigned to establish and support a dedicated coroner to service and be based in the northern region, and a dedicated coroner to service and be based in the southern region (as defined in Proposal 3).

THE CORONERS COURT IN THE JUDICIAL HIERARCHY

Another matter raised by Barnes in his 2008 review was the position of the Coroners Court and the Office of the State Coroner in the judicial hierarchy. As mentioned earlier, the Office of the State Coroner and the Coroners Court of Western Australia come within the Specialist Courts and Tribunals division of the Department of the Attorney General. Noting problems with staffing levels, resources and matters included in the office's budget (such as toxicology, pathology and body transport costs) over which the State Coroner has 'almost no control', as well as concerns that the budget submissions of the court were being 'ignored' by the department, Barnes recommended that the Commission consider a 'repositioning' of the Coroners Court.³⁶ These matters were also raised by the State Coroner in consultation with the Commission.³⁷

Barnes raised three options for repositioning of the Coroners Court:

- that an independent statutory authority controlled by the judiciary be established to manage the funding of all courts;
- that the Office of the State Coroner and Coroners Court be established as a 'separate legal and administrative unit ... much like the Corruption and Crime Commission'; and
- that the Coroners Court be 'moved under the umbrella of the District Court in the same manner as the Children's Court is currently positioned'.³⁸

36. Barnes M, *Review of the Coroners Act 1996 (WA)* (August 2008) 14–16, recommendation 4.

37. State Coroner, consultation (26 November 2009).

38. Barnes M, *Review of the Coroners Act 1996 (WA)* (August 2008) 15.

A further option, raised by the Chief Magistrate, was that the Coroners Court be subsumed within the Magistrates Court, with the Chief Magistrate being the State Coroner and a Deputy State Coroner being responsible for the magistrates acting as coroners in both the regions and in Perth.³⁹

The Commission has considered each of these options and is attracted to a repositioning of the Coroners Court that places it firmly within the established judicial hierarchy in Western Australia. While the Chief Magistrate's suggestion would have the advantage of a senior judicial officer being able to monitor and control the coronial output of regional magistrates perhaps more effectively than is currently the case,⁴⁰ the Commission notes that the coronial jurisdiction globally is moving toward professional dedicated coroners rather than part-time coroners who are also magistrates. While there is no doubt that magistrates are eminently capable of exercising the coronial jurisdiction given sufficient time and resources, this solution does not overcome the concerns raised by Barnes and outlined above. As noted earlier,⁴¹ the smaller jurisdictions of Tasmania and the Australian Capital Territory are the only Australian jurisdictions to have retained this model and a review in the latter jurisdiction has recently recommended that a dedicated coroner be established.⁴²

The alternative option of moving the Coroners Court within the umbrella of the District Court with a State Coroner being appointed from the District Court bench was the course recommended by the Ad Hoc Committee inquiry in 1989.⁴³ This opinion was also expressed by Commissioner Elliot Johnston QC in the final report of the Royal Commission into Aboriginal

Deaths in Custody (RCIADIC).⁴⁴ The most recent coronial law reform process (undertaken in Victoria) made a similar recommendation and the resulting *Coroners Act 2008* (Vic) provides that the State Coroner must be a judge of the County Court (equivalent to the District Court in Western Australia).⁴⁵ The Commission raised this possibility during its consultations and it received strong support from many counsel and coroners as a means of appropriately elevating the status and authority of the jurisdiction and including it more overtly within the judicial hierarchy of the state. This option also has the benefit of providing a clear line of accountability to a chief judicial officer (the Chief Judge of the District Court of Western Australia) and ensuring that the interests of the Coroners Court are appropriately represented at judicial conferences including meetings of heads of jurisdictions.

Many respondents to the Commission's consultations suggested that all coronial positions, including that of the State Coroner, should be of limited tenure. The primary reason given for this was to avoid the phenomenon of 'coronial burnout', but another strongly expressed view was that a finite term for coroners was appropriate to enable accountability within the jurisdiction. The Deputy State Coroner expressed that she was comfortable with her finite (renewable) term for this reason.⁴⁶

Currently the role of State Coroner in Western Australia is an appointment for life. In all other Australian jurisdictions with unitary coronial systems the appointment of State Coroner is for a finite term of between five and seven years with eligibility for reappointment.⁴⁷ The New Zealand Chief Coroner is appointed for a period of up to eight years, but is not eligible for reappointment.⁴⁸ In all jurisdictions (other than Western Australia) the State Coroner is a warranted judicial officer of a court other than the Coroners Court and can return to that court when his or her term as coroner is complete.

39. Chief Stipendiary Magistrate, consultation (26 November 2009).

40. Under the *Coroners Act 1996* (WA) s 21(1) the State Coroner may only give directions to regional coroners with the 'prior approval of the Chief Magistrate'. While there was no sense that the Chief Magistrate had ever withheld approval, it appeared to the Commission that the State Coroner was reluctant to direct regional magistrates in their coronial duties, viewing them (appropriately) as independent judicial officers: State Coroner, consultation (20 August 2008).

41. See 'Models in Other Australian Jurisdictions', above.

42. Ministry of Justice (ACT), *Review of the Coroners Act 1997* (2008).

43. *Report of an Ad Hoc Committee for the Review of the Coroners Act* (August 1989) recommendation 2. For discussion of this inquiry, see LRCWA, *Review of Coronial Practice in Western Australia*, Background Paper (September 2010) 8.

44. RCIADIC, *National Report* (1991) vol 1 [4.5.9].

45. *Coroners Act 2008* (Vic) s 91.

46. Deputy State Coroner, consultation (26 November 2009).

47. With the exception of the Northern Territory Coroner whose position is not a dedicated full-time position of coroner, but is combined with the position of general magistrate. The Australian Capital Territory and Tasmania do not have unified state coronial systems, but instead are led by the Chief Magistrate.

48. *Coroners Act 2006* (NZ) s 104(4).

Because the job of coroners can involve public criticism of government agencies, laws and policies, it is important that coroners be independent and their tenure secure.⁴⁹ A life appointment is appropriate in the current Western Australian system because (contrary to recommendation 9 of the RCIADIC) the State Coroner in Western Australia does not otherwise hold a judicial appointment.⁵⁰

Having considered the potential models for structural reform, the Commission has concluded that the Coroners Court should be re-established under the umbrella of the District Court in a similar manner to the Children's Court of Western Australia⁵¹ with a State Coroner being appointed from the District Court bench and with a Deputy State Coroner being appointed from the Magistrates Court bench. The Commission considers that an initial term of not more than five years, which may be renewed for one further term of five years, is appropriate for both the State Coroner and Deputy State Coroner. In regard to terms of appointment, the Commission suggests that time served as a State or Deputy State Coroner be taken, for the purposes of superannuation and pension, as time served on the court to which the person was first appointed.

PROPOSAL 5

Status and tenure of the State Coroner

1. That the State Coroner of Western Australia be a judge of the District Court appointed by the Governor upon the recommendation of the Attorney General made after consultation with the Chief Judge of the District Court.
2. That the appointment of the State Coroner be for an initial term of not more than five years and may be renewed once for a term of not more than five years.
3. That service in the office of State Coroner be taken for all purposes to be service in the office of a judge of the District Court of Western Australia.

49. Victorian Parliament Law Reform Committee (VPLRC), *Coroners Act 1985*, Final Report (2006) 597.

50. The Deputy State Coroner, on the other hand, is an officer of the Magistrates Court and can return to that court should her appointment not be renewed.

51. *Children's Court of Western Australia Act 1988* (WA) s 6.

PROPOSAL 6

Status and tenure of the Deputy State Coroner

1. That the Deputy State Coroner of Western Australia be a magistrate of the Magistrates Court appointed by the Governor upon the recommendation of the Attorney General made after consultation with the State Coroner and the Chief Magistrate of the Magistrates Court.
2. That the appointment of the Deputy State Coroner be for an initial term of not more than five years and may be renewed once for a term of not more than five years.
3. That service in the office of Deputy State Coroner be taken for all purposes to be service in the office of a magistrate in the Magistrates Court of Western Australia.

In order to accommodate future expansion of the coronial system it is necessary that the Coroners Act contain the facility for further coroners to be appointed on a permanent⁵² or temporary basis.⁵³ While it is desirable that appointments of full-time coroners (in particular, dedicated regional coroners) are advertised specifically to attract appropriate candidates, for the same reasons as stated earlier the Commission considers that coroners should be simultaneously appointed as a judicial officer of a court other than the Coroners Court and be appointed for a finite term. In the case of 'simple' coroners, the Commission considers that successful candidates for the position of coroner should be simultaneously appointed to the magistracy. For this reason, applicants for the position of coroner must be eligible to be appointed to the Magistrates Court of Western Australia.⁵⁴ For more temporary appointments, the facility to appoint directly from the magistracy is required. In these cases it is

52. By permanent the Commission means on a full-time contract basis for a period of up to five years, renewable once.

53. This facility is currently found in the *Coroners Act 1996* (WA) s 11.

54. The *Magistrates Court Act 2004* (WA) s 2 requires that the person has at least five years' experience in legal practice and be under 65 years of age.

appropriate that both the Chief Magistrate and State Coroner be consulted, and that regard be had to the experience and knowledge of the magistrate in relation to coronial investigations.⁵⁵

PROPOSAL 7

Status and tenure of other coroners including dedicated regional coroners

1. That a magistrate may be appointed coroner by the Governor upon the recommendation of the Attorney General made after consultation with the State Coroner and the Chief Magistrate of the Magistrates Court.
2. That a person, who is eligible to be appointed as a magistrate, may be appointed coroner by the Governor upon the recommendation of the Attorney General made after consultation with the State Coroner and that such person shall simultaneously be appointed as a magistrate.
3. That the appointment of a coroner be for an initial term of not more than five years and may be renewed once for a term of not more than five years.
4. That service as a coroner be taken for all purposes to be service in the office of a magistrate in the Magistrates Court of Western Australia.

Oath of office

Presently under the Coroners Act only the State Coroner is required to swear an oath of office before a judge of the Supreme Court.⁵⁶ The form of the oath (or affirmation) is provided for in the *Coroners Regulations 1997 (WA)* and is the same oath sworn by all judges and

55. Although the appointment of coroners from the magistracy should be made in consultation with the Chief Magistrate, once such a coroner is appointed that person must come under the direction and oversight of the State Coroner. The Commission therefore sees no need for the present requirement in s 21(1) of the Coroners Act for direction from the State Coroner to be made with the prior approval of the Chief Magistrate if this model is adopted by government.

56. *Coroners Act 1996 (WA)* s 9.

magistrates in Western Australia.⁵⁷ Because the current State Coroner does not hold a judicial appointment, provision in the Coroners Act for an oath of office to be sworn is appropriate. However, as mentioned earlier, neither the Deputy State Coroner nor coroners appointed under s 11(2) of the Coroners Act are required to be judicial officers and in these circumstances the failure of the Act to require that an oath of office be sworn by coroners is clearly an oversight. Although in practice the Deputy State Coroner is a magistrate and therefore has sworn an oath upon taking that office, there has been an appointment under s 11(2) of a non-judicial coroner who has not been required to swear an oath of office.

Under the Commission's proposals all coroners will hold judicial office in either the District Court (State Coroner) or the Magistrates Court (Deputy State Coroner and other coroners) so provision of an oath of office in the same form as that of a judge or magistrate is unnecessary. However, the Commission sees merit in the idea of establishing a coroner-specific oath of office to be undertaken by all appointed coroners. It is considered that this would appropriately identify the coronial jurisdiction as a specialist and inquisitorial jurisdiction.⁵⁸ The form of the coroner-specific oath of office should be established in consultation with the State Coroner and Deputy State Coroner.

PROPOSAL 8

Oath of office

1. That a person appointed as coroner under the Coroners Act must, before commencing to act as a coroner, take before a judge of the Supreme Court, an oath or affirmation of office.
2. That the prescribed form of the oath or affirmation of office for a coroner be specific to the duties as coroner, and be developed in consultation with the State Coroner and Deputy State Coroner.

57. *Coroners Regulations 1997 (WA)* reg 4.

58. See discussion in 'An Inquisitorial Jurisdiction', below.

CORONERS' REGISTRARS

Coroners' registrars are public servants appointed under Part 3 of the *Public Sector Management Act 1994* (WA) and include registrars of regional courthouses (previously known as clerks of court). The function of coroners' registrars is set out in s 13 of the Coroners Act:

A coroner's registrar may—

- (a) on behalf of a coroner, receive information about a death which a coroner is investigating otherwise than at an inquest;
- (b) issue a summons requiring a witness to attend an inquest to give oral evidence or to produce documents; and
- (c) carry out any other function authorised under this Act.

Section 10 of the Coroners Act permits the State Coroner to delegate to a coroner's registrar 'any power or duty of a coroner other than a prescribed power or duty or this power of delegation'. A typical delegation to a regional court registrar includes the authority to direct a pathologist to perform a post mortem examination pursuant to ss 34(1) or 37(2) and to remove tissue pursuant to s 34(2); to notify the Registrar of Births, Deaths and Marriages of the particulars required to register the death; and to issue a certificate permitting burial or cremation.⁵⁹ However, the delegations to the registrars within the Office of the State Coroner are more comprehensive and include the authority to determine whether a death certificate will be accepted or whether a death needs full coronial investigation and to restrict access to premises under s 32.⁶⁰ Currently the only prescribed restriction on delegation to a coroner's registrar is the power to conduct an inquest.⁶¹

While undoubtedly a consequence of insufficient resources, the significant delegation of powers to coroners' registrars, both in Perth and in the regions, is concerning.⁶² Many of the powers exercised by coroners' registrars

in Western Australia are required to be exercised by coroners in most other Australian jurisdictions.⁶³ In the Commission's opinion the current s 10 of the Coroners Act is too wide and the jurisdiction would benefit from having the functions and powers of a coroner that are capable of delegation to coroners' registrars specified in the Coroners Act. Having regard to delegation provisions in other Australian jurisdictions, the Commission proposes that a provision modelled on s 99 of the *Coroners Act 2008* (Vic) be inserted into the Coroners Act in the following terms.

PROPOSAL 9

Delegation from the State Coroner to a coroner's registrar

1. That the State Coroner may, in writing, delegate to a coroner's registrar any function or power of a coroner other than the functions or powers listed in subsection (2).
2. The following functions or powers of the State Coroner or a coroner cannot be delegated to a coroner's registrar (not including the Principal Registrar):
 - (a) the power of delegation in subsection (1);
 - (b) directing a forensic pathologist or medical practitioner to perform an internal post mortem examination;
 - (c) ordering an exhumation;
 - (d) releasing a body;
 - (e) ordering an inquest;
 - (f) making final determinations on any application under this Act;
 - (g) making findings or reviewing findings;
 - (h) making practice directions;
 - (i) authorising the restriction of access to an area; and
 - (j) such other functions as are prescribed by regulation.

59. Registry Manager, Office of the State Coroner (WA), email (9 August 2010).

60. Manager, Office of the State Coroner (WA), email (12 July 2010).

61. *Coroners Regulations 1997* (WA) reg 5.

62. This was a point also made by Barnes, see Barnes M, *Review of the Coroners Act 1996* (WA) (August 2008) 16.

63. For example, a direction to perform a post mortem examination can only be made by a coroner in Victoria and Queensland.

Principal Registrar

Victoria has led the way with professionalising the coronial jurisdiction in Australia and one way it has done so is by appointment of a Principal Registrar.⁶⁴ The Commission is aware that other Australian coroners' courts are also looking at establishing similar positions at a senior officer level.⁶⁵ In his 2008 review of the Coroners Act, Michael Barnes stated:

It can not be disputed that the work of a coroner's office is more demanding of its administrative officers than almost any other public sector workplace. The file content is confronting and distressing and the members of the public with whom the staff must interact are often more difficult to assist because of their bereavement. Therefore, more seniority and more supervision would be expected in the staff establishment profile than say, in a general court registry.⁶⁶

The Commission is of the opinion that appointment of a suitably qualified person as Principal Registrar of the Coroners Court would significantly alleviate the pressures upon the Office Manager and coroners in Perth, and provide a clear supervisory hierarchy that will assist to professionalise the jurisdiction. The Commission is particularly concerned that the current Office Manager has, through force of need, assumed many duties that should properly be performed by a dedicated registrar. This has taken the Manager away from the significant duties of his office which include managing the court's human resources and budget, and administering the day-to-day running of the court. It is an untenable position and should not continue.

The Commission proposes that the Principal Registrar would have such powers as prescribed by the Coroners Act or delegated by the State Coroner, which in addition to the powers currently delegated to registrars could include the following responsibilities:

- check the daily 'death' list, critically evaluate facts of initial police reports (P98 mortuary admission forms) and make such directions to police as seem appropriate in respect of initial coronial investigation (currently performed by Deputy State Coroner);⁶⁷
- make an initial assessment for coroners about cases that may be identified for inquest so that such cases can be assigned to counsel assisting to ensure appropriate management of the coronial investigation at an early stage;
- oversee the management of the Perth registry and coordinate operations between the Perth registry and regional registries;
- approve applications for file viewings by families and make determinations as to what can and cannot be viewed on the file (currently performed by coroners);⁶⁸
- determine whether a death, in respect of which an internal or external post mortem examination has concluded that the death was due to natural causes, requires coronial investigation (pursuant to Proposal 52);⁶⁹
- authorise restriction of access to premises and sign off on first extension to time for access (with further extensions to be approved by a coroner);⁷⁰
- authorise a coroner's investigator to enter and inspect premises and take possession of anything which the investigator reasonably believes is directly relevant to the investigation of the death;⁷¹
- notify the Director of Public Prosecutions or Commissioner of Police if the coroner investigating a death believes an indictable or summary offence may have been committed in connection with a death;⁷² and
- ensure that notification of particulars required to register and finalise death are

64. The Commission is aware that that the position of Principal Registrar in the Coroners Court of Victoria is largely an administrative role, the Commission contemplates a quasi-judicial Principal Registrar for the Western Australian Coroners Court.

65. Queensland Coroners Court has recently put forward a budget case for the employment of a legally trained Principal Registrar at senior officer level to make findings on natural causes deaths and to make determinations on certain matters such as whether or not to direct a post mortem examination in a case: Brigita White, Director of the Office of the State Coroner (Qld), consultation (13 December 2010).

66. Barnes M, *Review of the Coroners Act 1996 (WA)* (August 2008) 11.

67. Deputy State Coroner, consultation (26 November 2009).

68. Hope A, State Coroner of Western Australia, 'Review of the Coroners Act 1996 – Possible Issues' (unpublished, 12 June 2007) 5.

69. This would be a non-delegable function of the Principal Registrar. In regional areas, this function would be performed by the dedicated regional coroners. See further Chapter Five, 'Administrative Findings: Natural Causes Findings'.

70. *Coroners Act 1996 (WA)* s 32.

71. *Coroners Act 1996 (WA)* s 33.

72. *Coroners Act 1996 (WA)* s 27(4).

provided by coroners without delay to the Registrar of Births, Deaths and Marriages.⁷³

The Commission is of the opinion that the position of Principal Registrar should be a quasi-judicial position, similar to a Registrar of the District Court, and as such should be filled by a person who is eligible for appointment to the Magistrates Court.⁷⁴ The position should sit directly under the coroners in the Coroners Court hierarchy and report directly to the State Coroner. Unlike the position of coroner, the Commission does not see any reason why the Principal Registrar should be appointed for a finite term. This has the added advantage of providing a point of continuity in the system when coroners' terms of appointment expire.

PROPOSAL 10

Principal Registrar

1. That the position of Principal Registrar of the Coroners Court of Western Australia be established.
2. That the Principal Registrar be a suitably qualified person who is eligible to be appointed to the Magistrates Court of Western Australia.
3. That the Principal Registrar have such powers and functions as are prescribed under the Coroners Act or delegated in writing by the State Coroner.
4. That a decision of the Principal Registrar be capable of review by the State Coroner on its merits.

STRATEGIC REVIEW OF OFFICE OF THE STATE CORONER

It is apparent that for many years the Office of the State Coroner has struggled with constrained financial and human resources. As a result, undesirable practices have developed to cope with the strain on the system. Examples discussed in this chapter include the amount of unsupervised coronial power being routinely

delegated to coroners' registrars and the assumption by the Office Manager of significant duties outside his designated role. In his 2008 review of the Coroners Act, Michael Barnes also noted that he was 'alarmed by the demands placed on staff and the level of responsibility unavoidably born [sic] by very junior officers'.⁷⁵ He observed that:

Administrative staff members are frequently required to work overtime, even on weekends. Supervision of junior staff does not occur to the extent that would reasonably be expected because the supervisors are themselves heavily involved in casework.⁷⁶

As discussed earlier, in the past two years the Office of the State Coroner has received a non-recurrent increase in funding, which has allowed it to increase its workforce by 50%. The office has also now acquired a computer and database system sophisticated enough to manage the necessary data collection and death recording duties of the coroner. However, it is clear that the office is concentrating on the necessary task of reducing its substantial backlog of undetermined coronial cases and inquests and, as a result, has not sought to analyse the systems and administrative processes that are currently in place or strategically plan for its future.⁷⁷

If accepted by government, the Commission's restructuring proposals and system-wide jurisdictional reforms will require legislative reform which may take some time to develop and implement. It is therefore fundamentally important that a strategic review of the Office of the State Coroner be undertaken at the earliest opportunity to ensure that any sustained increase of human and financial resources is used to maximum effect and that systems and administrative processes, borne of necessity rather than design, are rigorously evaluated. In the Commission's opinion, such review should be undertaken by a suitably qualified independent person or persons and should seek to explore more efficient administrative processes in the Office of the State Coroner and advise the State Coroner and government about the extent of extra resourcing required for the effective and

73. *Coroners Act 1996* (WA) s 28.

74. The *Magistrates Court Act 2004* (WA) s 2 requires that the person have at least five years' experience in legal practice and be under 65 years of age.

75. Barnes M, *Review of the Coroners Act 1996* (WA) (August 2008) 11.

76. *Ibid.*

77. Manager, Office of the State Coroner (WA), consultation (8 February 2011).

efficient delivery of coronial services in the short to medium term.

PROPOSAL 11

Strategic review of the Office of the State Coroner

That a strategic review of the Office of the State Coroner be conducted by a suitably qualified independent person or persons. The review should include, but not be limited to:

1. an evaluation of administrative systems and processes;
2. an evaluation of infrastructure and human resourcing needs;
3. a review of the functions and supervision of administrative staff within the Office of the State Coroner;
4. a review of the office's risk management plans;
5. consideration of the implementation of administrative, policy and procedural recommendations of the Law Reform Commission of Western Australia; and
6. the development of a strategic plan for the efficient and effective delivery of coronial services.

Consultation with relevant stakeholders including the Registry of Births Deaths and Marriages, PathWest, Western Australia Police, the Office of Safety and Quality within the Department of Health, regional coroners and registries may also be required to inform the evaluation of administrative procedures that affect or involve those entities.

An inquisitorial jurisdiction

The institution of coroner in Australia has been described by one commentator as ‘an inquisitorial oasis in the broader adversarial landscape’.¹ The functions of a Western Australian coroner are quite different to a judge of an adversarial court: the coroner investigates the death, determines the questions to be answered and the witnesses to be heard at inquest, and decides his or her finding based on the evidence presented. Unlike in an adversarial court, there are no litigants (parties),² no rules of evidence and few formal court procedures. Further, a coroner may not determine or ‘appear to determine’ any question of civil or criminal liability.³ The coroner’s findings are not binding on any party and are without legal force: the coroner’s function is therefore primarily a fact-finding function.⁴

Although there is no overt mention in the *Coroners Act 1996* (WA) (‘the Coroners Act’) that the Coroners Court is inquisitorial (as opposed to adversarial) in nature, it has long been accepted as such.⁵ Certainly there is no question that the character of an inquest under the Coroners Act is inquisitorial.⁶ Indeed, s 41 of the Act permits a coroner to conduct an inquest in an inquisitorial manner by providing that a coroner is not bound by the rules of evidence and may ‘be informed and conduct an inquest in any manner the coroner reasonably thinks fit’.⁷ The powers listed under s 46 of the Coroners Act (such as the power to summon witnesses

and order them to answer questions) are also consistent with an inquisitorial jurisdiction.⁸

The Commission heard from the State and Deputy State Coroners that the legal profession, including the judiciary, in Western Australia 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.⁹ 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 in Western Australia. In light of evidence received from families and experts about the increasingly adversarial nature of coronial inquests and the detrimental effect of this approach, the Victorian Parliamentary Law Reform Committee (VPLRC) concluded that the inquisitorial nature of the coroners’ jurisdiction needed to be ‘strengthened and promoted’.¹⁰ While the VPLRC preferred to focus on training of coroners and counsel to resolve this issue, ultimately the Victorian Parliament determined that the inquisitorial nature of the Coroners Court should be made explicit in the *Coroners Act 2008* (Vic).¹¹ It appears that the Victorian Government’s rationale for this was that it was establishing a new court from what was an office of the executive with administrative status¹² and it wished to clearly delineate the Coroners Court from all other courts in the state.¹³ The Commission notes that no other jurisdiction has followed Victoria in explicitly entrenching its Coroners Court as an inquisitorial jurisdiction and that a September

1. Freckelton I, ‘Introduction’ in Freckelton I & Ranson D, *Death Investigation and the Coroner’s Inquest* (Melbourne: Oxford University Press, 2006) iiv.

2. Unlike an adversarial court, interested parties who appear at an inquest are not bound by the coroner’s findings: *Re the State Coroner; Ex parte the Minister for Health* [2009] WASCA 165, [21] (Buss J, Martin CJ and Miller JA agreeing).

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

4. Indeed, in *Perre v Chivell* [2000] SASC 279, [54], Nyland J states that the ‘jurisdiction of the coroner is limited to making findings of fact’.

5. See, eg, *R v South London Coroner; Ex parte Thompson* (1982) 126 SJ 625 (Lord Lane CJ); *Annetts v McCann* (1990) 170 CLR 596.

6. This is explicitly stated by the Court of Appeal in *Re the State Coroner; Ex parte the Minister for Health* [2009] WASCA 165, [21] (Buss J, Martin CJ and Miller JA agreeing).

7. *Coroners Act 1996* (WA) s 41.

8. *Re the State Coroner; Ex parte the Minister for Health* [2009] WASCA 165, [23] (Buss J, Martin CJ and Miller JA agreeing).

9. State Coroner and Deputy State Coroner, consultation (20 August 2008).

10. VPLRC, *Coroners Act 1985*, Final Report (2006) 592.

11. *Coroners Act 2008* (Vic) ss 1 (purposes) & 89 (establishment of the Coroners Court).

12. VPLRC, *Coroners Act 1985*, Final Report (2006) 586.

13. Victoria, *Parliamentary Debates*, Legislative Assembly, 9 October 2008, 4036 (Mr R Hulls, Attorney General).

2008 review of the *Coroners Act 1997* (ACT)¹⁴ received a lukewarm response to the question whether the jurisdiction should be statutorily described as inquisitorial. The ACT working group concluded that, among other things, the insertion of statements about the role and objectives of the coronial process was enough to clarify the nature of the jurisdiction.¹⁵

In the Commission's opinion there is no need in Western Australia to legislatively entrench the Coroners Court as an inquisitorial jurisdiction. As discussed earlier, there is no question that the Coroners Court of Western Australia is inquisitorial in its functions and the proposed objectives of the Act set out in Proposal 1¹⁶ clearly explain the role of the court. The Commission agrees with a submission to the ACT review that 'focus upon the inquisitorial function of the court is a matter to be shaped by the coroner's control of the proceedings'.¹⁷ The Commission therefore proposes that persons appointed as coroner be given specific training which, among other things, addresses the differences between the adversarial and inquisitorial systems of law. If the prevention role of coroners is to be accepted and embraced, such training should also include guidance in how to formulate meaningful recommendations. This is particularly important given that few legal practitioners would have experience in such matters. Further, given the different cultural beliefs and practices surrounding death, it is crucial that coroners (and coronial staff) receive cultural awareness training. This aspect of training is discussed in more detail in Chapter Seven.¹⁸

Training of those required to exercise functions under the Coroners Act has long been neglected in Western Australia. Significantly, as noted in the Background Paper, there is little or no training about the coronial jurisdiction offered to coronial investigators, coroners' registrars or magistrates required to exercise the jurisdiction

of coroner in regional areas.¹⁹ There is also, as Barnes pointed out in his 2008 review, very little by way of judicial guidance on the exercise of the coronial function from superior courts because coroner's decisions are so rarely appealed.²⁰ In these circumstances it is essential that comprehensive training is provided for new coroners and coroners' registrars.²¹ In making the following proposal the Commission notes that Victoria has legislated that the provision of professional development and training to coroners and coroners' registrars in that state is a responsibility of the State Coroner, and that directions can be made by the State Coroner to require coroners and coroners' registrars to participate in specified training.²²

PROPOSAL 12

Training of coroners and coroners' registrars

1. That the State Coroner provide for persons appointed as coroners to receive specific training in the coronial jurisdiction which, among other things, addresses the differences between the adversarial and inquisitorial systems of law; the prevention role of the coroner; guidance in the formulation of meaningful coronial recommendations; and training in cultural awareness.
2. That persons appointed as coroners registrars, or for whom a delegation of power under the Coroners Act is made, receive specific training about coronial practices and processes in Western Australia and in cultural awareness.

14. Legislation and Policy Branch, Department of Justice and Community Safety (ACT), *Review of the Coroners Act 1997*, Discussion Paper (September 2008).

15. Information provided by David Snell, Legislation and Policy Branch, Department of Justice and Community Safety (ACT).

16. See 'Objects of the Coroners Act', Chapter One above.

17. Information provided by David Snell, Legislation and Policy Branch, Department of Justice and Community Safety (ACT).

18. See Chapter Seven, 'Catering for a Culturally and Linguistically Diverse Community'.

19. LRCWA, *Review of Coronial Practice in Western Australia*, Background Paper (September 2010) 51. The Commission was also told during its consultation with regional magistrates that most did not know they were required to act as coroner when they were appointed as a magistrate and that many depended heavily on their court registrar to guide them in the role: Regional Magistrates, consultation (9 November 2009).

20. Barnes M, *Review of the Coroners Act 1996 (WA)* (August 2008) 16.

21. Proposals addressing the general education of the legal profession in coronial matters, and provision of training and information on the coronial system for healthcare professionals, coronial contractors and others are addressed in later chapters.

22. *Coroners Act 2008* (Vic) s 108.

Chapter Three

Reporting and Certification of Deaths

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Coroner's jurisdiction

The coroner's jurisdiction in Western Australia is statutory. Section 4 of the *Coroners Act 1996* (WA) ('the Coroners Act') provides that 'a rule of the common law that, immediately before the commencement of this section, would have operated to confer a power or impose a duty on a coroner or a coroners court ceases to have effect on or after the commencement of this Act'.

DEATHS

Exercise of the coroner's jurisdiction is predicated upon the occurrence of a death, which is defined in s 13C of the *Interpretation Act 1984* (WA) as:

When death of a person occurs

For the purposes of the law of this State, a person dies when there occurs—

- (a) irreversible cessation of all function of the person's brain; or
- (b) irreversible cessation of circulation of blood in the person's body.¹

Section 19 of the Coroners Act gives jurisdiction to Western Australian coroners to investigate deaths² 'if it appears to the coroner that the death is or may be a reportable death' under s 3 of the Coroners Act (set out below). A prerequisite to jurisdiction to investigate the death is that the death must be a Western Australian death. For the purposes of the Coroners Act, 'Western Australian death' is defined in s 3 to mean a death:

- (a) that occurred in Western Australia;
- (b) where the body is in Western Australia;
- (c) the cause of which occurred in Western Australia;
- (d) of a person who was ordinarily residing in Western Australia at the time of death; or

1. Until August 2008 Western Australia did not have a legislative definition of death. The current definition was enacted in response to the Commission's recommendation 3 in its *Review of the Law of Homicide* (September 2007).
2. Under s 3 of the *Coroners Act 1996* (WA) 'death' is defined to include a suspected death and thus all provisions of the Act applying to deaths apply equally to suspected deaths.

- (e) of a person who, at the time of death, was in an industry to and in relation to which the *Industrial Relations Act 1979* applies due to the operation of section 3 of that Act.³

Although this includes the deaths of Western Australian residents who have died elsewhere, the coroner is not required to investigate such deaths where an investigation is being held in another state or territory, unless directed to do so by the Attorney General.⁴

STILLBIRTHS

Under s 4 of the *Births, Deaths and Marriages Act 1998* (WA) ('the BDMR Act') 'stillbirth' means the birth⁵ of a stillborn child which in turn is defined as a child

- (a) of at least 20 weeks' gestation; or
- (b) if it cannot be reliably established whether the child's period of gestation is more or less than 20 weeks, with a body mass of at least 400 grams at birth,

that exhibits no sign of respiration or heartbeat, or other sign of life, immediately after birth.⁶

Where a child is stillborn and falls within the above definition, the doctor who was responsible for the care of the mother or who examined the body of the stillborn child after its birth must complete a Medical Certificate of Cause of Stillbirth or Neonatal Death.⁷ This is submitted to the Registrar of Births, Deaths and Marriages, along with the Death Registration Form, by the funeral director (or hospital) responsible for disposal of the deceased's remains.⁸ In 2010 there were 199 deaths of stillborn children

3. For a discussion about the jurisdiction of Western Australian coroners to investigate deaths in the Commonwealth Territory of Christmas Island, see Chapter Five, 'Mandated Inquests: Deaths in Commonwealth detention'.
4. *Coroners Act 1996* (WA) s 19(2).
5. Birth is defined as 'the expulsion or extraction of a child from its mother': *Births, Deaths and Marriages Act 1998* (WA) s 4.
6. This definition of stillborn is based on model legislation approved by the Standing Committee of Attorneys-General in 1995. All Australian states and territories feature the same or a substantially similar definition.
7. *Births, Deaths and Marriages Act 1998* (WA) s 44(2).
8. In order to register the death of the stillborn child, its birth must also be registered. In most circumstances, this is the

registered in Western Australia.⁹ The primary cause of stillbirth in Western Australia is congenital abnormality.¹⁰ Approximately 20% of fetuses over 20 weeks' gestational age are terminated because of 'lethal' congenital abnormality¹¹ and these are included in the figures for stillbirths.¹²

In Australia, no jurisdiction gives the coroner *explicit* power to investigate deaths of stillborn children. This echoes the position of the common law where stillborn children were considered to fall outside the coroner's jurisdiction because where there has been no independent life, there can be no death.¹³ However, it is noted that in Western Australia (as elsewhere) the Coroners Act specifically provides that common law rules in operation prior to its enactment 'cease to have effect'.¹⁴ In most jurisdictions (including Western Australia) the Coroners Acts make no mention of stillbirths, but in New South Wales and Queensland there is provision for a coroner to order a post mortem examination for the purposes of establishing whether a child is stillborn.¹⁵ If it is discovered that the child is stillborn then the coroner must immediately discontinue the investigation into the death and relinquish control of the body.¹⁶

The *Coroners Act 2008* (Vic) is the only Australian coronial legislation to expressly exclude stillbirths.¹⁷ This is in keeping with the determination of the Victorian Parliamentary Law Reform Committee in its *Review of the Coroners Act 1985*.¹⁸ However, the Commission notes that there was significant concern about

the exclusion of stillborns in parliamentary debates on the Coroners Bill 2008 in Victoria and an amendment to invoke coronial jurisdiction over stillborns of over 32 weeks' gestational age where the mother had requested the coroner to investigate the death was only narrowly defeated in the Legislative Council.¹⁹

As discussed earlier in this chapter, s 13C of the *Interpretation Act 1984* (WA), set out above, provides the definition of 'death of a person' for the purposes of the law in Western Australia. It is this reference to personhood that has governed the question whether the coroner's jurisdiction is invoked in relation to stillbirths that fall into the definition of reportable deaths under the Coroners Act. The most recent (and apparently the only) decision of a higher court in this area is a 2010 decision by the Full Court of the Supreme Court of South Australia – *Barrett v Coroner's Court of South Australia* – which decided the matter on the basis of the 'born alive' rule.²⁰ The born alive rule 'holds that for a fetus to achieve legal personhood, the infant must have been born alive'.²¹ It is established law in Australia that the born alive rule is satisfied by any indicia of independent life²² including evidence that the infant breathed, had a pulse or heartbeat or moved voluntarily.²³ In *R v Iby* (which applied the rule for the purposes of establishing whether a child who died in close proximity to birth could be the subject of a manslaughter charge), Spigelman CJ held that the born alive rule must now 'be applied consistently with contemporary conditions by affirming that *any* sign of life after delivery is sufficient'.²⁴ In *Barrett*, the Full Court of the Supreme Court of South Australia determined that evidence of pulseless electrical activity in the heart of a newborn²⁵ was sufficient to establish life. The baby, therefore, was considered a person the death of which invoked the jurisdiction of the coroner.²⁶

responsibility of the parents of the child: *Births, Deaths and Marriages Act 1998* (WA) s 15.

9. This is a reduction on previous years – in 2008, there were 218 stillborn deaths registered and in 2009 there were 229: Brett Burns, Registrar of Births, Deaths and Marriages (WA), email (2 March 2011).

10. Department of Health, *The 13th Report of the Perinatal and Infant Mortality Committee of Western Australia for Deaths in the Triennium 2005–2007* (February 2011) 106.

11. Alan Joyce, Acting Manager, Maternal and Child Health, Department of Health (WA), email (9 March 2011). Lethal congenital abnormality includes central nervous system and chromosomal abnormalities.

12. Terminations of fetuses over 20 weeks' gestational age in Western Australia must be approved by a ministerial panel: Department of Health, *The 13th Report of the Perinatal and Infant Mortality Committee of Western Australia for Deaths in the Triennium 2005–2007* (February 2011) 1.

13. *Levine on Coroner's Courts* (London: Sweet & Maxwell, 1999) 142.

14. *Coroners Act 1996* (WA) s 4.

15. *Coroners Act 2009* (NSW) s 89(2); *Coroners Act 2003* (Qld) s 19.

16. *Coroners Act 2003* (Qld) ss 12(2)(c) & 26(2)(c).

17. *Coroners Act 2008* (Vic) s 3.

18. VPLRC, *Coroners Act 1985*, Final Report (2006) 177–87.

19. Victoria, *Parliamentary Debates*, Legislative Council, Second Reading Debates on the Coroners Bill 2008, 2 December 2008, 5262–5394 (Mr Dalla-Riva).

20. *Barrett v Coroner's Court of South Australia* [2010] SASCFC 70.

21. *Ibid* [22].

22. *R v Iby* [2005] NSWCCA 178, [56].

23. *Barrett v Coroner's Court of South Australia* [2010] SASCFC 70, [24].

24. *R v Iby* [2005] NSWCCA 178, [65] (emphasis added).

25. Discernable by application of electrocardiogram.

26. *Barrett v Coroner's Court of South Australia* [2010] SASCFC 70.

Unlike South Australia, Western Australia's Coroners Act does not refer to death of 'a person' in the section that governs the jurisdiction of the coroner to investigate a death: it merely refers to 'a death'.²⁷ 'Death' is not independently defined in the Interpretation Act, which refers (as noted above) to 'death of a person'. Indeed, the only relevant Act that defines 'death' independent of the word 'person' is the BDMR Act, which includes stillborn in its definition of death.²⁸ While it is clear that this definition is confined to application for the purposes of registration of the death of a stillborn under the BDMR Act, the lack of reference to 'a person' in the jurisdictional sections of the Coroners Act may be enough to evoke uncertainty about whether the death of a stillborn is technically within the coroner's jurisdiction in this state.

In practice, it appears that in Western Australia the Office of the State Coroner has never considered stillborns to be within the coronial jurisdiction.²⁹ The Commission was advised that:

The philosophy is a person must be born alive in order to die, nevertheless it is not an issue that can be disregarded. The drawing of breath is the key to whether we have jurisdiction to deal with the death (provided it meets the requirements of Sect. 3) or not. A heart beat alone is not sufficient.³⁰

This interpretation of whether or not an infant is born alive such as to invoke the coroner's jurisdiction is obviously much narrower than that established in the precedents discussed above. It is also much narrower than the definition of stillborn in the BDMR Act, which refers to any 'sign of respiration or heartbeat, or other sign of life, immediately after birth'.³¹ In the Commission's opinion, this interpretation is open to challenge.

27. *Coroners Act 1996* (WA) s 19. Neither (and again, unlike South Australia) does it refer to person in the lead in to the definition of 'reportable death' in the *Coroners Act 1996* (WA) s 3. The relevant section of the Act merely states that 'reportable death means a Western Australian death – (a) that appears to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from injury'.

28. *Births, Deaths and Marriages Registration Act 1998* (WA) s 4. While all jurisdictions include stillborns in the definition of birth in their respective Births, Deaths and Marriages Acts, Western Australia is one of only two Australian jurisdictions to include stillborn children in the definition of death; the other being South Australia.

29. Manager, Office of the State Coroner (WA), email (2 March 2011).

30. *Ibid.*

31. *Births, Deaths and Marriages Registration Act 1998* (WA) s 4.

In the interests of certainty, the Commission proposes that the position of the coroner in rejecting jurisdiction over stillborn children should be legislatively clarified. This will require two changes to the current Act – the first being the addition of the words 'a person' in s 19 governing jurisdiction and the second being a declaration (similar to that in Victoria) that a stillbirth, as defined in s 4 of the BDMR Act is not a death for the purposes of the Coroners Act. In coming to this conclusion, the Commission notes that there is little utility in the coroner assuming jurisdiction over stillbirths in this state. Western Australia is fortunate to possess an excellent statutory body committed to the investigation and research of perinatal deaths. The Perinatal and Infant Mortality Committee of Western Australia investigates each death of a stillborn over the gestational age of 26 weeks where the stillbirth is not the known result of a termination.³² 'The membership of the Committee comprises a panel of experts, as prescribed by the *Health Act 1911* (WA), with the Chair being the Professor of Obstetrics at The University of Western Australia.'³³ Stillborn deaths (including homebirth deaths) are reported to the Committee by doctors, hospitals and midwives pursuant to established procedures under the *Health Act*.³⁴ These data are crosschecked with records from the Registry of Births, Deaths and Marriages. Each case is assigned a specialist medical investigator³⁵ who, after examining the medical notes and findings of post mortem examination,³⁶ compiles a report for the Committee about the circumstances of the death.³⁷ 'Each case is assessed for cause of death, possible preventable factors and other issues of public health significance. The Committee examines cumulative data obtained from analyses of deaths, along with broader statewide perinatal data, to propose recommendations aimed at reducing perinatal and infant mortality rates'.³⁸

32. Department of Health, *The 13th Report of the Perinatal and Infant Mortality Committee of Western Australia for Deaths in the Triennium 2005–2007* (February 2011) 1.

33. *Ibid* 16.

34. *Ibid.*

35. Current investigators include two general practitioner-obstetricians, a specialist neonatal paediatrician, a general practitioner and a specialist obstetrician: *ibid* 15.

36. A post mortem examination is conducted in almost 60% of perinatal and infant deaths: *ibid* 9.

37. The Committee uses these reports to provide feedback to the medical practitioner or midwife who provided clinical care in each case: *ibid* 16.

38. *Ibid.*

In view of the fact that individual specialist medical investigations independent of the hospital mortality and morbidity process are already undertaken in respect of each relevant death and the fact that the Committee makes preventative recommendations to government, including system-wide recommendations, the Commission can see no role for the coroner in this area.

PROPOSAL 13

Coroner's jurisdiction

1. That the section of the Coroners Act governing the jurisdiction of the coroner to investigate a death (currently s 19) explicitly refer to the 'death of a person' in order to bring the Coroners Act into conformity with the definition of 'When death of a person occurs' in s 13C of the *Interpretation Act 1984* (WA).
2. That the Coroners Act stipulate that a stillbirth, as defined in s 4 of the *Births, Deaths and Marriages Registration Act 1998* (WA), is not a death for the purposes of the Act.

REPORTABLE DEATHS

Under s 17 of the *Coroners Act 1996* (WA) ('the Coroners Act') a person is obliged to report to the coroner or a police officer a death that is, or may be, a reportable death immediately upon becoming aware of the death.³⁹ Section 3 of the Coroners Act defines 'reportable death' as 'a Western Australian death':

- (a) that appears to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from injury;
- (b) that occurs during an anaesthetic;
- (c) that occurs as a result of an anaesthetic and is not due to natural causes;
- (d) that occurs in prescribed circumstances;⁴⁰

39. Unless 'the person has reasonable grounds to believe that the death has already been reported': *Coroners Act 1996* (WA) s 17. See further 'Obligation to Report a Death', below.

40. To the Commission's knowledge, no circumstances have ever been prescribed under this section. Nonetheless, it is considered an essential tool to enable coroners to properly exercise their prevention role and to protect the public health. For example, some diseases (including new strains of exotic viruses) may lead to an expected death by natural causes, but for public health reasons it may be expedient and desirable to prescribe these deaths as reportable. This enables the coroner to investigate the connection between the disease and the

- (e) of a person who immediately before death was a person held in care;
- (f) that appears to have been caused or contributed to while the person was held in care;
- (g) that appears to have been caused or contributed to by any action of a member of the Police Force;
- (h) of a person whose identity is unknown;
- (i) that occurs in Western Australia where the cause of death has not been certified under section 44 of the *Births, Deaths and Marriages Registration Act 1998*; or
- (j) that occurred outside Western Australia where the cause of death is not certified to by a person who, under the law in force in that place, is a legally qualified medical practitioner.

Sub-section (a) is a general provision and forms the traditional jurisdiction of the coroner.⁴¹ Examples of deaths that fall into the categories 'unexpected, unnatural or violent or to have resulted, directly or indirectly, from injury' include suicides, traffic deaths, accidents, sudden unexplained deaths of infants, deaths following an injury or fall, deaths from drug overdose, unexpected deaths during or following a surgical procedure, deaths from drowning or electrocution and homicides. The remaining sub-sections are quite specific and relate to deaths that have occurred in certain definable circumstances. Sub-sections (e) and (f) refer to a 'person held in care', which is further defined in s 3 to mean:

- (a) a person under, or escaping from, the control, care or custody of—
 - (i) the CEO as defined in section 3 of the *Children and Community Services Act 2004*;
 - (ii) the Chief Executive Officer of the department of the Public Service principally assisting the Minister

deceased's exposure to environmental factors (among other things) and to order a post mortem examination which will improve the collection of data in the area. For example, the connection between mesothelioma deaths and contact with asbestos was the subject of a series of coronial investigations from 1989–1991, which resulted in greater public appreciation of the risks of asbestos. Although these deaths were expected and from natural causes, in the absence of a provision allowing for prescribed circumstances, the former Perth Coroner was required to declare the deaths 'unnatural' and advise the medical profession to report them to the coroner: David McCann, former Perth Coroner, correspondence (28 October 2009) 14–16.

41. Similar wording is found in Coroners Acts in all Australian jurisdictions, except for the Australian Capital Territory, whose legislation spells out in detail the types of deaths to fall under the coroner's jurisdiction.

- administering the *Prisons Act 1981* in its administration; or
- (iii) a member of the Police Force;
- (aa) a person for whom the CEO as defined in the *Court Security and Custodial Services Act 1999* is responsible under section 10, 13, 15 or 16 of that Act, whether that person is at a custodial place as defined in that Act, is being moved between custodial places or escapes, or becomes absent, from a custodial place or during movement between custodial places;
- (b) a person admitted to a centre under the *Alcohol and Drug Authority Act 1974*;
- (c) a person who is an involuntary patient within the meaning of the *Mental Health Act 1996*, or who is apprehended or detained under Part 3 of that Act;⁴² or
- (d) a person detained under the *Young Offenders Act 1994*.

The definition of 'person held in care' is discussed in detail in Chapter Five.⁴³ For present purposes it is sufficient to note that the Commission has proposed that the definition of 'person held in care' in the Coroners Act be separated into two categories: 'person held in custody' and 'person held in care'.⁴⁴ The proposed definition for each of these categories covers deaths that fall within the current definition of 'person held in care' as well as deaths in further defined circumstances (eg, deaths in Commonwealth detention). The Commission also emphasises that deaths of persons falling within the definitions of 'person held in custody'⁴⁵ and 'person held in care'⁴⁶ are reportable deaths for the purposes of the Coroners Act.⁴⁷

OBLIGATION TO REPORT A DEATH

Section 17 of the Coroners Act obliges a person to report a reportable death to either the coroner or the police immediately after becoming aware of the death.⁴⁸ Failure to do so is an offence. Section 17 provides:

42. This includes a person on a community treatment order under the *Mental Health Act 1996* (WA).
43. See Chapter Five, 'Mandated Inquests'.
44. As discussed in Chapter Five, the primary rationale for dividing deaths in care and deaths in custody for the purposes of the Coroners Act is to confine the circumstances under which a death in care must (mandatorily) be inquested to deaths in circumstances that raise issues about the deceased person's care. In contrast, deaths in custody must (mandatorily) be inquested regardless of the circumstances of the death.
45. 'Person held in custody' is defined in Chapter Five, Proposal 54.
46. 'Person held in care' is defined in Chapter Five, Proposal 55.
47. See Chapter Five, Proposal 53.2.
48. It is important to note that under s 19(1) a coroner has jurisdiction to investigate a death that falls under the definition of 'reportable death' in s 3 of the *Coroners Act 1996* (WA)

- (1) A person must report a death that is or may be a reportable death to a coroner or a member of the Police Force immediately after he or she becomes aware of the death, unless the person has reasonable grounds to believe that the death has already been reported.
Penalty: \$1 000.
- (2) A person to whom a death has been reported under subsection (1) must inform the State Coroner of the reported death immediately.
- (3) A doctor who is present at or soon after the death of a person must report the death immediately to a coroner if —
- (a) the death is or may be a reportable death;
- (b) the doctor is unable to determine the cause of death; or
- (c) in the opinion of the doctor, the death has occurred under any suspicious circumstances.
Penalty: \$1 000.
- (4) If more than one doctor is present at or soon after a death and one of them reports it to a coroner, the other doctors need not report the death but must give to the coroner investigating the death any information which may help the investigation.
- (5) The death of a person who, immediately before death, was a person held in care must be reported immediately to a coroner by the person under whose care the deceased was held.
Penalty: \$1 000.

In his 2008 review of the Coroners Act, Barnes highlighted the seriousness of the offence of failure to report a death and suggested that the current penalty of \$1,000 does not 'adequately signify the gravity of the offence'.⁴⁹ He also noted 'anecdotal evidence that the small amount of the maximum fine discourages police from taking any action to prosecute even blatant breaches' of the provision.⁵⁰ He recommended that the maximum penalty be increased to \$20,000 and one year's imprisonment.

The Commission's examination of other Coroners Acts reveals that Western Australia has the lowest penalty for failure to report a

- even if the death has not been reported to the coroner. A coroner may learn about such a death through media or other means.
49. Barnes M, *Review of the Coroners Act 1996* (WA) (August 2008) 24.
50. *Ibid.*

death. Only two jurisdictions – South Australia and the Australian Capital Territory – have a fine and imprisonment attaching to the offence of failure to report a death. All other Australian jurisdictions have monetary penalties of between \$1,100 and \$5,320. South Australia has the highest penalty at \$10,000 or two years' imprisonment.⁵¹ The Commission observes that penalties throughout the Coroners Act need to be increased to keep pace with other Australian jurisdictions and to highlight the seriousness of breaching offences that impact upon coronial investigation of deaths. It is clear from recent amendments to the Coroners Act that Parliament agrees that coronial offences warrant serious penalties: the offence of disobeying a coroner, inserted in 2004, carries a fine of \$100,000 and five years' imprisonment.⁵² Having considered penalties for similar offences in other jurisdictions, the Commission believes that a fine of up to \$10,000 or imprisonment for up to one year is appropriate for all three offences⁵³ of failing to report a reportable death currently contained in s 17 of the Coroners Act.

PROPOSAL 14

Increase penalties for failure to report a death

That the penalties for all three offences of failure to report a reportable death currently contained in s 17 of the Coroners Act be increased to \$10,000 or 12 months' imprisonment.

SUSPECTED DEATHS

Under the Coroners Act 'death' is defined to include a suspected death⁵⁴ and thus all provisions of the Act applying to deaths apply equally to suspected deaths. Section 23 of the Coroners Act provides that 'where a person is missing and the State Coroner has reasonable

51. *Coroners Act 2003* (SA) s 28(1).

52. *Coroners Act 1996* (WA) s 46A. Summary conviction of the same offence carries a fine of \$40,000 and two years' imprisonment.

53. There are three offences and concomitant penalty provisions currently contained in s 17 – the general failure to report; an offence specifically aimed at doctors present at or soon after the death failing to report; and an offence specifically aimed at persons responsible for a person held in care failing to report.

54. *Coroners Act 1996* (WA) s 3.

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 Western Australian coroners include suspected deaths by drowning where a body has not been recovered (eg, after a boating or fishing accident or following a failed rescue attempt), and cases of unlawful homicide where criminal proceedings have concluded and the victim's remains have never been found. Where a suspected death is investigated by the coroner an inquest must be held into the circumstances of the suspected death.⁵⁵ It is therefore classified as a mandated inquest.⁵⁶ Not all reports of suspected deaths are made by authorities; sometimes, suspected deaths are reported to the coroner by a family member many years after the disappearance of the person. Therefore, inquests may be held many years after the time of the suspected death.⁵⁷

In his 2008 review of the Coroners Act, Michael Barnes noted that there is no obligation in the Act to report a suspected death to the coroner.⁵⁸ He recommended the Act be amended to provide for a police officer to report a suspected death (which would otherwise be reportable) to a coroner.⁵⁹ The Commission sees merit in specifying this obligation in the Coroners Act.

PROPOSAL 15

Obligation to report a suspected death

That the Coroners Act provide that where a police officer has reasonable cause to suspect that a missing person has died and that the death would be reportable, the police officer must report the suspected death to the coroner.

55. *Coroners Act 1996* (WA) s 23(2).

56. The Commission discusses the current requirement that suspected deaths be subject to mandatory inquest: see Chapter Five, 'Mandated Inquests'.

57. Indeed, the Commission is aware of one inquest into a suspected death held 52 years after the person's disappearance.

58. The Commission notes that it is police policy to report the suspected death of a missing person 'where police believe on reasonable grounds that a missing person is deceased': Western Australia Police, *COPs Manual*, CR-10.8 'Persons Lost in Bush or at Sea'.

59. Barnes M, *Review of the Coroners Act 1996* (WA) (August 2008) 24.

ASSUMPTION OR REJECTION OF JURISDICTION

Even if a death is reported under s 17 of the Coroners Act, the coroner only assumes jurisdiction over the death 'if it appears to the coroner that the death is or may be a reportable death' as defined in the Coroners Act.⁶⁰ Therefore, the coroner has implicit power to determine whether or not a death is within the coronial jurisdiction. Similar provisions to that existing in Western Australia are found in the Northern Territory, Tasmania and New South Wales.⁶¹ However, recent reforms in Queensland and Victoria make the determination of whether a death notified to the coroner is a reportable death more explicit in their legislation, requiring written reasons to be given if a coroner determines that a death is not reportable.⁶² Both jurisdictions also provide for an appeal from a coroner's determination that a death is not a reportable death.⁶³ In Queensland a person dissatisfied with a coroner's decision that a death is not a reportable death may apply to the State Coroner for a review of the decision within 14 days of receiving the decision or, if the decision was made by the State Coroner, an application may be made to the District Court.⁶⁴ While in Victoria, an appeal may be made to a single judge of the Supreme Court within three months of the coroner's decision.⁶⁵

The Victorian provision was enacted in December 2008. Apart from a reference to the limited review rights in the previous Coroners Act there is no justification for the provision noted in parliamentary debates.⁶⁶ Certainly it was not recommended or, it appears, even discussed by the Victorian Parliamentary Law Reform Committee. The explanatory memorandum to the Coroners Bill 2008 (Vic) noted that an example of when a coroner may

determine that a death is not a reportable death is when a death certificate is provided by the deceased's doctor after the death is reported.⁶⁷ Presently, in Western Australia, this determination is made administratively – if it is apparent that the death was not unexpected or of a known natural cause and the coroner's office is advised that the deceased's doctor is away for a short time and cannot certify the death, then the body will be taken to the state mortuary to await the doctor's return.⁶⁸

The Queensland provision was inserted in late 2009 (along with other amendments) without any parliamentary debate on the matter. There is no explanation for the amendment either in the second reading speech or the explanatory memorandum to the Bill. The most recently enacted coronial legislation—the *Coroners Act 2009* (NSW)—declined to introduce a similar provision, preferring the more flexible approach currently taken in Western Australia. The Commission notes that the current approach to coroners determining reportability in Western Australia is efficient and effective. There has been no suggestion to the contrary either in the Commission's extensive consultations or in Barnes' 2008 review of the Act. To require written reasons from a coroner would, in the Commission's opinion, add an unnecessary burden upon a system that is already struggling for resources and in these circumstances the Commission suggests that the current method of assuming or rejecting jurisdiction over a death should remain.

60. *Coroners Act 1996* (WA) s 19(1).

61. *Coroners Act* (NT) s 14(1); *Coroners Act 1995* (Tas) s 21(1); *Coroners Act 2009* (NSW) s 21(1). The Australian Capital Territory does not employ the concept of reportable death in its legislation, instead specifying circumstances of death over which a coroner has jurisdiction, while the South Australian legislation arguably implies that the State Coroner may determine whether or not a notified death is reportable: *Coroners Act 2003* (SA) s 29.

62. *Coroners Act 2003* (Qld) s 11(2) read in conjunction with s 11A (inserted in 2009); *Coroners Act 2008* (Vic) s 16.

63. *Coroners Act 2003* (Qld) 11A; *Coroners Act 2008* (Vic) s 78.

64. *Coroners Act 2003* (Qld) 11A.

65. *Coroners Act 2008* (Vic) s 78.

66. Victoria, *Parliamentary Debates*, Legislative Council, 2 December 2008, 5263 (Mr Dalla-Riva).

67. Explanatory Memorandum, Coroners Bill 2008 (Vic) cl 16.

68. Hope A, 'Inside the Coroners Court' (2010) 37(1) *Brief: Journal of the Law Society of Western Australia* 8, 9.

Proposed changes to reportable death categories

ANAESTHETIC-RELATED DEATHS

In recent years questions have been raised by commentators and law reform bodies about the usefulness of a general category of anaesthesia-related deaths.¹ Significantly, it has been argued by professional bodies that the category can be confusing to doctors where anaesthesia is not a contributory factor to the cause of death.² In his 2008 review of the Coroners Act Barnes observed:

Currently the Western Australian Act makes reportable a death that occurs during an anaesthetic or as the result of an anaesthetic. This is a hangover from a time when this was the most dangerous aspect of surgery and fails to take into account the numerous other medical complications, failings or oversights which may contribute to a preventable death occurring in a hospital.³

Barnes recommended that a more specific criterion be created to deal with deaths in a medical setting.⁴ The Commission notes that recent reforms in New South Wales, Victoria and Queensland have replaced the category of anaesthesia-related deaths with categories that relate more specifically to medical procedure or healthcare-related deaths. The Commission agrees with these authorities that the category of anaesthesia-related deaths is outmoded and does not necessarily catch the types of medical adverse events that should be investigated by coroners. The Commission proposes that the category be removed and discusses a new category of healthcare-related deaths below.

1. See, eg, VPLRC, *Coroners Act 1985*, Final Report (2006) 108–14; Freckelton I & Ranson D, *Death Investigation and the Coroner's Inquest* (Melbourne: Oxford University Press, 2006) 172–3.
2. See, eg, discussion of the submission of the Victorian Council on Anaesthetic Mortality and Morbidity in VPLRC, *ibid* 108–9, and the submission of the New South Wales Regional Committee of the Australian and New Zealand College of Anaesthetists in New South Wales Parliament, *Second Reading Speech: Coroners Bill 2009*, 4 June 2009 (Mr J Hatzistergos, Attorney General).
3. Barnes M, *Review of the Coroners Act 1996 (WA)* (August 2008) 22.
4. *Ibid*. This issue is discussed further in the next section.

PROPOSAL 16

Removal of specific categories of anaesthesia-related deaths

That the categories that specify reportability of a death during an anaesthetic or as the result of an anaesthetic be removed from the Coroners Act.

HEALTHCARE-RELATED DEATHS

As noted above, several Australian jurisdictions have included healthcare-related or medical procedure related death provisions in their Coroners Acts. These include Queensland, Victoria, South Australia, New South Wales and the Australian Capital Territory.⁵ Of these, New South Wales and Queensland are the most recently enacted provisions, commencing in January 2010 and November 2009 respectively.

The *Coroners Act 2009* (NSW) was informed by an internal review that sought to improve the efficiency and effectiveness of the coronial jurisdiction in that state.⁶ Section 6 of the *Coroners Act 2009* (NSW) relevantly provides that a death is reportable if 'the person died in circumstances where the person's death was not the reasonably expected outcome of a health-related procedure'.⁷ Health-related procedure is defined as 'a medical, surgical, dental or other health-related procedure (including the administration of an anaesthetic, sedative or other drug), but does not include any procedure of a kind prescribed by the regulations as being an excluded procedure'.⁸ The *Coroners Regulations 2005* (NSW) expressly exclude a

5. *Coroners Act 2003* (Qld) s 8 & 10AA; *Coroners Act 2008* (Vic) ss 3 & 4; *Coroners Act 1996* (SA) s 3; *Coroners Act 2009* (NSW) s 6; *Coroners Act 1997* (ACT) s 13.
6. New South Wales Parliament, *Second Reading Speech: Coroners Bill 2009*, 4 June 2009 (Mr J Hatzistergos, Attorney General).
7. *Coroners Act 2009* (NSW) s 6(1)(e).
8. *Coroners Act 2009* (NSW) s 6(3).

number of defined health procedures 'that are undertaken in response to impending death [eg, resuscitation and palliative care measures⁹] to ensure that matters are not unnecessarily reported to the coroner'.¹⁰

Although the New South Wales provision is the most recently enacted in Australia, it was modelled on the former Queensland provision which was in force at the time the New South Wales Act was drafted. As noted below, this provision has since been amended to 'clarify the circumstances in which medical deaths are reportable and make it clear that a failure to provide health care is captured'.¹¹ It appears that amendment to the Queensland provision was made after the New South Wales Act was passed, but before it was proclaimed.¹²

Section 10AA of the *Coroners Act 2003* (Qld) was inserted in 2009 in response to the Queensland Public Hospitals Commission of Inquiry (the Davies Inquiry), which was precipitated by 13 deaths at Bundaberg Base Hospital attributed to unacceptable medical care by Dr Jayant Patel.¹³ Only two of these 13 deaths were reported to the coroner under the former provision,¹⁴ which was in the same terms as the current New South Wales provision set out above. The Davies Inquiry found that the terminology of 'reasonably expected outcome' in the original Queensland provision was ambiguous and open to broad interpretation.¹⁵

Section 3 of the *Coroners Act 2003* (Qld) now provides that a death is a reportable death 'if the death was a health care related death'. Section 10AA defines 'health care related death' as:

- (1) A person's death is a health care related death if, after the commencement, the person dies at any time after receiving health care that—
 - (a) either—
 - (i) caused or is likely to have caused the death; or
 - (ii) contributed to or is likely to have contributed to the death; and
 - (b) immediately before receiving the health care, an independent person would not have reasonably expected that the health care would cause or contribute to the person's death.
- (2) A person's death is also a health care related death if, after the commencement, the person dies at any time after health care was sought for the person and the health care, or a particular type of health care, failed to be provided to the person and—
 - (a) the failure either—
 - (i) caused or is likely to have caused the death; or
 - (ii) contributed or is likely to have contributed to the death; and
 - (b) when health care was sought, an independent person would not have reasonably expected that there would be a failure to provide health care, or the particular type of health care, that would cause or contribute to the person's death.
- (3) For this section—
 - (a) health care contributes to a person's death if the person would not have died at the time of the person's death if the health care had not been provided; and
 - (b) a failure to provide health care contributes to a person's death if the person would not have died at the time of the person's death if the health care had been provided.
- (4) For this section, a reference to an independent person is a reference to an independent person appropriately qualified in the relevant area or areas of health care who has had regard to all relevant matters including, for example, the following—
 - (a) the deceased person's state of health as it was thought to be when the health care started or was sought;

Example of a person's state of health—
an underlying disease, condition or injury and its natural progression
 - (b) the clinically accepted range of risk associated with the health care;
 - (c) the circumstances in which the health care was provided or sought.

9. *Coroners Regulations 2005* (NSW) reg 3A. Excluded procedures include intravenous therapy, insertion of a urethral catheter, insertion of a line or cannula, the giving of injections, acupuncture, cardio-pulmonary resuscitation and artificial ventilation.

10. New South Wales Parliament, *Second Reading Speech: Coroners Bill 2009*, 4 June 2009 (Mr J Hatzistergos, Attorney General).

11. Office of the State Coroner (Qld), *Guide to the 2009 Amendments to the Coroners Act 2003* (2009).

12. The Coroners Act 2009 (NSW) was passed on 19 June 2009 and commenced on 1 January 2010, while the *Coroners and Other Acts Amendment Act 2009* (Qld) was passed on 26 August 2009 and commenced on 2 November 2009.

13. *Queensland Public Hospitals Commission of Inquiry*, Report (2005) ch 1.

14. *Coroners Act 2003* (Qld) s 8(3)(d).

15. *Queensland Public Hospitals Commission of Inquiry*, Report (2005) 527.

Example for paragraph (c)—

It would be reasonably expected that a moribund elderly patient with other natural diseases would die following surgery for a ruptured aortic aneurysm.

(5) In this section—

commencement means the commencement of this section.

health care means—

- (a) any health procedure; or
- (b) any care, treatment, advice, service or goods provided for or purportedly for the benefit of human health.

Having examined the provisions relating to reportability of healthcare-related deaths in all relevant Australian jurisdictions,¹⁶ the Commission has determined that the Queensland provision represents the best and most comprehensive formulation. In the Commission's opinion it makes clear the circumstances under which deaths from a healthcare-related procedure should be reported and should encourage greater compliance in reporting by doctors of healthcare-related deaths. It also explicitly covers matters, such as deaths resulting from failure to treat, that remain unaddressed by the provisions in other states. In arriving at its conclusion the Commission notes the comments of the Health Consumers' Council¹⁷ and others consulted for this reference who identified ambiguity in the existing Western Australian provisions. The Commission also acknowledges the recommendation of Barnes in his 2008 review of the Coroners Act which encouraged the adoption of the (then draft) Queensland formulation.¹⁸

PROPOSAL 17

Reportability of healthcare-related deaths

That the definition of reportable death in the Coroners Act include a 'healthcare-related death' with a definition to be modelled on s 10AA of the *Coroners Act 2003* (Qld).

- 16. That is, where such provision exists, eg Queensland, Victoria, South Australia, New South Wales and the Australian Capital Territory.
- 17. Michele Kosky, Executive Director, Health Consumers' Council, correspondence (17 December 2009).
- 18. Barnes M, *Review of the Coroners Act 1996 (WA)* (August 2008) 22.

MENTAL HEALTH-RELATED DEATHS

The definition of a person held in care includes 'a person who is an involuntary patient within the meaning of the *Mental Health Act 1996*, or who is apprehended or detained under Part 3 of that Act'.¹⁹ This definition is not confined to inpatients of mental health facilities but includes a person on a leave of absence from an authorised hospital,²⁰ a person on a community treatment order²¹ and a person subject to a transport order under the *Mental Health Act*.²² Deaths of individuals in any of these circumstances are not only reportable under the Coroners Act, but are also subject to mandatory inquest.²³ In the Commission's opinion such provision is appropriate.

In its response to the Coroners Bill 2008 (Vic), the Federation of Community Legal Centres raised concerns about the reportability of deaths of persons following discharge from a mental health facility.²⁴ It was noted that 'people are often most vulnerable after discharge' and recommended that 'deaths should be reportable for at least eight weeks after discharge' from a mental health facility.²⁵ In response to this submission, an amendment was moved in the Legislative Council by a minor party seeking the insertion of a provision permitting family members to report a death of a person to the coroner if the person was discharged from a mental health service within three months of the person's death.²⁶ Although it was noted by members that the provision had 'no legal effect' because such deaths are already reportable as unexpected or unnatural deaths,²⁷ the amendment was ultimately passed to provide an opportunity for families to call attention to a possible link between the mental health service and the death.²⁸

- 19. *Coroners Act 1996* (WA) s 3.
- 20. *Mental Health Act 1996* (WA) s 59.
- 21. *Mental Health Act 1996* (WA) s 67.
- 22. *Mental Health Act 1996* (WA) s 71.
- 23. *Coroners Act 1996* (WA) s 22(1)(a).
- 24. Federation of Community Legal Centres (Victoria), submission to Victorian Parliament on the Coroners Bill 2008 (10 November 2008) 2.
- 25. *Ibid.*
- 26. Victoria, *Parliamentary Debates*, Legislative Council, 3 December 2008, 5395 (Ms S Pennicuik, Greens Senator).
- 27. See, eg, Victoria, *Parliamentary Debates*, Legislative Council, 3 December 2008, 5396 (Mr JM Madden).
- 28. Victoria, *Parliamentary Debates*, Legislative Assembly, 4 December 2008, 5036 (Mr Clark). See *Coroners Act 2008* (Vic) s 12(2).

The Commission notes that non-natural deaths of vulnerable persons discharged from a mental health service fall under the general definition of reportable death in Western Australia (ie, a death that is unexpected, unnatural or violent or to have resulted, directly or indirectly, from injury). Although this does not necessarily mean that the coroner will always be aware of the person's mental health history, the Commission was told that in Western Australia an informal arrangement exists where, in cases of suicide or suspicious death, the Coronial Investigation Unit (CIU) will contact the Office of the Chief Psychiatrist (OCP) to enquire whether the deceased had been in contact with mental health services in the years leading up to the death. If there is a record of contact, the CIU will request a report from the last mental health facility to deal with the deceased to inform the coronial investigation. In light of this arrangement, the Commission can see no benefit to amending the Coroners Act to provide for reporting of deaths by family. However, the Commission notes that the CIU does not investigate all coronial deaths in Western Australia and that vital information about a person's mental health history may therefore be missing from some coronial investigations. In these circumstances the Commission believes that the State Coroner should produce guidelines for police requiring that in all coronial investigations into suicides, drug deaths and deaths in suspicious circumstances, the police must liaise with the OCP to determine whether the deceased had contact with a mental health service in the five years preceding the death.

PROPOSAL 18

State Coroner's guidelines: investigation of possible mental health-related deaths

That the State Coroner produce guidelines for police requiring that in all cases of death by suicide, drug overdose or deaths in suspicious circumstances, the police should liaise with the Office of the Chief Psychiatrist to determine whether the deceased had any contact with mental health services in the five years preceding the death and if so, that the police should seek a report from the relevant mental health service about the condition and treatment of the deceased.

DEATHS OF PERSONS IN RESIDENTIAL CARE FACILITIES FOR THE DISABLED

In Chapter Five, the Commission discusses the peculiar vulnerability of people with profound or severe disabilities living in supported residential facilities.²⁹ In that chapter the Commission proposes that deaths of disabled people residing in residential care facilities that are operated by or wholly or partly funded either directly or indirectly by the Disability Services Commission be included in the definition of 'person held in care' under the Coroners Act.³⁰ Under the Commission's Proposal 53, these cases will be subject to mandatory inquest if the coroner believes that the circumstances of the death raise issues about the deceased person's care. However, for present purposes, it is noted that inclusion in the definition of 'person held in care' means that these deaths come within the definition of 'reportable death' in the Coroners Act.

29. See Chapter Five, 'Deaths in Residential Facilities for the Disabled'. For a discussion of systemic review of deaths of persons in residential disabled care facilities, see Chapter Four, 'Ombudsman Review of Certain Deaths'.

30. See Chapter Five, Proposal 55.

Reporting of deaths in practice

As discussed earlier, s 17 of the *Coroners Act 1996* (WA) ('the Coroners Act') applies generally to any person who becomes aware of a death, and specifically to doctors present at or soon after death and to a person under whose care or custody the deceased was held. Deaths may be reported either to a police officer or a coroner, unless the death is of a person held in care¹ in which case the death must be reported directly to a coroner. 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.² Under s 44 of the *Births, Deaths and Marriages Registration Act 1998* (WA), a doctor must 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.³

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,⁴ the doctor is advised if a death certificate will be accepted in respect of the particular death or whether the death is reportable and requires

a coronial investigation.⁵ 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.⁶ Once a death certificate is issued the coronial case falls away, unless information later comes to light to suggest the death is reportable.⁷ An example might be where an elderly person has died in hospital of a brain aneurysm, but the certifying doctor was not aware that the deceased had fallen and sustained an injury prior to admission. The possibility that the aneurysm (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, deaths from injuries, and mining and workplace accidents)⁸ 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,⁹ but police officers may only do so in cases where there is 'obvious death' (ie, in cases of extensive trauma, well-

1. 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. 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 an inability to reliably determine cause of death.
3. Special provisions apply in relation to certifying the deaths of stillborns and neonates: *Births, Deaths and Marriages Registration Act 1998* (WA) s 44(2) & (3).
4. 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 (though this decision is usually deflected to the Office of the State Coroner regardless of the location). These officers act as 'coroner's registrars' under delegation of power under s 10 of the Coroners Act. 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.

5. On the medical certificate of cause of death form (BDM202) there is a section which asks whether the death has been reported to the coroner. In cases where the doctor has discussed the death with the coroner's registrar and has been advised that a death certificate may be issued, the doctor is also advised to tick 'yes' to this question to show that the doctor has complied with the Coroners Act.
6. 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).
7. 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 in need of a full coronial investigation.
8. 'Non-natural causes' is the terminology employed by the Office of the State Coroner to describe these types of deaths.
9. 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).

established or advanced decomposition).¹⁰ 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 death¹¹ within 14 days of the date of death, finding of the deceased's body or 'placement'¹² 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.¹³

UNDERREPORTING OF CORONIAL DEATHS

A number of reviews and studies both in Australia and elsewhere have highlighted the possible underreporting or non-reporting of coronial deaths by medical practitioners and hospitals.¹⁴ In Western Australia, the Douglas Inquiry identified the need to improve systems of reporting in one public hospital and recommended that procedures be adopted to ensure appropriate reporting of deaths to the coroner.¹⁵ In its submission, the Health Consumers' Council identified 'ambiguity about under what circumstances a death resulting from a medical procedure should be reported' as a significant problem and urged the Commission to consider reforms to improve consistency of reporting of deaths in these circumstances.¹⁶ This position was supported

by the coroners' registrars in the Office of the State Coroner who explained that they were required to deal with a great many calls from doctors seeking clarification as to whether or not a particular death constituted a reportable death under the Coroners Act. The Commission also heard from a number of sources that, while small improvements to reporting of medical or healthcare-related deaths may have been made with the introduction of the 'death in hospital' form, medical practitioners' understanding of what constitutes a reportable death remains a concern in Western Australian hospitals.

The Queensland State Coroner's Guidelines¹⁷ are an important means of clarifying the reporting requirements of that state's Coroners Act. The guidelines are published online and provide an explanation of the coroner's role and the requirements of the Act, including a plain English explanation of what is a reportable death. The guidelines further provide detailed case examples of the types of deaths that fall into the various categories of reportability. This is an extremely useful tool for police, funeral directors and medical practitioners to guide their decisions about whether or not a death must be reported to the coroner.

In view of the proposed changes to reportability of deaths (detailed above), and in particular in light of the proposal to introduce a category of healthcare-related death, it is the Commission's view that the State Coroner should publish detailed guidelines to assist persons who may be required to report a death to comply with their reporting obligations under the Coroners Act.¹⁸ For new categories such as healthcare-related deaths, it will be necessary for the guidelines to step the reader through the process of determining whether a particular death is reportable.¹⁹ Legislative formulations should be interpreted and explained and examples should be provided. The Commission commends the Queensland State Coroner's Guidelines as a

10. See Coroners Court of Western Australia, 'Life Extinct Form'.
 11. 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.
 12. 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).
 13. *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.
 14. See, eg, Charles A et al, 'Under-reporting of Deaths to the Coroner by Doctors: A retrospective review of deaths in two hospitals in Melbourne Australia' (2007) 19 *International Journal for Quality in Health Care* 232; United Kingdom, *Death Certification and Investigation in England, Wales and Northern Ireland*, Final Report (Cmd 5831, June 2003) ('the Luce Report'); United Kingdom, *Death Certification and the Investigation of Deaths by Coroners*, Third Report (Cmd 5854, July 2003) ('the Shipman Inquiry'); Start RD et al, 'Clinicians and the Coronial System: Ability of clinicians to recognise reportable deaths' (1993) 306 *British Medical Journal* 1038; Ranson D, 'How Effective, How Efficient' (1998) 23 *Alternative Law Journal* 284.
 15. *Inquiry into Obstetric and Gynaecological Services at King Edward Memorial Hospital 1990-2000*, Final Report (November 2001) ('the Douglas Inquiry') recommendation 162.
 16. Michele Kosky, Executive Director, Health Consumers' Council, correspondence (17 December 2009).

17. Queensland State Coroner's Guidelines (December 2003) [3.1.1] <<http://www.courts.qld.gov.au/Factsheets/M-OSC-StateCoronersGuidelines.pdf>> (accessed 15 February 2010).
 18. For deaths of a 'person held in care' or a 'person held in custody' (pursuant to the Commission's proposed amendments), see discussion in Chapter Five and, in particular, Proposal 56.
 19. For example, in relation to healthcare-related deaths the Queensland State Coroner's Guidelines ask a series of questions to assist medical practitioners to establish whether a health procedure caused the death and whether death was an 'unexpected outcome' of the procedure. The answers to specific questions guide the practitioner in determining whether the death is reportable.

useful model for similar guidelines in Western Australia.

PROPOSAL 19

State Coroner's guidelines: reportable deaths

That the State Coroner, in consultation with medical advisers, develop comprehensive guidelines explaining the role of the coroner, detailing the categories of reportable deaths under the Coroners Act, interpreting key provisions or terms of the Coroners Act and providing examples of types of deaths that may fall into each of the categories of reportable death under the Coroners Act.

In addition to its comprehensive State Coroner's Guidelines, the Office of the State Coroner in Queensland conducted education sessions with medical professionals following changes to reporting requirements in that jurisdiction. This helped to heighten awareness of the amendments and the available guidelines.²⁰ The Commission understands that both the Manager of the Office of the State Coroner in Perth and the part-time medical adviser to the State Coroner have made presentations about the role of the coroner to medical professionals, highlighting their responsibilities in the reporting process. The medical adviser has also written a short 'handbook' on the coronial process in Western Australia for medical practitioners, which is available for download from the Coroners Court website.²¹ The Commission commends these initiatives and suggests that the Office of the State Coroner should work together with the Office of Safety and Health in the Department of Health and the Royal Australian College of General Practitioners to develop ways of appropriately delivering to Western Australian medical practitioners information about any relevant changes to their obligations under the Coroners Act.

PROPOSAL 20

Informing medical practitioners of relevant changes to the Coroners Act

That the Office of the State Coroner work together with the Office of Safety and Health in the Department of Health and the Royal Australian College of General Practitioners to develop ways of appropriately delivering to Western Australian medical practitioners information about any relevant changes to their obligations under the Coroners Act.

20. Brigita White, Director of the Office of the State Coroner (Qld), consultation (13 December 2010).

21. Turnbull R, *The Coronial Process in Western Australia: A handbook for medical practitioners and medical students* (June 2010).

Death certification

As noted above, under s 44 of the *Births, Deaths and Marriages Registration Act 1998* (WA), the doctor who was responsible for the person's medical care immediately before death or who has examined the deceased's body must provide a certificate as to cause of death within 48 hours of the death if the death is not reportable under the *Coroners Act 1996* (WA).¹ A non-reportable death in the community will usually be certified by the deceased's general practitioner, while a death in hospital will generally (but not always) be certified by a member of the team responsible for the patient's care.² Failure to provide a death certificate in these circumstances is an offence which carries with it a penalty of \$1,000.³ This penalty does not apply if the death is reported to the coroner.

AUTHORISING ISSUE OF CAUSE OF DEATH CERTIFICATE

If a death is or may be a reportable death it must, under s 17 of the *Coroners Act*, be reported to the coroner. In these circumstances an attending doctor is not permitted to issue a death certificate in relation to that death, even if the cause of death is known. In some cases, deaths which do not warrant a coronial investigation are reported to the coroner. Michael Barnes, the State Coroner for Queensland, has provided the following example of such a case:

A common example is a geriatric who fractures her femur as a result of a fall at home; goes to hospital; has the fractured [femur] successfully pinned but then dies from hospital acquired pneumonia 10 days later as a result of immobility. The peri-operative care of such cases poses significant challenges that

the health sector is actively engaging with. A coronial investigation into an isolated example of one such death is unlikely to assist that process.⁴

In this case, although the death may have been expected, it is unlikely that the woman would have contracted pneumonia had she not acquired it through her hospital visit and being immobilised. Therefore, the death is reportable as having 'resulted, directly or indirectly, from injury'.⁵ In his 2008 review of the *Coroners Act*, Barnes noted that 'nothing would be gained by conducting an autopsy' in these circumstances⁶ and recommended that the Act should be amended to provide that:

Notwithstanding that a death is reportable, the coroner to whom it is reported may authorise a medical practitioner to issue a cause of death certificate, without any autopsy examination being undertaken, if the cause of the death is sufficiently certain and the coroner is satisfied that no further investigation of the death is warranted.⁷

While the Commission agrees in principle with Barnes' recommendation, it notes that the proposed formulation permits a coroner to authorise a medical practitioner to issue a cause of death certificate in cases other than the type described by Coroner Barnes. There are many circumstances in which the cause of death may be sufficiently certain without the need to conduct a post mortem examination and these would include many suicides. It is possible that in some of these cases an inexperienced coroner may determine that no further investigation is warranted. A primary concern of the Commission is that important coronial data with regard to certain deaths (in particular, suicides) may be lost if coroners authorised the issuing of death certificates in circumstances wider than the example provided

1. Special provisions apply in relation to certifying the deaths of stillborns and neonates: *Births, Deaths and Marriages Registration Act 1998* (WA) ss 44(2) & (3).
2. The Commission's consultations with representatives of the Health Department and public hospitals indicated that if a death occurs after hours, certification may be done by a rostered medical officer who has not attended to the deceased and has no knowledge of his or her history: Health Department, consultation (30 September 2008).
3. *Births, Deaths and Marriages Registration Act 1998* (WA) s 44.

4. Barnes M, *Review of the Coroners Act 1996* (WA) (August 2008) 21–2.
5. *Coroners Act 1996* (WA) s 3 'reportable death'.
6. Barnes M, *Review of the Coroners Act 1996* (WA) (August 2008).
7. *Ibid.* Barnes recommended that this be inserted as a new subsection of the *Coroners Act 1996* (WA) s 19.

by Barnes. Further, in the Commission's opinion it should be made clear that any such authority must not be exercised in relation to a death in custody (as defined in Proposal 54) or in any other circumstances where an inquest to determine cause of death must mandatorily be held.⁸

The recommended amendment appears to be modelled on s 12(2)(b) of the *Coroners Act 2003* (Qld), which provides that a coroner must stop investigating a death if the coroner's investigation shows that a post mortem examination of the body is not necessary and the coroner decides to authorise a doctor to issue a cause of death certificate. The Commission has been informed by Barnes that, while in theory this provision may apply to any death (other than deaths in custody or where the identity of the deceased is unknown),⁹ in practice this provision is only utilised in Queensland for hospital deaths.¹⁰ Barnes advised that the 'vast majority of our usage relates to hospital deaths of very sick people in circumstances where reasonable minds might differ as to whether the procedure or the various co-morbidities were the dominant cause'.¹¹ Queensland has established comprehensive procedures which include the completion of a detailed form and the provision to the coroner of the deceased's discharge summary, recent hospital admission notes and draft cause of death certificate.¹² The doctor seeking to certify the death is also required to obtain input from the family and communicate to the coroner 'any concerns the family may have either in relation to the events which preceded hospitalisation or the care provided in hospital'.¹³ The State Coroner's Guidelines in Queensland make it clear that the body is to remain in the hospital mortuary until the coroner has determined whether or not a death certificate will be accepted.¹⁴ It appears that while a death certificate may be accepted

8. For example, in cases of a death of a person held in care where the circumstances of the death raise issues about the deceased person's care. See Proposal 53.4.

9. These deaths are expressly excluded by the *Coroners Act 2003* (Qld) s 12(2)(b)(i).

10. Michael Barnes, State Coroner Queensland, email (21 February 2011).

11. Ibid.

12. See Queensland's Form 1A <<http://www.courts.qld.gov.au/Forms/COR/COR-f-1A.pdf>>.

13. Michael Barnes, State Coroner Queensland, email (21 February 2011).

14. Queensland State Coroner's Guidelines (December 2003) [3.1.1] <<http://www.courts.qld.gov.au/Factsheets/M-OSC-StateCoronersGuidelines.pdf>> (accessed 15 February 2010).

in these cases (which means no investigations are undertaken and no findings are made by the coroner), the death still appears as a reportable death in coronial data and is therefore recorded in the National Coroners' Information System.¹⁵

An alternative approach is found in New South Wales where the *Coroners Act 2009* (NSW) provides for a medical practitioner (independently of the coroner) to issue a cause of death certificate in defined circumstances similar to the example provided by Barnes. Pursuant to s 38 of that Act a medical practitioner may certify death where the deceased was aged 72 years or older, and died after sustaining an injury in an accident that was attributable to the age of the person, contributed substantially to the death of the person and was not caused by the act or omission of any other person. The death must not have been a suspicious death, a death in care or custody or the unexpected outcome of a health-related procedure. Although the section does not require the medical practitioner to consult with family, he or she may not issue a cause of death certificate if there is an objection from a relative of the deceased. In those circumstances, the death must immediately be reported to the coroner.

While the New South Wales provision no doubt has a positive effect on coronial resources by removal of such cases from the coronial jurisdiction, the Commission is advised by the Office of the State Coroner that cases of deaths caused indirectly by injury are

the most common types of death that [are] either underreported, not reported or reported late ... Each case is different consequently [it] is highly recommended that such deaths are reported so that each case can be considered on its merits.¹⁶

The Commission also notes Barnes' point that it is desirable that deaths of elderly people that may be contributed to by an injury sustained in a fall be reported 'so that the family can

15. Michael Barnes, State Coroner Queensland, email (21 February 2011).

16. Manager, Office of the State Coroner (WA), email (24 February 2011). The Commission's consultations with representatives from the Health Department confirmed that deaths where there may have been a fall preceding the death caused the most confusion in relation to whether a death was reportable. It was noted that many doctors judged it (erroneously) on whether the fall was accidental or suspicious.

confirm that there was nothing suspicious about the fall and that they are happy with the treatment their elderly relative received at the hospital'.¹⁷ The Commission therefore proposes that a provision be inserted in the Coroners Act as recommended by Barnes. However, in the Commission's opinion the exercise of such authority should be expressly confined so that it does not apply to persons held in custody or care (as defined in Proposals 54 and 55). In the Commission's view the power to authorise the issue of a cause of death certificate should be a non-delegable power under the Coroners Act. The Commission notes that the State Coroner has access to in-house medical advisers¹⁸ and expects that they will greatly assist in training coroners to recognise appropriate cases for the exercise of this power. The Commission also proposes (in Chapter Four) the establishment of a specialist investigation team to assist the coroner in the investigation of healthcare-related deaths.¹⁹

In Queensland in 2010 approximately 700 deaths (of 4500 total reportable deaths) were finalised by a coroner-authorized cause of death certificate.²⁰ Of the 506 deaths currently under investigation by the Western Australia Police Coronial Investigation Unit, 138 (or 27%) are hospital deaths.²¹ Coronial police estimate that between 70% and 80% of hospital deaths are of elderly people and are attributed to complications following falls in uncontroversial circumstances.²² Unfortunately, the completion of investigations in these cases is often delayed because deaths with more pressing investigation needs will generally take priority. Therefore many families—even those who have no questions or concerns about the death of their elderly relative—must wait a significant time to receive a coronial finding and

finalise their relative's affairs. The Commission therefore expects that the following proposal, if implemented, will significantly improve the experience of the coronial system for families of deceased in these circumstances. In addition, it will permit the Coronial Investigation Unit and the coroner to concentrate their efforts on those cases where questions or concerns surround the circumstances of death or where the coronial investigation may inform strategies to prevent future deaths in similar circumstances.

PROPOSAL 21

Authorisation to issue a cause of death certificate

That notwithstanding that a death is a reportable death under the Coroners Act, a coroner be permitted to authorise a medical practitioner to issue a cause of death certificate, without any post mortem examination being undertaken, if—

- (a) the death is not a death of a person held in care or a person held in custody; and
- (b) the cause of the death is sufficiently certain; and
- (c) the coroner is satisfied that no further investigation of the death is warranted.

The Commission further proposes that the State Coroner issue guidelines outlining the circumstances in which this authority may be exercised by a coroner and any procedures that must be observed by the medical profession. In addition, the Commission proposes a review of the current Death in Hospital Form to incorporate any changes to reporting requirements under the Coroners Act,²³ and to provide for a requirement that a doctor obtain input from family members about any concerns regarding events leading to hospitalisation and the treatment of the deceased in hospital. The Commission commends the Queensland Form 1A²⁴ and accompanying guidelines to the State Coroner and suggests that a similarly

17. Barnes M, *Review of the Coroners Act 1996 (WA)* (August 2008) 22.

18. There are currently two part-time medical advisers attached to the Coroners Court. Together they work two-and-a-half days per week.

19. See Chapter Four, 'Deaths in Healthcare Facilities'.

20. Michael Barnes, State Coroner Queensland, email (21 February 2011).

21. Data as at 6 April 2011: Detective Sergeant Rohan Ingles, email (6 April 2011). Hospital deaths also represent 56% of all death scenes attended by the Coronial Investigation Unit. Scene attendance for hospital deaths therefore represent a significant amount of policing hours, especially where deaths are in hospitals in the outer-metropolitan area. In the Commission's opinion, this is a questionable use of police time in non-controversial cases.

22. Detective Sergeant Rohan Ingles, Coronial Investigation Unit, consultation (5 April 2011)

23. In particular any changes to encompass a category of healthcare-related deaths as proposed by the Commission (Proposal 17).

24. See <<http://www.courts.qld.gov.au/Forms/COR/COR-f-1A.pdf>>.

comprehensive procedure be established in Western Australia.

PROPOSAL 22

State Coroner's guidelines: authorisation to issue a cause of death certificate

That the State Coroner, in consultation with medical advisers, produce guidelines outlining the circumstances in which a coroner may authorise a medical practitioner to issue a cause of death certificate in relation to a reportable death including any procedures that must be observed by medical practitioners seeking authorisation to certify a death.

PROPOSAL 23

Review of Death in Hospital and Medical Cause of Death forms

1. That the State Coroner, in conjunction with the Department of Health and relevant stakeholders, should review the current 'Death in Hospital' form to incorporate changes to reporting requirements under the Coroners Act, and to provide for a requirement that a doctor obtain input from family members about any concerns regarding events leading to hospitalisation and the treatment of the deceased in hospital.
2. That the State Coroner should review the current 'Medical Certificate of Cause of Death' (Form BDM 202) to provide, among other things, for the certifying doctor to note, in the case of a reportable death, on whose authority the cause of death certificate was issued.

THE SHIPMAN PHENOMENON

In 2000 Dr Harold Frederick Shipman, a general practitioner in England, was convicted of the murder of 15 of his patients and sentenced to life imprisonment.²⁵ During investigation of

these crimes many other potential murders were also discovered by police.²⁶ Soon after his conviction, a public inquiry was announced to be chaired by High Court judge Dame Janet Smith. This inquiry has become known as the Shipman Inquiry. The first report of the Shipman Inquiry found that Shipman had 'killed at least 215 of his patients over a period of 24 years'.²⁷ It described a typical Shipman killing as consisting of an intravenous injection of a strong opiate after which the body would be 'discovered' by Shipman and a death certificate issued by Shipman citing natural causes.²⁸ The majority of Shipman's victims were cremated. In this way, Shipman eluded coronial investigation of the deaths in all but two cases.

Among other things, the Shipman Inquiry uncovered a number of systemic failings in relation to the medical certification of cause of death and certification for cremation. These matters, along with the role of the coroner, were the subject of the third report of the inquiry. They were also the subject of a fundamental review commissioned by the United Kingdom government which ran in tandem with, and reported just one month prior to, the third report of the Shipman Inquiry.²⁹ Both reports noted the need for training and expertise in the coronial system and medical profession, and clarification of the types of deaths that should be reported to coroners.³⁰ The fact that doctors were given very little assistance in death certification was also noted.³¹ In addition, recommendations were made about auditing and supervising death certification

25. See <<http://www.the-shipman-inquiry.org.uk/backgroundinfo.asp>> (accessed 24 February 2011).

26. The deaths only came to light in 1998 after a fellow general practitioner reported the excessive number of deaths among Dr Shipman's elderly patients to the coroner. While the police investigation at that time was inconclusive, Shipman came to the attention of police again soon after following the death of an elderly patient whose forged will purported to leave Shipman an entire and substantial estate.

27. United Kingdom, *Death Certification and the Investigation of Deaths by Coroners* ('the Shipman Inquiry'), Third Report (Cmd 5854, July 2003) v; First Report (Cmd 5854, July 2002) 26. The Shipman Inquiry investigated a total of 887 deaths believed to be linked to Dr Shipman. Dame Janet Smith gave written decisions in respect of 493 cases where some suspicion attached to the circumstances of death. Of these, 215 deaths were found to be attributable to the actions of Dr Shipman.

28. The Shipman Inquiry, First Report (Cmd 5854, July 2002) 200. Shipman's victims were primarily elderly women who died alone, at home, and had not been particularly ill before death: The Shipman Inquiry, Second Report (Cmd 5854, July 2003) 2.

29. United Kingdom, *Death Certification and Investigation in England, Wales and Northern Ireland: The report of a fundamental review*, Final Report (Cmd 5831, June 2003) ('the Luce Report').

30. See, eg, *ibid*, 34; the Shipman Inquiry, Third Report (Cmd 5854, July 2003) 490–2.

31. The Luce Report, *ibid* 42; the Shipman Inquiry, *ibid* 502.

by doctors.³² The Luce Report recommended a system whereby a medical assessor attached to the office of the coroner audited death certificates, while the Shipman Inquiry recommended that all deaths be reported to the coroner which would take responsibility for death certification. In 2010 the United Kingdom government unveiled its program to introduce a unified system of death and cremation certification which includes scrutiny of death certificates issued by doctors (ie, outside the coronial process) by government-appointed medical examiners.³³ The reforms are due to commence in April 2012.³⁴

In Australia, the recommendations of both the Shipman Inquiry and the Luce Report have been considered in detail by the Victorian Parliamentary Law Reform Committee (VPLRC). The VPLRC recommended its own review process for death certification by doctors with certificates audited by medical specialists at the Victorian Institute of Forensic Medicine.³⁵ These recommendations were not implemented by the legislative reform process following the VPLRC report.

Changes to requirements of death certification

It has been observed by those responsible for the reforms in England that there is no way to guarantee that there will never be another Shipman, even under the system that has been developed in response to his appalling crimes.³⁶ Substantial safeguards (such as three 'independent' doctors signing a cremation certificate containing cause of death)³⁷ were in place to prevent unscrupulous practice at the time of Shipman, and yet his crimes were

so subtle as to escape detection for 24 years. The Chair of the Shipman Inquiry declared that she was not confident that he would ever have been caught, but for his 'grossly incompetent forgery' of a patient's will purportedly leaving her entire estate to Shipman.³⁸ That patient's death was the last that Shipman certified.

Of course, a review by an independent medical expert of every death certificate issued by a doctor would provide the highest possible level of scrutiny. But, as observed by others, such a system would be extremely resource intensive³⁹ and may have unintended consequences of delaying burial or cremation unnecessarily. However, the Commission observes that there are less resource-intensive procedural reforms that can substantially assist in improving the degree of underreporting or non-reporting of coronial deaths. As noted above, one of the major conclusions of both the Shipman Inquiry and the Luce Report was that doctors were not professionally trained in death certification and that there was a lack of clarity about what was a reportable death. A 1992 study in Western Australia found that many 'major errors' in the completion of death certificates arose from a misunderstanding by doctors of the certification process.⁴⁰ In particular, confusion between the cause and the mechanism of death was rife leading to 16% of certificates being 'completed in such a manner that the underlying cause of death was either unclear or misplaced'.⁴¹ It was highlighted that 'little attention has been paid to the mundane but important consideration of whether the diagnosis once arrived at is correctly transposed onto the certificate'.⁴²

While this study was directed toward the collection of accurate cause of death data, confusion between cause and mechanism of

32. The Luce Report, *ibid* 44; the Shipman Inquiry, *ibid*.

33. Department of Health (UK), *Improving the Process of Death Certification in England and Wales: Overview of Programme* (January 2010).

34. Department of Health (UK) <<http://www.dh.gov.uk/en/Managingyourorganisation/DeathCertification/index.htm>> (accessed 24 February 2011).

35. VPLRC, *Coroners Act 1985 - Final Report* (2006) recommendations 7-14.

36. Department of Health (UK) <http://www.dh.gov.uk/en/Managingyourorganisation/DeathCertification/FAQ/DH_084878> (accessed 24 February 2011).

37. These include the signatory of the Certificate of Medical Attendant (usually the doctor who certifies the death), the signatory of the Confirmatory Medical Certificate and the signatory of the Authority to Cremate. Each of these forms has multiple questions relating to the cause of death and the independence of the signatories from the deceased and the certifying doctor. See the Shipman Inquiry, Third Report (Cmd 5854, July 2003) ch 11.

38. The Shipman Inquiry, First Report (Cmd 5854, July 2002) 200.

39. VPLRC, *Inquiry into the Coroners Act 1985*, evidence of Dr Ian Freckelton (20 September 2005) 208.

40. Weeramanthri T & Beresford B, 'Death Certification in Western Australia: Classification of major errors in certificate completion' (1992) 16 *Australian Journal of Public Health* 431, 431.

41. *Ibid* 432 & 434. The study found no significant variance between the rate of error in city and country areas, nor between teaching hospitals and other locations.

42. *Ibid* 431. The Commission notes that the current instructions to doctors completing the Medical Certificate of Cause of Death (BDM202) ask the doctor to specify the disease or condition directly leading to the death and the antecedent or underlying causes of death. Examples of such causes are noted in the instructions of how to complete a death certificate.

death⁴³ or failure to specify the underlying cause of death⁴⁴ is an area that can contribute to a decision by a doctor as to whether a death is reportable to the coroner.⁴⁵ A number of proposals in this Discussion Paper seek to address concerns about underreporting or non-reporting of coronial deaths. These include better information for medical practitioners,⁴⁶ coroners and coronial investigators; the issuing of comprehensive coronial guidelines to assist the coronial investigation process and to assist medical practitioners in determining whether a death is reportable; and the proposed procedures surrounding coronial authority to issue a death certificate in certain cases (discussed immediately above). Further, the Commission has proposed that the penalty for failure to report to the coroner a reportable death be increased to a \$10,000 fine or 12 months' imprisonment. This significant increase in penalty should act as some deterrent to doctors who may otherwise be less than attentive in ensuring the accuracy of cause of death certificates issued in their names.

In his 2008 review of the Coroners Act, Barnes noted that there was a need for 'more rigour around the circumstances in which a certificate may issue'.⁴⁷ He suggested that it may be appropriate for the issuing doctor to be required to undertake an external examination of the body whenever practicable. Further, and probably in recognition of the fact that many deaths in hospitals are currently certified by junior doctors or registrars, he suggested that there be a requirement that the certifying doctor state that he or she is satisfied that the 'care provided by the attending doctor ... was

reasonable and had no bearing on the death'.⁴⁸ And finally, Barnes suggested that the cause of death certificate should require the doctor to state why the death is not reportable and contain a reference to the offence of failing to comply with the reporting requirements of the Coroners Act.⁴⁹

The Commission believes that all of these suggestions are sensible; however, it seeks submissions about whether these requirements are practical and whether, in the wake of Shipman, any other requirements should be placed upon doctors seeking to certify a death.

QUESTION A

Requirements in relation to death certification

1. The Commission seeks submissions on whether the cause of death certificate should require a certifying doctor to:
 - (a) Undertake an external examination of the deceased's body, where practicable, and note any observations on the death certificate.
 - (b) State (if the death was a hospital death) that he or she is satisfied that the care provided by the attending doctor was reasonable and had no bearing on the death.
 - (c) State why, in his or her opinion, the death is not reportable to the coroner under the terms of the Coroners Act.
 - (d) Acknowledge that he or she is aware that it is an offence to fail to report a reportable death under the Coroners Act.
2. Should any other requirements be placed upon a doctor seeking to issue a cause of death certificate?

43. Cause of death is defined as the pathological condition that produced death, while mechanism of death refers to the physiological changes that led to death: Iyer P (et al), *Medical Legal Aspects of Medical Records* (Arizona: Lawyers and Judges Publishing Co, 2006) 880.

44. That is, the disease or injury which acted through an unbroken chain of events to cause the death: Bryant CD, *Handbook of Death and Dying* (California: Sage, 2003) 527.

45. For example, in the case discussed above of the old lady who dies of hospital-contracted pneumonia following an operation to pin her fractured femur, the immediate cause of death would be pneumonia, the mechanism of death would likely be respiratory failure, while the underlying proximate cause of death was the fractured femur.

46. The Commission notes that orientation for the interns in the major hospitals covers coronial reporting and preparation of death certificates, but otherwise training of future medical practitioners is often limited to an elective course at university.

47. Barnes M, *Review of the Coroners Act 1996 (WA)* (August 2008) 21.

48. *Ibid.*

49. *Ibid.*

Death registration

NOTIFICATION OF A DEATH

Section 42 of the *Births, Deaths and Marriages Registration Act 1998* (WA) ('the BDMR Act') requires the funeral director responsible for disposal of a deceased's remains or the scientific institution where a deceased's remains are 'placed' for the purpose of education or research, to notify the Registrar of Births, Deaths and Marriages of the particulars required to register the death.¹ In cases of suspected death for which an inquest has been held, the coroner must officially notify the Registrar.² The Death Registration Form asks whether a coronial inquiry is pending in relation to the deceased and this is recorded on the register as an 'incomplete' death registration.³ Notification enables registration of the death, which is required to effect probate or to issue a formal death certificate for other purposes. The penalty for failing to notify the Registrar of a death is \$1,000.

The Commission has recently been informed of a number of cases where the Registrar has not been notified of a death by the funeral director.⁴ Many of these cases are coronial cases and the registry is therefore only formally apprised of the death when the coronial findings are received: this may be some years after the death.⁵ Because a prosecution under s 42

must be commenced within 12 months of the date the offence was allegedly committed,⁶ there are few successful prosecutions under this section for deaths the subject of coronial inquiry.⁷ The Commission understands that since mid-2010 the Office of the State Coroner has forwarded copies of the 'daily death list' to the registry of Births, Deaths and Marriages to advise the cases being dealt with by the coroner.⁸ The Registrar of Births, Deaths and Marriages submitted that it would be useful if, in addition to this information, the coroner could advise to whom the deceased's body was released in all coronial cases.⁹ Generally, this will be the funeral director who is responsible for notification under the BDMR Act and this will allow the Registrar to commence prosecution in a timely manner if notification obligations are not complied with.

PROPOSAL 24

Coroner to inform Registrar of Births, Deaths and Marriages of certain information

That, in addition to the name, age and date of death of a deceased who is the subject of a coronial inquiry, the Office of the State Coroner or regional coroner's registry inform the Registrar of Births, Deaths and Marriages to whom the deceased's body is released.

1. Within 14 days of the death or of finding the body. Notification is done either by completing a copy of the death registration form or by lodging the relevant information online and forwarding a copy of the signed Medical Certificate of Cause of Death. Approximately 80% of deaths are registered online by funeral directors: Rohan Quinn, Registration Manager, Registry of Births, Deaths and Marriages, consultation (6 August 2010).
2. *Births, Deaths and Marriages Registration Act 1998* (WA) s 43.
3. In such a case there will be no Medical Certificate of Cause of Death and cause of death will be confirmed by the coroner when his or her findings are made. For further discussion, see 'Impact of Delays in Death Registration', below.
4. Rohan Quinn, Registration Manager, Registry of Births, Deaths and Marriages, consultation (6 August 2010). The Commission is aware of a number of cases of failure to notify a death by an East Kimberley funeral director who also held the contract for coronial transportation services.
5. Approximately 44% of current non-notified cases are coronial cases: Brett Burns, Registrar, Registry of Births, Deaths and Marriages, email (2 March 2011).

6. That is, 12 months and 14 days after the date of death. See *Criminal Procedure Act 2004* (WA) s 21(2).
7. Instead most prosecutions are commenced under s 50(2) of the *Births, Deaths and Marriages Registration Act 1998* (WA) by the Registrar seeking information by way of notice. If the notice is not complied with a prosecution can commence and the same penalty applies.
8. Brett Burns, Registrar, Registry of Births, Deaths and Marriages, email (2 March 2011).
9. Ibid.

NOTIFICATION OF CORONER'S DETERMINATION

Section 28(1) of the *Coroners Act 1996* (WA) ('the Coroners Act') provides that 'a coroner investigating a death must notify the Registrar of Births, Deaths and Marriages as soon as possible of the particulars found by the coroner which are needed to register the death'. During the Commission's initial consultation with the Registrar of Births, Deaths and Marriages, concerns were expressed about the possibility that the Registrar was not being notified of all the information required to register a death the subject of a coronial inquiry. An audit of Births, Deaths and Marriages records undertaken by the Registrar in 2008 showed a number of deaths between 1994 and 1997 which had been finalised by a coroner but where the particulars required to register the death in full (ie, the cause of death) had not been communicated to the registry. Burial records and initial registry notifications showed that a number of files that had purportedly been investigated by the coroner were not able to be found in the coroner's system (and may not have been reported) and a further number were confirmed by the coroner as having been reported but the files were no longer recoverable.¹⁰ As noted in the Commission's Background Paper, the Office of the State Coroner was without adequate computerisation of records until relatively recently and this may have contributed to the failure to recover information in respect of these deaths.¹¹ The Commission also notes that the deaths in question were during a time of flux in the coronial system when the legislation governing the current system was being developed and implemented. Nonetheless, it highlights the need for regular communication and sound information sharing practices between the Office of the State Coroner and Registry of Births, Deaths and Marriages.¹²

A major finding of the Shipman Inquiry and the Luce Report in the United Kingdom was that the

10. Registry of Births, Deaths and Marriages, consultation (26 September 2008).
11. LRCWA, *Review of Coronial Practice in Western Australia*, Background Paper (September 2010) 49.
12. As noted above, information sharing between the Office of the State Coroner and the Registry of Births, Deaths and Marriages has improved over the past 12 months by the institution of daily updates about deaths referred to the coroner. This is good practice and the Office of the State Coroner is to be commended.

systems of death certification, death registration and coronial investigation were so separate that 'there was little to stop an unscrupulous doctor from certifying his way out of trouble'.¹³ Internal fragmentation was also a major issue with a great many coronial registries and death registries working completely independently of each other. In Western Australia we are fortunate to have a unified coronial system under the coordination of a State Coroner and a single registry of Births, Deaths and Marriages. In order to ensure that death certification and registration is effective and accurate, ongoing attention needs to be paid to the relationship between the State Coroner and Registrar of Births, Deaths and Marriages and to ways in which both entities can work together to improve death registration processes.

IMPACTS OF DELAY IN DEATH REGISTRATION

As noted earlier, in coronial cases the lack of necessary particulars to successfully register a death will mean that the registration is designated as 'incomplete'; full registration (and a complete death certificate) will follow after the coroner has made a finding about the cause of death.¹⁴ This may be some years after the death. While this delay will not usually affect the granting of probate,¹⁵ it may affect the payout of insurances which often require formal certification of cause of death.¹⁶ A small number of family members of deceased people the subject of coronial inquiry have informed the Commission about the impact of delay in the coronial process on their ability to finalise

13. United Kingdom, *Death Certification and Investigation in England, Wales and Northern Ireland: The report of a fundamental review*, Final Report (Cmd 5831, June 2003) ('the Luce Report') 16.
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. If a death certificate is issued before the coronial investigation is complete it will be endorsed 'in a manner that the Registrar considers appropriate to indicate that fact': s 48(4).
15. The only issues that will affect the granting of probate after notification but prior to the completion of death registration will be if the date of death is unknown or if a beneficiary of the will is implicated in the deceased's death: Trevor Ormesher, Coordinator Probate Office, Supreme Court of Western Australia, consultation (25 February 2011).
16. While a death certificate may be ordered on an 'incomplete' death registration, the certificate will not show a cause of death unless such cause has been provided by the coroner: Registry of Births, Deaths and Marriages, consultation (26 September 2008).

the deceased's affairs. For example, one family member advised the Commission:

As the executor of my late sister's estate, I have had to borrow \$20,000 to fund her funeral and arrange for the return of her furniture, car and personal effects to Victoria. In addition to this, I have the responsibility for her mortgage, council rates, storage fees and other bills. I have my own mortgage and associated financial responsibilities, and I am currently doing this on an average income. My sister had taken out mortgage insurance at the insistence of the lender when she applied for her home loan. ... the Bank won't pay out her mortgage insurance until they are supplied with copies of the final death certificate and the Coroner's Report. Likewise, her superannuation fund.¹⁷

At the time of writing the above submission to the Commission, an interval of two years had passed since the death of the deceased. As can be seen from the submission, any excessive delay can represent a significant burden for families.

The Commission was advised by the Registrar of Births, Deaths and Marriages that in the past an interim coronial determination was made available to the Registrar in every case for the purposes of enabling registration. It included the name of the person, age, date of death, place of death and interim cause of death. In many cases the interim determination was non-specific as to cause of death (eg, 'multiple injuries sustained in a motor vehicle accident') or may have simply noted the mechanism of death rather than the cause (eg, motor vehicle accident). While the registration remained incomplete until a full coronial finding was made, the interim determination did enable the registry to issue a death certificate that apparently satisfied the needs of families, insurance companies and others. The Commission understands that the practice of providing interim determinations was particularly useful in cases of apparent homicide where no suspect had been identified or charged.¹⁸ Such cases remain as open coronial files (and therefore incomplete registrations) until such time as a person is tried and convicted for the death and the coroner completes his or her finding.¹⁹

17. Name withheld, email (21 October 2010).

18. Registry of Births, Deaths and Marriages, consultation (26 September 2008).

19. Although the Commission notes that nothing in the *Coroners Act 1996* (WA) prevents a coroner from making a coronial

The provision of an interim determination is facilitated by s 28(2) of the Coroners Act which provides:

- (2) If a coroner believes—
- (a) that there will be a delay in concluding an investigation; and
 - (b) that there is sufficient evidence to determine the identity of the deceased and the date, place and cause of death,

then the coroner may make that determination for the purpose of enabling registration of the death to be effected or completed, and must notify the Registrar of Births, Deaths and Marriages of the particulars of the determination.

It appears that interim determinations were forwarded to the Registry of Births, Deaths and Marriages by the coroner pursuant to this section until approximately 10 years ago.²⁰ The Commission is not aware why the practice stopped; however, the Office of the State Coroner advised that in cases where people experience difficulties with insurers they now offer a 'letter of comfort' to families, which contains the relevant particulars of the death and a statement, if necessary, regarding the absence of suspicious circumstances for the purposes of enabling a claim against the deceased's insurance policy.²¹ In view of submissions made to the Commission by some members of the public, it is not clear that this practice satisfies the requirements of insurers.²²

In light of the substantial delays experienced in the coronial process it would obviously be helpful if some arrangement could be reached with insurers about the information they require to enable families to finalise the deceased's affairs at the earliest opportunity. In some cases, in particular those where the cause of death is not readily apparent or where the potential of a finding as to cause of death that may void the insurance exists, it may be impossible to provide information to the satisfaction of insurers in the absence of a full coronial finding. However,

determination where no person has been charged with causing the death of a deceased.

20. Registry of Births, Deaths and Marriages, consultation (26 September 2008).

21. Manager, Office of the State Coroner (WA), consultation (1 March 2011).

22. Nonetheless, the Commission notes that a 'letter of comfort' generally provides all the details found in a full coronial finding but without the coroner's 'verdict' (ie, accident, misadventure, suicide, unlawful homicide, lawful homicide, natural causes or open).

there will be a great number of uncontroversial cases where the post mortem examination findings and circumstances of the death disclose a sufficiently certain cause of death to enable an interim determination to be provided for the purpose of finalising a deceased's affairs.²³

As insurers' requirements and practices vary and they are private commercial entities, it is difficult to know what can be done by government to assist the timely settlement of claims in coronial cases that are the subject of inordinate delay. A great number of the proposals in this paper are concerned with addressing the underlying causes of coronial delays and the Commission is aware that the government has actively sought to reduce delays by increasing resources available to the Office of the State Coroner. The Commission notes that the reduction in the backlog of current coronial cases will take some considerable time. In the meantime, the Commission suggests that in those cases where delay is expected to be over six months and where the information necessary to effect registration is available, the Office of the State Coroner consider reviving its practice of providing interim determinations to enable the issuing of a death certificate at the earliest opportunity.

PROPOSAL 25

Provision of interim coronial determinations to the Registrar of Births, Deaths and Marriages

That the Office of the State Coroner consider reviving its practice of providing interim determinations under s 28(2) of the Coroners Act with as much detail as possible about the circumstances and cause of death so as to enable the issuing of a death certificate at the earliest opportunity to facilitate the timely settlement of insurance and superannuation claims in certain coronial cases.

23. The Commission was advised by the Financial Ombudsman Service that they 'have not dealt with many disputes of this type. One of our most senior case workers ... can only recall a handful of disputes that have concerned an insurer's insistence on a final death certificate and coroner's finding before paying a death benefit': Angus Trewavas, Manager (acceptance), Financial Ombudsman Service, email (7 March 2011).

Chapter Four

Death Investigation

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Introduction

As noted in Chapter One, coronial investigations are undertaken on behalf of the coroner by the Western Australia Police.¹ In the Perth metropolitan area, a dedicated unit—the Coronial Investigation Unit—is responsible for the investigation of most coronial deaths,² while in regional Western Australia these are investigated by local police. In some cases external investigations by specialist bodies run simultaneously with (and may contribute to) the coronial investigation by provision of specialist reports or advice. These include cases of workplace or industrial deaths (investigated by WorkSafe), electrocution deaths (investigated by EnergySafety), mining deaths (investigated by the Department of Mines and Petroleum) and aviation deaths (investigated by the Australian Transport Safety Bureau).

An important part of many coronial investigations is the post mortem examination of the deceased, which is undertaken to determine a medical cause of death. Typically, a post mortem examination in Western Australia will consist of a full internal examination of the body of a deceased and will include the taking of tissue and other samples for forensic testing. Almost all post mortem examinations in coronial cases in Western Australia are performed by forensic pathologists at the State Mortuary and PathWest facility in Perth and bodies are transported to Perth from regional areas for this purpose.³

This chapter examines the coronial death investigation process and the powers under the *Coroners Act 1996* (WA) ('the Coroners Act') that support or facilitate coronial investigations. It also looks at specific types of deaths where the Commission believes a reconsideration of the current approach to coronial investigations

is warranted. These include healthcare-related or hospital deaths (currently investigated by the Coronial Investigation Unit) and deaths in police presence or prison custody (currently investigated by the Major Crime Squad with oversight by the Internal Affairs Unit). Finally, this chapter addresses the need for legislative reform to provide more clearly for assistance to and from coroners in other jurisdictions.

1. See Chapter One, 'Coronial Process Snapshot'.
2. Other police units investigate deaths in defined circumstances: see 'Coroner's Investigators', below.
3. There is an exception for probable natural causes deaths in the Albany area where an experienced doctor performs post mortem examinations locally. Post mortem examinations in all non-natural causes deaths or deaths in controversial circumstances are performed in Perth.

Coroner's investigators

Section 14 of the *Coroners Act 1996* (WA) ('the Coroners Act') deals with the appointment of 'coroner's investigators'. It provides:

- (1) The Attorney General, on the recommendation of the State Coroner, may appoint by notice published in the *Gazette* persons to be coroner's investigators.
- (2) Every member of the Police Force of the State is contemporaneously a coroner's investigator.
- (3) A coroner's investigator must—
 - (a) assist a coroner in carrying out his or her duties under this Act;
 - (b) carry out all reasonable directions of a coroner.
- (4) Subsection (3) does not require or authorise a member of the Police Force to carry out a direction of a coroner if that direction is inconsistent with a direction of the Commissioner of Police.
- (5) The State Coroner is to cause to be issued to a coroner's investigator, who is not a member of the Police Force of the State, an identity card.
- (6) Where a person in possession of an identity card ceases to be a coroner's investigator, that person is to return the card as soon as is practicable to the State Coroner.

Penalty: \$1 000.

It was apparently intended by Parliament that s 14(1) would be used for the appointment of specialist coroner's investigators to enable the investigation of deaths in custody or in police presence independent of the police.¹ However, the Commission understands that no person has ever been appointed a coroner's investigator under this section.² Under s 14(2) of the Coroners Act all police officers are contemporaneously coroner's investigators and in every coronial case there is some degree of police investigation. There are a number of

different units or divisions within the Western Australia Police that investigate reportable deaths and report to the coroner:

- **Coronial Investigation Unit (CIU)** investigate non-suspicious deaths, natural causes deaths, drug-related deaths,³ hospital or medical-related reportable deaths, deaths caused by (or proximate to) falls or injuries,⁴ deaths of involuntary patients in mental health facilities, workplace deaths and sudden unexplained infant deaths.⁵ This unit is the primary unit assisting the coroner and is discussed in more detail below.
- **Major Crime Squad** investigate suspected homicides or suspicious deaths, deaths in police custody or presence (oversighted or jointly investigated by Internal Affairs) and deaths in prison custody or juvenile detention (oversighted or jointly investigated by Internal Affairs).⁶
- **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).

1. Western Australia, *Parliamentary Debates*, Legislative Assembly, 22 June 1995, 5705 (Ms C Edwardes, Attorney General).

2. This issue is discussed in detail in 'Deaths in Custody', below.

3. If illicit drugs are involved there may also be an investigation by the Organised Crime Squad.

4. For example, this would include a case of an elderly person who died from hospital-acquired pneumonia some time after an operation to repair a broken femur following a fall at home. For further discussion of this type of case, see Chapter Three, 'Authorising Issue of cause of death certificate'.

5. Sudden unexplained deaths of children under the age of 14 years are jointly attended by an officer from the Major Crime Squad to ensure that there is no criminality involved in the death. A Choice One Nurse also attends at the scene of a child death to provide support to the family during the forensic process and to interview the person responsible for caring for the child at the time of death. According to police approximately 1% of child death cases feature suspicious circumstances: Western Australia Police, consultation (18 August 2008).

6. 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).

- **Local Police** investigate some deaths in the metropolitan area 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, sudden unexplained infant deaths⁷ and workplace accidents (ie, deaths that fall within the CIU attendance 'charter'),⁸ 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 coronial death, so deaths that are most likely deaths by natural causes are generally attended by local police and the CIU become involved at the stage that the report is formulated for the coroner.⁹

Investigations of 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 appear to take a lot longer. When completed investigation reports are forwarded

7. 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).
8. The CIU has an internal charter specifying the scenes of coronial deaths at which they must, wherever possible, attend. The charter covers the types of deaths which typically require the specialist skills of coronial police: suicides, drug overdoses, sudden unexplained deaths of infants and children under 14 years of age; workplace deaths; and hospital deaths. Statistics for CIU scene attendance for 2010 show that more than half (56.43%) of the scenes attended by CIU officers were for hospital deaths. Less than 1% of attendances were for workplace deaths and all other charter death attendances were between 11% and 12% each: Detective Sergeant Rohan Ingles, CIU, email (4 April 2011)
9. In most cases where local police attend a death which is clearly coronial, but falls outside the CIU's attendance charter, they will complete the initial paperwork, admit the body to the mortuary and then transfer the file to the CIU for investigation. However, where local police have attended the scene and criminality has been in issue in the death they may retain the investigation when it is recast as a coronial investigation: Detective Sergeant Rohan Ingles, CIU, consultation (5 April 2011).

to the coroner they are checked by the two police sergeants based at the Office of the State Coroner. These sergeants act as a liaison between the coroner and the investigating officers to ensure that everything required for inquest or to finalise an administrative finding 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.¹⁰

CORONIAL INVESTIGATION UNIT

The CIU is staffed by a team of approximately 27 sworn and unsworn police officers,¹¹ and covers the entire Perth metropolitan area. In response to concerns expressed by coroners about the standard of coronial investigations and matters identified by an internal Commissioner's Assurance Team review in October 2009, the CIU has undergone a number of changes. First among these was the appointment of a very experienced Detective Inspector to the role of the officer in charge of CIU. Over the past 18 months, the officer in charge of the CIU has audited the role, resource needs and processes of the unit, and has implemented a best practice case management system.¹² Standard operating procedures for coronial deaths have also been reviewed and CIU attendance at scenes of deaths has increased.¹³

Training of police coronial investigators

As part of the overhaul of the CIU, a comprehensive training and mentoring program has been implemented for CIU investigations staff. Training includes instruction in the role and requirements of the coroner; standards and needs of police reporting under the Coroners Act; obligations and powers of coroner's investigators under the Coroners Act; training in identification techniques and the post mortem examination process in conjunction with PathWest;¹⁴ the

10. Sergeant Geoff Sorrell, Coroner's Office (WA), consultation (27 October 2008) 2-3.
11. Including four detective constables and a senior sergeant.
12. Detective Inspector Mark Bordin, OIC Coronial Investigation Unit, consultation (11 March 2011).
13. Ibid
14. PathWest staff also contribute significantly to coronial police training in types of deaths including modules on identifying and dealing with deaths as a result of blunt force and sharp force injury; electrocution; gunshot injuries; asphyxia; bodies found in water; fire deaths; child deaths; hidden homicides; and celebrity deaths. Police are also trained to recognise

role of external service providers such as body transport contractors and toxicology; the roles of specialist investigators (such as WorkSafe, ombudsman, etc); procedures for investigating deaths in hospitals; and the use of operational equipment for scene examination. CIU investigative staff undertake written and practical assessments on a yearly basis.¹⁵

Recognising that coronial investigations are undertaken by a variety of police officers including some without any death investigation experience, the CIU has assumed responsibility for presenting the police academy training module in the area of coronial deaths. This has been redesigned to focus on the questions that coroners need answered in a coronial death investigation including concerns about public safety and prevention of death and injury. A presentation has also been designed for delivery to operational officers and this will be delivered in 2011.¹⁶

As discussed in Chapter Two, the quality of coronial investigations has been a particular issue in regional areas.¹⁷ This appears to be due to both the lack of direction and guidance from regional coroners at the initial stages of coronial investigations and to lack of training of regional police officers. In particular, the Commission heard that police were sometimes unsure of the coroner's requirements once it was clear that the death being investigated did not involve any overt criminal offence. This is an issue that will be partly addressed by a CIU initiative to come into effect in the first half of 2011. The initiative involves the development of an operational aide memoire designed for officers in metropolitan and regional districts which details investigative procedures to be followed in the event of each type of coronial death. This will be augmented at the supervisory level by an internal procedural document designed to assist those with oversight of coronial investigations to critically assess their officers' reports from a coronial perspective and

increase their understanding of the coronial jurisdiction.¹⁸

Guidance from the Coroners Court

As discussed in the Background Paper, the Commission's initial 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.¹⁹ Police had also stated that they would welcome more direct guidance and feedback from coroners during the initial investigation stage. Since publication of the Background Paper, it appears that communication between the CIU (in Perth) and the Coroners Court has substantially improved. Since February 2011, every Monday the Deputy State Coroner attends at the CIU to examine the P98 (mortuary admission) forms from the previous week. These forms (completed by police attending the scene of death) provide a brief description of the circumstances of the death. This permits the Deputy State Coroner to make directions to CIU officers defining the investigation requirements of each case, including whether certain lines of inquiry need to be followed relating to public health and safety aspects of particular deaths.²⁰ The officer in charge of the CIU has also instigated a monthly meeting with the State and Deputy State Coroners where information is shared regarding current cases, and a new process has been established to address any flaws in investigation reports at an earlier stage.²¹

However, the Guidelines for Police issued by the State Coroner under s 58 of the Coroners Act appear to be in need of review. Section 58 relevantly provides that:

- (1) The State Coroner must issue guidelines with respect to the principles, practices and procedures of the State coronial system, but those guidelines must not be inconsistent with this Act or any other written law.

the stages of decomposition and injury patterns: Detective Inspector Mark Bordin, OIC Coronial Investigation Unit, email (18 March 2011).

15. Detective Inspector Mark Bordin, OIC Coronial Investigation Unit, consultation (11 March 2011).

16. Ibid.

17. See Chapter Two, 'An Alternative Model'.

18. Detective Inspector Mark Bordin, OIC Coronial Investigation Unit, consultation (11 March 2011).

19. LRCWA, *Review of Coronial Practice in Western Australia*, Background Paper (September 2010) 50.

20. Detective Inspector Mark Bordin, OIC Coronial Investigation Unit, consultation (11 March 2011).

21. Coroners fill out an 'additional request form' for remedial work required on files submitted to the Office of the State Coroner by police (including regional police): Detective Inspector Mark Bordin, OIC Coronial Investigation Unit, consultation (11 March 2011).

- (2) Without limiting the generality of subsection (1), the State Coroner may issue guidelines relating to—
- (a) the administration of the State coronial system;
 - (b) forms that are to be used and the circumstances when a particular form is appropriate;
 - ...
 - (e) the functions of coroners, coroner's clerks and coroner's investigators and the manner in which those functions are to be carried out;
 - ...

The Guidelines for Police issued pursuant to s 58 provide information about the obligation of police officers to report certain deaths to the coroner; the procedure to follow when notifying the next of kin of the death; how to deal with objections to (or requests for) a post mortem examination; the use of powers under the Coroners Act to restrict access to premises and to enter premises, inspect them and take possession of documents and things; what to do when a death is the subject of a criminal charge; and the procedure to follow in respect of deaths in police lockups.²² The Commission was advised that the guidelines were written when the Act came into force in 1997 and have not been reviewed or updated since that time.²³ As such, they contain outdated information (in particular, changes to procedure and telephone and fax numbers) and do not address major amendments to relevant sections of the Coroners Act since 1997.²⁴ The Commission therefore proposes that the State Coroner review and update the Guidelines for Police, taking into account any relevant protocols and procedures currently in place within the Western Australia Police.

PROPOSAL 26

State Coroner's guidelines: police

That the State Coroner review and update the Guidelines for Police.

22. State Coroner, *Guidelines for Police* (undated).

23. Manager, Office of the State Coroner (WA), email (9 March 2011).

24. In particular the amendments introduced by the *Coroners Amendment Act 2003* (WA), which amended the powers exercised by police under s 33 (powers of entry, inspection and possession)

NATIONAL POLICE FORM

Following the launch of the National Coroners Information System (NCIS) in 2000, representatives from the police, legal, medical and research communities met to develop a common data set for use by police in their initial reports of deaths to the coroner. The NCIS had highlighted the lack of standard reporting across Australian jurisdictions and the desirability of standardised data to provide consistent and improved information for coroners, pathologists and toxicologists about the circumstances of death to assist in the coronial investigation.²⁵ 'Such standardisation of data would also improve the volume and quality of information on reportable fatalities nationally for research and prevention purposes'.²⁶

The NCIS was funded by the Commonwealth Department of Health and Ageing to develop a national police form for use in all Australian jurisdictions.²⁷ The form contains all the usual identification and incident-related information but also features a number of fields covering different types of death (eg, suspected drug/alcohol/poison-related death; drowning/water-related death; healthcare-related death; child/infant death; suspected SUDI death; fire/burn-related death; suspected suicide; transport-related death; work-related death; and death involving a weapon). It is effectively a questionnaire containing the essential questions that a coroner or forensic pathologist need answered about the circumstances of the death before a post mortem examination is undertaken to determine cause of death. It has a largely check-box approach but also enables the input of narrative about the incident.

A successful pilot was undertaken in Victoria in 2002–2003 and versions (both electronic and paper) of the national police form are now used in a number of Australian states and territories. During consultations the Chair of the Western Australian Ministerial Council for Suicide Prevention and the Western Australia Police urged the Commission to consider proposing the adoption of the national police form in Western

25. Jessica Pearse, Manager NCIS, 'National Police Form for Reporting Death to a Coroner' (March 2011).

26. *Ibid* 1.

27. 'National Police Form Project' <http://www.ncis.org.au/web_pages/national_police_form.htm> (accessed 14 March 2011).

Australia.²⁸ As well as the benefits to forensic pathologists identified above, the Commission can see the following advantages to adoption of the national police form in Western Australia:

- The replacement of many forms with a single form. For example, the national police form would replace the Hanging Protocol, the Mortuary Admission Form (P98), the Certificate of Life Extinct (P99); the Report of Non Boating Aquatic Death; the Initial Report of Suspected Drug related Death; and the Investigative Checklist for Child Fatalities.
- The improved consistency of initial information about a reportable death allowing coroners to make better-informed decisions about how an investigation should proceed and whether a post mortem examination is warranted.
- The standardisation across Western Australia of police reporting and initial investigation into a death.²⁹
- The standardisation of information available for input onto NCIS.
- The early report and identification of circumstances surrounding a death that may assist in the identification of clusters of deaths (eg, pool drowning and suicides), thereby enabling the faster rollout of prevention strategies.

The NCIS reports that the jurisdictions currently using a version of the national police form are pleased with the comprehensiveness and consistency of the information received.³⁰ Better results appear to be obtained in those jurisdictions where the form is able to be completed and submitted electronically, and where coronial investigators are guided through the form by automated prompts.³¹ The national police form has been shown to particularly assist in the identification of possible suicides and risk factors, and the 2010 Australian Government

28. Professor Sven Silburn, former Chair, Ministerial Council for Suicide Prevention, consultation (29 October 2008); Western Australia Police, consultation (26 November 2009); Coronial Investigation Unit, consultation (14 March 2011); Detective Senior Sergeant Steve Potter, former officer in charge, CIU, email (21 August 2008).

29. The Commission also notes that the national police form provides an effective aide memoire for those police officers who may only attend a few deaths in their careers.

30. Jessica Pearse, Manager NCIS, 'National Police Form for Reporting Death to a Coroner' (March 2011) 3.

31. Ibid.

Senate inquiry into suicide in Australia recommended its adoption by all Australian governments.³² In the Commission's opinion, the benefits of adopting the national police form are obvious. In making the following proposal, the Commission notes that Western Australia Police are negotiating funding with the Suicide Prevention Strategy for the development of a statewide coronial database allowing sharing of information with relevant bodies including PathWest (forensic pathology), ChemCentre (toxicology), the Office of the State Coroner, Western Australia Police and the Ministerial Council for Suicide Prevention.³³ Such a database would be improved by the electronic use of the national police form for initial coronial death reporting purposes.

PROPOSAL 27

Adoption of the National Police Form

That the Western Australia Police and the Office of the State Coroner (in consultation with PathWest, ChemCentre, the National Coroners Information System and relevant death prevention research bodies) develop and implement an electronic variant of the national police form for use throughout Western Australia for initial reports of coronial deaths.

POWERS OF CORONERS AND CORONERS' INVESTIGATORS

Restriction of access to area

The Coroners Act empowers coroner's investigators to control the scene where a death has taken place by restricting access to premises. Section 32 provides:

- (1) A coroner, or coroner's investigator, investigating a death may take reasonable steps to restrict access to the place where the death occurred, or the place where the event which caused or contributed to the death occurred.
- (2) A coroner must, in writing, agree with any restriction imposed by a coroner's investigator under subsection (1) as soon

32. Australian Government, Senate Community Affairs Reference Committee, *Suicide in Australia: The hidden toll* (2010) recommendation 4.

33. Coronial Investigation Unit, consultation (14 March 2011).

as is practicable after the restriction is imposed.

- (3) A restriction imposed by a coroner's investigator ceases to have effect 6 hours after it is imposed unless subsection (2) has been complied with by that time.
- (4) A prescribed notice may be put up at the place to which access is to be restricted.
- (5) A person must not without good cause enter or interfere with an area to which access is restricted under this section.
Penalty: \$2 000.
- (6) A coroner is to ensure that access to an area is not restricted for any longer than necessary.
- (7) Any person aggrieved by the operation of this section may apply to the State Coroner and the State Coroner may order the variation or removal of the restriction.

As can be seen from the above, police (as coroner's investigators) may immediately impose a restriction on access to an area and that restriction must, before the elapse of six hours, be confirmed in writing by a coroner. Although there is no time limit on a restriction order, the Commission was told by police that in practice extensions were often only awarded for a further six hours.³⁴ The Commission was informed that the period of six hours specified in s 32(3) was not always sufficient for police to undertake necessary forensic procedures to determine whether the case is properly a coronial case or whether there were suspicious circumstances requiring police to utilise their powers under the *Criminal Investigation Act 2006* (WA).³⁵ The Commission notes that the time limit was questioned in Parliament during the passage of the Act with one member raising the issue of the possible difficulty of contacting a coroner in very remote areas within the six-hour period.³⁶ A perhaps even more persuasive argument is the difficulty in some areas (including metropolitan areas) of securing forensic investigators to assess the scene of the death to establish whether the death comes

within the exclusive jurisdiction of the Coroners Court or whether it also potentially involves a criminal investigation within the first six hours.

The Commission was urged by various police representatives to consider time limits of between 24 and 72 hours before an application was required to be made to a coroner for a possible extension of time. The officer in charge of the CIU suggested that 24 hours was sufficient time to cover the types of potential difficulties referred to above. The Commission agrees; however, to protect against potential abuse it is the Commission's opinion that in the first instance a restriction imposed by a coroner's investigator should be approved in writing by a coroner or a senior police officer of the rank of sergeant or above within six hours of its imposition.³⁷ In cases where the restriction has been approved by a senior police officer it should cease to have effect 24 hours after it is imposed unless a continuance of the restriction is approved by a coroner in writing. Section 32(6) requiring a coroner to ensure that access to an area is not restricted for any longer than necessary and s 32(7) providing a mechanism for aggrieved persons to challenge the order should remain.

Another issue relating to restriction of access to an area under the Coroners Act is the level of penalty involved. The State Coroner has submitted that there is a need to upgrade all penalty provisions in the Coroners Act and, as discussed in Chapter Three in relation to failure to report a death, the penalties that apply under the Coroners Act in Western Australia are low when compared to other jurisdictions. In respect of similar sections in other Australian jurisdiction, penalties vary between \$1300³⁸ and \$11,000³⁹ with alternatives of imprisonment for a period of between three and six months.⁴⁰ In light of increases to penalties for other offences mentioned throughout this paper, the Commission proposes that a fine of \$10,000 or imprisonment of six months is the appropriate

34. Western Australia Police, consultation (26 September 2009).

35. In cases where criminality or suspicion is detected the case is transferred to the Major Crime Squad and restriction of access to the area would be via a protected forensic area order established under the *Criminal Investigation Act 2006* (WA).

36. Western Australia, *Parliamentary Debates*, Legislative Assembly, 18 October 1995, 9381 (Mr Reibeling). Ultimately this issue was not followed up at the Committee stage of the Bill.

37. A broadly similar process exists in relation to the creation of protected forensic areas under the *Criminal Investigation Act 2006* (WA).

38. *Coroners Act 1997* (Tas) s 34(3) being 10 penalty units (at \$130) or 3 months' imprisonment.

39. *Coroners Act 1995* (ACT) s 65(2) being 100 penalty units (at \$110 for individuals and \$550 for corporations).

40. An alternative period of six months' imprisonment is provided for in the Coroners Acts of Victoria and the Northern Territory for entering a site which is subject to a restriction order under the Act.

statutory penalty for an offence involving entry of or interference with a restricted area.⁴¹

PROPOSAL 28

Restriction of access to area

That the power to restrict access to an area under the Coroners Act (currently contained in s 32) provide that:

1. A coroner, or coroner's investigator, investigating a death may take reasonable steps to restrict access to the place where the death occurred, or the place where the event which caused or contributed to the death occurred.
2. A restriction imposed by a coroner's investigator ceases to have effect 6 hours after it is imposed unless approved in writing by a coroner or a senior police officer of the rank of sergeant or above.
3. A restriction that has been approved by a senior police officer ceases to have effect 24 hours after it is imposed unless a continuance of the restriction is approved by a coroner in writing.
4. A prescribed notice may be put up at the place to which access is to be restricted.
5. A person must not without good cause enter or interfere with an area to which access is restricted under this section.
Penalty: \$10,000 or 6 months' imprisonment
6. A coroner is to ensure that access to an area is not restricted for any longer than necessary.
7. Any person aggrieved by the operation of this section may apply to the State Coroner and the State Coroner may order the variation or removal of the restriction.

Powers of entry, inspection and possession

Coroner's investigators have wide search and seizure powers under s 33 of the Coroners Act. The original powers, which were exercisable by or under authorisation of a coroner, were broadened significantly by amendment to the Coroners Act in 2003 to permit police officers and coroner's investigators to enter and inspect places, and to take possession of material without a warrant or written approval of a coroner. Section 33 now provides:

- (1) A coroner who has jurisdiction to investigate a death may, with any help thought fit—
 - (a) enter and inspect any place and anything in it;
 - (b) take a copy of any document relevant to the investigation; and
 - (c) take possession of anything which the coroner reasonably believes is relevant to the investigation and keep it until the investigation is finished.
- (2) A coroner may only exercise those powers if the coroner reasonably believes it is necessary for the investigation.
 - (2a) If a death has occurred that, in the opinion of a coroner's investigator, is or may be a reportable death, the coroner's investigator may, with any help thought fit and without the consent of any occupier of a place, or any authority other than this subsection—
 - (a) enter the place where the body is or where, in the opinion of the coroner's investigator, the death, or the event which caused or contributed to the death, occurred;
 - (b) inspect the place where the body is or where, in the opinion of the coroner's investigator, the death, or the event which caused or contributed to the death, occurred; and
 - (c) take possession of anything which the coroner's investigator reasonably believes is directly relevant to an investigation of the death.
 - (2b) Anything taken by a coroner's investigator under subsection (2a) is to be kept and dealt with in accordance with the regulations, until the investigation of the death is finished, or it is decided that there is no jurisdiction under this Act to investigate the death.

41. In reaching this conclusion the Commission has also considered provisions for breach of a protected forensic area under the *Criminal Investigation Act 2006 (WA)* s 47, which provides for a fine of \$12,000 and imprisonment for 12 months.

- (2c) A coroner's investigator (other than a member of the Police Force of the State who is in uniform) exercising, or about to exercise, a power under subsection (2a) must, at the reasonable request of a person apparently in charge of the place or any other person at the place, produce for inspection by that person—
- (a) in the case of a member of the Police Force, written evidence of the fact that he or she is a member of the Police Force; or
 - (b) in any other case, his or her identity card.
- (3) A coroner may, if the coroner reasonably believes it is necessary for the investigation, in writing authorise a coroner's investigator at or between specified times during a specified period (not exceeding one month after the authority is given)—
- (a) to enter a specified place;
 - (b) to inspect a specified place and anything in it;
 - (c) to take a copy of specified documents or classes of documents; and
 - (d) to take possession of specified things or classes of things.
- (4) A coroner's investigator must not exercise a power under an authority unless the investigator has given a copy of the authority to the owner or occupier of the place or the person in possession of the document or thing inspected, copied or taken.
- (5) A coroner may release anything kept under subsection (1)(c) or (3)(d) and may require a person to whom the thing is released to give an undertaking to comply with any reasonable conditions of release.
- (6) A person must comply with an undertaking concerning release.
- Penalty for an offence against this subsection: \$2 000.
- (7) A person must not delay, obstruct or otherwise hinder a coroner or a coroner's investigator exercising a power under this section.
- Penalty: \$2 000.
- (8) A coroner or a coroner's investigator exercising a power under this section is to conform as far as is practicable to such reasonable requirements of the owner or occupier of the place where the power is being exercised as are necessary to prevent the lawful use of the place being obstructed.

It appears that the 2003 amendments were considered necessary to ensure the immediate and appropriate investigation of a coronial death. The second reading speech for these amendments noted:

To ensure the rights of the individual are protected, the amendments limit the items to be seized to those which a coroner's investigator reasonably believes are directly relevant to a death. It is envisaged that these would be items such as ligatures, weapons, drugs, drug containers and implements, suicide notes and the like.⁴²

The Commission notes that although s 33(2b) states that things seized by a coroner's investigator under s 33(2a) are to be 'kept and dealt with in accordance with the regulations', there are no provisions in the *Coroners Regulations 1997* (WA) dealing with this matter.⁴³ This seems to be an oversight that should be rectified at the earliest opportunity.

During consultations, the police expressed satisfaction with the terms of s 33. The only matter of concern was in respect of the penalty attaching to the offence of obstructing a coroner or coroner's investigator acting in accordance with the provision. The Commission has examined the penalties attaching to similar offences in other jurisdictions (which range in fines between \$5,320⁴⁴ and \$11,000)⁴⁵ and found that the current penalty is too low.⁴⁶ The Commission believes the same penalty as that applying to a breach of restriction of access to an area should apply and makes the following proposal.⁴⁷

42. Western Australia, *Parliamentary Debates*, Legislative Council, 14 November 2001, 5511b–5512a (Mr Griffiths).

43. *Coroners Regulations 1997* (WA) reg 14 deals with forms of undertaking and requests for release of things taken under s 33(3). No mention is made of s 33(2a) in the regulations.

44. *Coroners Act* (NT) s 36(2).

45. *Coroners Act 2009* (NSW) s 44. The New South Wales provision includes the potential of imprisonment for two years in addition to or instead of a fine. Penalties of \$10,000 exist in Queensland and South Australia.

46. In making its proposal below that this offence carry a term of imprisonment, the Commission notes that the offence of Obstructing a Public Officer under the *Criminal Case* (WA) s 172 carries a penalty of three years' imprisonment if dealt with on indictment or a fine of 18,000 and 18 months' imprisonment if dealt with summarily.

47. The Commission also notes that the *Coroners Act 1996* (WA) s 54 provides for a general offence of obstructing or hindering a coroner or a person acting under a coroner's authority in exercising the powers under the Act. That offence currently has a penalty of \$5,000 and in the interests of consistency it is the Commission's view that this penalty should also be increased to a fine of \$10,000 or imprisonment for six months.

PROPOSAL 29

Penalty for obstructing a coroner or coroner's investigator

That the penalty for delaying, obstructing or otherwise hindering a coroner or a coroner's investigator exercising a power of entry, inspection and possession under the Coroners Act (currently s 33) be increased to a fine of \$10,000 or 6 months' imprisonment.

Power to request doctor to provide report

An important source of information for a coroner investigating a death is the medical history of the deceased. Although s 33 (discussed above) empowers coroner's investigators to seize original medical records, there is nothing in the Coroners Act which empowers the coroner (outside the context of an inquest) to require the deceased's medical practitioner to prepare a report summarising the medical history or medical treatment and care of the deceased to assist the coronial investigation.⁴⁸ Such provisions now exist in Victoria, New South Wales and New Zealand, which are the three most recently enacted Coroners Acts. For example, the *Coroners Act 2006* (NZ) provides that:

A coroner may, by written notice to a doctor who attended a person before death, require the doctor to give the coroner a written report (containing information specified in the notice) relating to the person.⁴⁹

The penalty for failure or refusal (without reasonable excuse) to provide such a report is \$1,000.⁵⁰ A similar provision exists in New South Wales.⁵¹ The Victorian provision is arguably wider and provides as follows:

48. Currently police send a request to the deceased's usual medical practitioner on behalf of the coroner. Requests often specify that the report should be comprehensive, covering the deceased's medical history including referrals, psychiatric history (if known), prescribed medications and when the deceased was last seen as a patient. The request generally states that an interpretation of the person's medical history is required, not merely a copy of the person's file or medical notes: Manager, Office of the State Coroner (WA), email (18 March 2011).

49. *Coroners Act 2006* (NZ) s 40.

50. *Coroners Act 2006* (NZ) s 137.

51. *Coroners Act 2009* (NSW) s 53 gives the coroner 'power to direct that a document be produced relating to the medical care or treatment of a person'. Failure to comply with a notice

Registered medical practitioner to assist

- (1) This section applies to a death that is being investigated by a coroner.
- (2) A registered medical practitioner—
 - (a) who was responsible for a person's medical care immediately before that person's death; or
 - (b) who was present at or after the person's death—must give the coroner any information or assistance that the coroner requests for the purposes of the investigation.
Penalty: 20 penalty units [\$2,389].⁵²

This provision may be read in conjunction with *Coroners Act 2008* (Vic) s 42 which gives the coroner the power to request prepared statements and is discussed below. As well as being a useful tool enabling the coroner to compel the production of information necessary for a coronial investigation, a statutory power of this kind can protect medical practitioners from allegations of breaching doctor-patient confidentiality. The potential exposure to such complaints induced legal counsel who had experience representing doctors in the Coroners Court—including counsel for the Medical Defence Association of Western Australia—to urge the Commission to consider a statutory power of compulsion.⁵³ The State Coroner also asked the Commission to consider such an amendment to the Coroners Act to overcome the concerns of doctors in respect of possible breach of doctor-patient confidentiality.⁵⁴ The Commission can find no argument against such a power and proposes that a section requiring medical practitioners to assist the coroner by provision of prepared statements or reports be inserted in the Coroners Act.⁵⁵ Noting that it is currently the practice for a dedicated medical officer to prepare and provide such reports

under s 53 without reasonable excuse carries a fine of 10 penalty units (\$1,100).

52. *Coroners Act 2008* (Vic) s 33.

53. Lawyer, consultation (25 September 2008); Medical Defence Association of Western Australia Lawyer, consultation (30 September 2008). The Commission notes that where a state law requires the provision of such information for the purposes of court proceedings this is permitted under the *Privacy Act 1988* (Cth) Information Privacy Principle 2.1(g).

54. Alastair Hope, State Coroner, 'Review of the Coroners Act 1996 – Possible Issues', correspondence (12 June 2007) 2.

55. Under the current request regime the Office of the State Coroner offers to pay doctors the 'reasonable costs associated with the preparation' of such reports and allows 28 days for their completion. In the Commission's opinion it is appropriate that doctors are recompensed and believes that a similar payment system should continue under the Commission's proposal.

when requested of hospitals, the Commission proposes that the provision explicitly permit such practice.

Under the current request regime the Office of the State Coroner offers to pay doctors the 'reasonable costs associated with the preparation' of such reports and allows 28 days for their completion. In the Commission's opinion, it is appropriate that doctors are recompensed for providing a report requested by the coroner pursuant to the Act. The Commission notes that regulation 21 of the *Coroners Regulations 1997 (WA)*⁵⁶ provides for fees to be paid to doctors, who are not in the receipt of a salary from the state, for attending at a scene to certify life extinct or to perform a post mortem. The Commission suggests that a suitable standard fee for the provision of a medical report requested by the coroner should be provided for by regulation.

PROPOSAL 30

Coroner may require medical practitioner to report

1. That the Coroners Act provide that a coroner or coroner's investigator investigating a death under the Act may, by written notice, require a medical practitioner who—
 - (a) was responsible for a person's medical care immediately before that person's death; or
 - (b) was present at or after the person's death; or
 - (c) is nominated by the hospital in which the person died;to give the coroner a written report relating to the deceased person.
2. That the notice specify the provision of the Coroners Act under which the notice is served, the information required by the coroner and a reasonable time period for compliance.
3. That the penalty for failure to comply, without lawful excuse, with such a request within the period specified in the notice is a fine of \$2,000.

56. See also *Coroners Regulations 1997 (WA)* sch 2.

4. That the Coroners Regulations be amended to provide for a fee for the provision of a medical report requested by the coroner pursuant to this power.

Seizure of medical records

During consultations with PathWest the Commission heard that occasionally the post mortem examination had to be delayed because the medical notes pertaining to the deceased were not provided in a timely manner.⁵⁷ Section 33, discussed above, allows police or coroner's investigators to seize medical records and 'admission bloods'⁵⁸ of a deceased who has died in hospital or while under medical care. These are crucial sources of information for the forensic pathologist undertaking a post mortem examination because they detail the medical treatment the deceased was receiving at the time of death which permits the pathologist to properly assess the potential for medical misadventure or error.

The Commission understands that when a person dies in hospital and that death is classified as a 'sentinel event',⁵⁹ there is great demand for access to the medical notes to support the reporting requirements of the Department of Health, the coroner and the investigations of the hospital's internal morbidity and mortality committee. Because of these competing demands, police are sometimes unable to seize the original records immediately upon attendance at the hospital. Further, the Office of the State Coroner has an arrangement with the three major hospitals in Perth⁶⁰ to permit them to retain the medical records of the deceased for a period of up to 24 hours in order to enable a copy of the file to be made. The guidelines issued by the Manager of the Office of the State

57. PathWest, consultation (26 November 2009).

58. These are the routine blood samples taken from patients upon admission to a hospital.

59. Sentinel events are adverse events (causing harm or death) in nationally endorsed categories which require mandatory reporting to the Office of Safety and Quality in Healthcare in the Department of 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.

60. Royal Perth Hospital, Sir Charles Gairdner Hospital and Fremantle Hospital.

Coroner in this regard highlight that the original medical notes and admission bloods must be delivered to the State Mortuary by hospital courier within the stipulated time.⁶¹

Coronial police in Perth advised the Commission that they had encountered problems with this arrangement; in particular, they found they were often required to attend twice at a hospital death – once to photograph the scene and make the initial report, and a second time to seize the original records where hospitals had failed to forward them in accordance with the abovementioned guidelines. The police also indicated some discomfort with the practice of leaving medical records with hospitals for 24 hours, suggesting that the ‘continuity and integrity of the evidence’ was at risk (ie, that records could be altered).⁶² The Commission agrees that the preservation of necessary evidence is an important matter, but it also recognises the difficulties for busy hospitals which are required to copy the full file before provision of the original to police.⁶³ The Commission notes that Proposal 21⁶⁴ permitting the coronial authorisation of death certificates in certain cases will greatly reduce the number of hospital death cases subject to a full coronial investigation, and likewise will reduce the impact on hospitals and police. However, there is clearly a need for a power under the Coroners Act to request documents (such as medical records) and a concomitant offence for failure to comply with such a request in the stipulated timeframe. This issue is discussed immediately below.

Power to request documents and prepared statements

According to the CIU, it is very rare in Western Australia that police investigating a hospital death will question the doctor and take a

statement. The information is usually provided by way of a requested medical report or a statement that is provided through the doctor’s legal representative.⁶⁵ The Commission heard from one regional magistrate that doctors appeared to ignore correspondence from police requesting statements and this could contribute significantly to delay in finalising a coronial finding for a death in hospital. Police also observed that doctors were often only posted at regional hospitals for a short period of time. In these circumstances the opportunity to obtain statements very quickly passes and police may be required to track down doctors who have moved to another location to obtain statements. This not only exacerbates the delay in the coronial process, but may also result in statements that are not informed by the necessary medical records or are inaccurate because of the passage of time.

As discussed above, there is no power (in the absence of an inquest)⁶⁶ to compel a person to comply with such a request and no offence is committed. This is clearly a significant oversight of the current Act and needs to be remedied at the earliest opportunity. Section 42 of the *Coroners Act 2008* (Vic) provides a useful model.

Documents and prepared statements requested by coroner

- (1) If a coroner is of the opinion that a document or a prepared statement is required for the purposes of the investigation, the coroner may require a person—
 - (a) to give the document to the coroner; or
 - (b) to prepare a statement addressing matters specified by the coroner and give the statement to the coroner.
- (2) A request made by the coroner under subsection (1) must—
 - (a) be in the prescribed form; and
 - (b) specify a reasonable period of time for compliance with the request; and
 - (c) be served on the person in accordance with the rules.

61. Office of the State Coroner, ‘Guidelines for Provision of Medical Records and Admission Bloods to the Coroner’s Office and the Police Coronial Investigation unit’ (14 March 2007).

62. Coronial Investigation Unit, consultation (14 March 2011). Although, as noted in Chapter Two, ‘An Alternative Model’, the integrity of coronial evidence was found to be less of a concern for police in one regional district where police told the Commission that patient records are usually received three weeks after a hospital death and even then they only received copies.

63. A hospital requires a full copy of its file on a deceased in order that it may pursue its own investigations and be in a position to prepare a report for the coroner if requested.

64. See Chapter Three, ‘Authorising issue of cause of death certificate’.

65. Detective Sergeant Rohan Ingles, CIU, email (23 March 2011). The Commission and police recognise problems with this practice. For detailed discussion on the effective investigation of deaths in healthcare facilities, see ‘Deaths in Healthcare Facilities’, below.

66. Or, taking the *Coroners Act 1996* (WA) s 46A at its widest, a decision to inquest.

- (3) A person who is requested to give a document or prepared statement to the coroner under subsection (1) must not, without a lawful excuse, fail to comply with the request within the period specified by the coroner.

Penalty: 20 penalty units [\$2,389].⁶⁷

The Commission notes that, while this provision is essential to address the problems experienced by police in obtaining documents and prepared statements from doctors in both the metropolitan area and the regions, it is a provision of broader application and as such may apply to specialist investigators whose statements addressing specified matters may assist in the coronial investigation.⁶⁸

PROPOSAL 31

Power to request documents or prepared statements

1. That the Coroners Act provide that if a coroner is of the opinion that a document is required for the purposes of the coronial investigation into a death a coroner may require, by written notice in a form prescribed by regulation, a person to provide the document to the coroner within a reasonable period of time specified in the notice.
2. That the Coroners Act provide that if a coroner is of the opinion that a prepared statement is required for the purposes of the coronial investigation into a death a coroner may require, by written notice in a form prescribed by regulation, a person to prepare a statement addressing matters specified in the notice and provide the statement to the coroner within a reasonable period of time specified in the notice.
3. That the penalty for failure to comply, without lawful excuse, with such a request within the period specified in the notice is a fine of \$2,000.

67. *Coroners Act 2008 (Vic)* s 42.

68. See 'Specialist Investigators: Cooperation with coronial investigation', below.

Provision of information to the coroner

Section 18 of the Coroners Act provides:

- (1) A person who reports a death must give to the coroner investigating the death any information which may help the investigation.

Penalty: \$1 000.

- (2) A member of the Police Force who has information relevant to an investigation must report it to the coroner investigating the death.

Penalty: \$1 000.

Section 18(1) is standard in most Australian Coroners Acts and penalties for failure to provide information range from \$1,000 in Western Australia to \$5,320 in the Northern Territory.⁶⁹ Western Australia has the lowest penalty of all the jurisdictions and, like most penalty provisions in the Coroners Act, it should be upgraded. In light of the penalties applied in other jurisdictions for the same offence the Commission proposes that the penalty for s 18(1) be upgraded.

The penalty attaching to s 18(2) is somewhat unique in Australian Coroners Acts. While similar sections exist to require police to provide information in other jurisdictions, no offence is created and no penalty attaches to the provision.⁷⁰ However, Queensland has a general provision that applies to any person, including police officers, and carries a fine of \$5,000 for failure to provide information on request by a coroner.⁷¹ Under that provision a person must comply with the requirement unless he or she has a reasonable excuse, which can include that compliance would tend to incriminate the person.⁷²

Police officers in the Internal Affairs Unit advised the Commission that the power in s 18(2) was an important tool for their coronial investigations where police were alleged to have caused or contributed to a death. In these circumstances Internal Affairs officers will often be required to question officers under what is known as

69. *Coroners Act (NT)* s 13.

70. See, eg, *Coroners Act 2003 (SA)* s 28(2); *Coroners Act 2008 (Vic)* s 36; *Coroners Act 1995 (Tas)* s 20; *Coroners Act (NT)* s 13.

71. *Coroners Act 2003 (Qld)* s 16.

72. *Coroners Act 2003 (Qld)* s 16(6).

a 'disciplinary demand'.⁷³ When placed under this demand officers are required to answer all questions put to them even if the answers would tend to incriminate the officer; however, the Commission understands that officers generally do so with a caveat that they be used for police disciplinary purposes only and are not to be released to a third party unless authorised by the officer.⁷⁴ However, as pointed out by the State Coroner, both the police officers involved in the incident and the Internal Affairs officers interviewing those police are required by s 18(2) to provide any information relevant to the death to the coroner who is investigating the circumstances of the death.⁷⁵ Given that a witness can be compelled to answer questions at an inquest⁷⁶ under offer of a certificate which provides that the evidence is not admissible in criminal proceedings,⁷⁷ it seems that the information should be transmitted to the coroner as a matter of course in the interests of determining the true cause and circumstances of the death.⁷⁸ Police officers should, of course, be advised that the information they provide will be provided to the coroner investigating the death and that this will satisfy their obligation under s 18(2). It is the Commission's opinion that this advice should be given at the time of the disciplinary demand.

The State Coroner submitted that 'it is difficult to image [sic] a situation where police would actually prosecute a member of the police force for not providing information to a coroner, particularly in the context of the very low penalty of \$1,000'.⁷⁹ The Commission agrees. It is noted that the penalty for police officers was inserted into the Coroners Bill at the Committee stage and did not feature in the original Bill.⁸⁰ The parliamentary debates give some background

to the insertion showing that members were concerned that there was no penalty for police failing to provide information to a coroner when there was a penalty for the general public. It was noted that:

With regard to deaths in custody, there should be a much higher penalty and obligation on members of the Police Force who have information about a death so that they provide that information to the coroner.⁸¹

Given that Parliament has made clear its will that police officers be subject to at least the same penalty for failure to provide information as the general public, the Commission makes the following proposal to increase the penalty for breach of the offence in s 18(2) to a fine of \$5,000.

PROPOSAL 32

Penalty for failure to provide information to a coroner

That the penalty for failure to provide information to a coroner investigating a death by a person who reports a death or by a member of the Western Australia Police who has information relevant to the investigation (currently found in s 18 of the Coroners Act) be increased to \$5,000.

73. Pursuant to the *Police Force Regulations 1979* (WA) reg 603 'Lawful order not to be disobeyed'.

74. Alastair Hope, State Coroner, 'Matters for Consideration by the Law Reform Commission', letter (7 January 2010).

75. Ibid.

76. An inquest is mandatory in cases where police may be involved in the death: *Coroners Act 1996* (WA) s 22(1)(b).

77. *Coroners Act 1996* (WA) s 47.

78. The Commission understands that the practice of Internal Affairs was to advise the officer in writing prior to the file being submitted to the coroner that his or her transcript of interview would be forwarded to the coroner as required by s 18(2) allowing 14 days for objection: Detective Superintendent Fred Zagami, Deaths in Custody Investigations, Western Australia Police, consultation (28 February 2008).

79. Alastair Hope, State Coroner, 'Matters for Consideration by the Law Reform Commission', letter (7 January 2010).

80. Western Australia, *Parliamentary Debates*, Legislative Assembly, 29 November 1995, 11890 (Ms C Edwardes, Attorney General).

81. Western Australia, *Parliamentary Debates*, Legislative Assembly, 18 October 1995, 9380 (Mr Riebling).

Specialist investigators

There are a number of cases where additional specialist investigations are undertaken by non-police investigators. These investigations run concurrently with a police coronial investigation and may contribute to the coronial investigation by provision of specialist reports or advice. In some cases, specialist investigations are completely independent and undertaken by statutory bodies established specifically for the purpose of investigating deaths¹ in certain circumstances. In other cases, concurrent investigations are undertaken internally by the institution in which the death occurred (eg, hospitals, prisons, mental health facilities).

Specialist investigators (and areas of investigation) in Western Australia include:

- **WorkSafe:** industry-based WorkSafe inspectors investigate workplace deaths or industrial accidents and prosecute offences under the *Occupational Safety and Health Act 1984* (WA).
- **EnergySafety:** industry-based inspectors investigate deaths involving electricity or gas and prosecute for breaches of regulations under the *Electricity Act 1945* (WA) and the various Gas Standards Regulations.
- **Department of Mines and Petroleum:** 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, some 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.²

1. Or injuries or incidents.

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

- **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 deaths in similar circumstances.³
- **Office of the Chief Psychiatrist:** following a death in a mental health facility (in particular, sentinel events such as suicide of an inpatient),⁴ 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.⁵
- **Department of Corrective Services:** the Custodial Standards and Review Team within the Department of Corrective Services conducts internal reviews of deaths in corrections facilities. The team reports to the department on the circumstances of the death and makes recommendations for change to policies or procedures to prevent future deaths in similar circumstances.⁶

The investigation reports of these specialist bodies can often add significant value to the coroner's investigation.

COOPERATION WITH CORONIAL INVESTIGATION

As mentioned above, investigations by specialist bodies such as WorkSafe, EnergySafety and the Department of Mines and Petroleum ('workplace safety investigations') run in tandem with the police coronial investigation

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

4. Office of Safety and Quality in Healthcare, Department of Health (WA), *Sentinel Event Policy* (undated) 3.

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

6. See 'Deaths in Prison Custody: Concurrent Internal Review', below.

into a death. As coroner's investigators, police have control of the scene from the time of death and they cooperate with inspectors from relevant agencies to permit access for workplace safety investigations that may lead to prosecutions under workplace safety laws. Police are tasked by the coroner⁷ to investigate the circumstances of the death to determine the cause of death and whether there are any issues in respect of public safety (which may lead to comments or recommendations at inquest to prevent future deaths in similar circumstances) or administrative breaches (eg, breaches of internal policies that may have contributed to or caused the death).⁸ Workplace safety investigations have substantially similar aims to the coronial investigation, but additionally have the authority to prosecute for offences for breaches of safety standards and regulations under relevant workplace safety Acts.

Despite this similarity in the aims of the concurrent investigations, there appears to be limited cooperation between investigators attending at the scene of a workplace fatality. For example, witnesses to the fatal incident may have lengthy interviews with both the workplace inspectors and with police where the content of the interviews may be substantially similar. This can be distressing for witnesses in the immediate wake of a traumatic event. There may also be conflicting information given at each interview and yet, it appears, the statements are not shared between the agencies. In the Commission's opinion there is clearly a need for better cooperation between workplace safety authorities and coronial police to aid the investigations of both parties and to avoid the unnecessary duplication of investigation and consequent waste of resources. This may be achieved in a number of ways including:

- joint training of investigators;
- cooperative briefings at the scene of the fatality and after preliminary investigations have been made by all parties;
- development of protocols to harmonise activities on-site and to ensure that

unnecessary duplication of investigations, interviews and scene examinations is avoided;

- joint interviews of key witnesses (where practicable and appropriate);
- the provision of statements or reports of specialist investigators prepared pursuant to the power contained in Proposal 31; and
- sharing of information, wherever possible, in particular material to which no privilege attaches (eg, witness statements, scene maps and data) during the investigation process.

Police are conscious of their lack of specialist knowledge in workplace deaths and to some extent depend upon the expertise of workplace safety inspectors to assess whether workplace practices that may have contributed to a death (and are therefore of interest to the coroner) are standard or unusual. The Commission is advised that police are currently seeking to undertake relevant training with Western Australian workplace safety authorities to enable them to gain an awareness of standard workplace practices and technical terms, and to improve communication between police and workplace investigators on the site of a fatality. Coronial investigations officers have already undertaken training with the ATSB which will clearly assist police to better investigate aviation deaths. This is an excellent initiative and the Commission encourages Western Australian workplace safety agencies to accommodate the training of coronial police where possible.

PROPOSAL 33

Cooperation between workplace safety inspectors and coronial police

That the Coronial Investigation Unit and workplace safety agencies (ie, WorkSafe, EnergySafety and the Department of Mines and Petroleum) consider the development of cooperative protocols to facilitate communication between parties investigating workplace fatalities in the interests of avoiding unnecessary duplication during investigations of workplace deaths.

7. Police also have an initial general mandate to determine whether the death is a suspicious death or involves any criminality.

8. Coronial Investigation Unit, consultation (14 March 2011).

Impact of prosecutorial delay

Many of the specialist investigators listed earlier in this section undertake death investigations in order to recommend or require relevant changes to practices, procedures and policies that could prevent similar deaths in the future. However, as noted above, WorkSafe, EnergySafety and the Department of Mines and Petroleum also have authority under their respective Acts to prosecute for negligent practices or actions resulting in deaths. Section 53 of the *Coroners Act 1996* (WA) ('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.

The Commission was made aware of problems with delay in relation to coronial findings where deaths were subject to a WorkSafe investigation. Section 52(3) of the *Occupational Health and Safety Act 1984* (WA) gives WorkSafe investigators three years to determine whether charges should be laid 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. Depending on the case and the complexity of the WorkSafe investigation this can be anywhere between 12 months and three years after the date of death.⁹ As discussed in Chapter Three, any delays in the coronial process have the capacity to impact negatively on families wishing to finalise a deceased's financial affairs.¹⁰ The Commission is aware that the State Coroner and WorkSafe have relatively recently negotiated a protocol for coronial access to privileged investigation

documents to enable a faster coronial response to workplace deaths.¹¹ However, such documents appear only to be provided once WorkSafe has made a final decision not to prosecute in connection with the death, so the impact on delay is negligible.¹²

Although it is obviously desirable to have access to as much information pertaining to a death as possible, there will be some cases where the police investigation provides sufficient information for a coroner to make a finding under s 25 or an interim determination under s 28(2) of the Coroners Act.¹³ 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. Indeed, in the Commission's opinion, unless there is reason to believe a decision to prosecute is imminent, a coroner should not wait for WorkSafe to make a decision whether or not to charge a person with occupational safety and health offences in connection with the death where the police investigation suggests to the coroner that an inquest should be held. In such cases, a coroner should give reasonable notice to the relevant prosecuting body of his or her intention to hold an inquest and the dates set down for inquest. Obviously, this process would be assisted, to the benefit of all parties, by continuing communication between the Office of the State Coroner and WorkSafe, and by greater cooperation between coronial and workplace safety investigators as discussed in Proposal 33 (above).

The *Coroners Act 2008* (Vic) makes clear that it is Parliament's intention that coroners liaise with specialist investigators to avoid unnecessary duplication of investigations and to expedite coronial or other investigations where appropriate. Section 7 of that Act provides:

It is the intention of Parliament that a coroner should liaise with other investigative authorities, official bodies or statutory officers—

(a) to avoid unnecessary duplication of inquiries and investigations; and

9. Data provided to the Commission by WorkSafe for fatalities investigated between 2004 and 2007 indicates that approximately half of WorkSafe's completed fatality investigations are forwarded to the coroner within 12 months of the commencement date of the WorkSafe investigation (which may be after the date of death). These cases are ones in which no charges have been laid. The longest delay in forwarding a non-prosecution case to the coroner appears to be just over two years. Where charges are brought, the elapse of time can be up to four years: WorkSafe, *Report on Fatal Accidents Investigated by WorkSafe from 1 July 2004 to 30 June 2008 – Completion Times* (24 December 2008).

10. See Chapter Three, 'Impacts of Delay in Death Registration'.

11. Manager, Office of the State Coroner (WA), consultation (28 June 2010).

12. Ibid.

13. In relation to the latter, see Chapter Three, 'Impacts of Delay in Death Registration'.

- (b) to expedite the investigation of deaths and fires.

The Commission considers this to be a sensible provision and makes the following proposal.

PROPOSAL 34

Avoidance of unnecessary duplication

That the Coroners Act provide that in the interests of avoiding unnecessary duplication of investigations and to expedite coronial or other investigations where appropriate, coroners should take reasonable measures to liaise and cooperate with bodies undertaking specialist investigations into deaths also the subject of coronial investigation, and be authorised to obtain information from and provide information to other investigative agencies.

OMBUDSMAN REVIEW OF CERTAIN DEATHS

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.¹⁴

The Commission has received a submission from a member of the public asking that the potential for ombudsman review of deaths of persons with a disability living in a residential facility be considered. In New South Wales, the Ombudsman has a similar review function to the Western Australian Ombudsman in respect of child deaths, but is also tasked with the review of deaths of disabled people in residential care facilities.¹⁵ The New South Wales Ombudsman is required to report to Parliament¹⁶ about activities undertaken in respect of reviewable

deaths. Typical reports include data collected about, and information relating to, reviewable deaths that occurred in the specified period; recommendations and information about the implementation or otherwise of previous recommendations; and material on policy, funding and other developments and ongoing issues of concern.¹⁷

Recognising their special vulnerability, the Commission has proposed in Chapter Five that disabled people in full-time residential care be included in the definition of 'person held in care' under the Coroners Act.¹⁸ However, while the coroner may hold a public inquest into a death (or deaths) and make recommendations about matters directly related to the death, the benefit of the Ombudsman's review in these cases is that greater attention can be given to systemic concerns. In particular, it is possible that gaps in service provision can be more quickly identified and policies more directly influenced by preventative recommendations that impact across the system. In these circumstances, the Commission seeks submissions on whether the Western Australian Ombudsman's role in reviewing certain deaths should be extended to include deaths of disabled people in residential care facilities.

QUESTION B

Ombudsman review of deaths of disabled people in residential care facilities

Should deaths of disabled people that occur in residential care facilities be subject to review by the Ombudsman to enable the identification of possible systemic issues?

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

15. Ombudsman (NSW), *Community Services Division Factsheet No 3*, available at <<http://www.ombo.nsw.gov.au>>.

16. *Community Services (Complaints, Reviews and Monitoring) Act 1993* (NSW) s 43.

17. See, eg, Ombudsman (NSW), *Deaths of People With Disabilities in Care* (2007) vol 1.

18. See Chapter Five, 'Deaths in Residential Facilities for the Disabled', Proposal 55.

Forensic medical investigation

Once a death becomes a coronial case the coroner investigating the death assumes control of the body of the deceased.¹ At the earliest opportunity police telephone the designated coronial body transport contractor to collect the body and transfer it to the State Mortuary. The body is tagged for identification and a P98 (Mortuary Admission) form is completed by police² detailing the circumstances of the death, including where the body was found and who certified life extinct.³ 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,⁴ after which time the body will be transported to the State Mortuary in Perth for post mortem examination.

This section describes the current post mortem examination process in Perth and looks at some issues impacting on forensic medical investigations undertaken on behalf of the coroner. The rights of next of kin to object to a post mortem examination and the potential for introduction of preliminary external post mortem examinations are discussed in Chapter Seven.

POST MORTEM EXAMINATION

Under s 34 of the *Coroners Act 1996* (WA) ('the Coroners Act') if a coroner 'reasonably believes

that it is necessary for an investigation of a death, the coroner may direct a pathologist or a doctor to perform a post mortem examination on the body'. 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.⁵ 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. PathWest has a team of experts who may contribute to a coronial investigation, including forensic pathologists (who conduct post mortem examinations and collect specimens for analysis), 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.⁶

In Western Australia it appears that, in the vast majority of coronial cases,⁷ 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

1. *Coroners Act 1996* (WA) s 30.

2. The P98 form has a tear-off part that remains with the body so that it may be matched with the full P98 form (which includes a detailed description of the circumstances of death), which is sent electronically to the State Mortuary by CIU.

3. Ambulance officers, nurses and doctors may certify life extinct in all cases, 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, or skeletal remains).

4. Objections to post mortem examination under *Coroners Act 1996* (WA) s 37 are discussed in Chapter Seven. Although no time period for objection is stated in the Act, the State Coroner's Guidelines require that a period of 24 hours (including one full working day) pass after the senior next of kin is advised of the right to object to a post mortem examination and before a direction to perform a post mortem is made by the coroner or coroner's delegate: State Coroner of Western Australia, 'Guidelines for Coroners' (undated) guideline 9.

5. 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.

6. PathWest, consultation (19 August 2008).

7. PathWest estimate between 90% and 95% of coronial deaths will be subject to post mortem examination: PathWest, consultation (26 November 2009).

eye' inspection.⁸ 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.⁹ In most coronial cases, samples¹⁰ 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 (or in some circumstances, complete)¹¹ post mortem report is forwarded to the coroner. The interim post mortem report may contain a preliminary determination as to cause of death or it may be classified as 'undetermined' subject to the receipt of toxicological analysis and other tests ordered by the forensic pathologist. The completed post mortem report usually takes from 2–18 months¹² to be received by the coroner. Forensic 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).¹³ 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.¹⁴

8. 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.
9. PathWest, consultation (19 August 2008) 3.
10. Generally these samples are taken from liver tissue, urine, blood, bile from the gall bladder and stomach contents.
11. In some cases, no further testing is required to arrive at the cause of death or testing (such as histopathology) may be undertaken and results recorded on the same day as the internal post mortem examination. In these cases a complete post mortem examination finding report is forwarded directly to the coroner on the day of the examination.
12. 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.
13. Only one neuropathologist in Western Australia currently works on coronial cases: PathWest, consultation (26 November 2009).
14. 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.

ISSUES AFFECTING POST MORTEM EXAMINATION

Provision of information to forensic pathologists

Forensic pathology is a highly specialised and complicated area of practice. Putrefactive changes in deceased tissue can mask underlying disease or introduce environmental factors that may impact upon a finding. It has been remarked that a post mortem examination may reveal 'the disease and lesions that the person lived with and not necessarily those which killed him'.¹⁵ In this regard, Professor Roger Byard, former Chief Forensic Pathologist of South Australia, has noted that the significance of findings of underlying disorder identified during post mortem examination must be assessed in the context of the circumstances of death and the deceased's medical history.¹⁶

For example, let us examine the cause and manner of death in a 55-year-old man with significant atherosclerotic vascular disease that has occluded his left anterior descending artery. If he collapsed and died in front of others while playing a game of squash, the cause of death would be ischaemic heart disease (manner—natural); if depressed and found alone with a note and an empty syringe of insulin beside him, death would be due to hypoglycaemia (manner—suicide); if a perpetrator confessed to placing a plastic bag over his head after a financial dispute, death would have been due to plastic bag asphyxia (manner—homicide); and finally, if found in a sewer with high levels of methane and carbon dioxide and negligible amounts of oxygen, death would be due to asphyxia (manner—accident) – and yet the pathological findings in each case will in all likelihood be identical.¹⁷

To enable forensic pathologists to critically assess their findings, they require as much information as possible about the circumstances of death.¹⁸ Protocols have been established by PathWest in conjunction with police for the provision of necessary information in certain types of deaths (eg, hanging deaths, child deaths), and

15. Professor Bernard Knight as quoted in Byard RW, 'Forensic Pathology and Problems in Determining Cause of Death' (2008) 4 *Forensic Science, Medicine and Pathology* 73, 74.
16. Byard, *ibid* 74.
17. *Ibid*.
18. Information about the circumstances of death is also helpful to ensure that appropriate tests are ordered by pathologists; for example, in cases where medication bottles are found at the scene of death it is useful for a pathologist to know about these so as to order appropriate toxicology testing for known drugs.

the provision of crucial medical notes in medical care cases is discussed earlier in this chapter.¹⁹ However, in most cases forensic pathologists must proceed on the information provided by police in the P98 Mortuary Admission Form. In some cases the information provided by investigating officers can be extremely brief.²⁰ The Commission has been informed that the Coronial Investigation Unit (CIU) now provides an oversight function of P98 forms submitted from district offices.²¹ Those that do not provide sufficient information are rejected and returned to the investigating officer to complete. While this is appropriate, it may unnecessarily delay the performance of a post mortem examination. In these circumstances, the training being developed by the CIU for operational officers (discussed earlier) to improve the quality of police reporting in coronial matters and the possible adoption of the national police form (which specifies questions that can assist forensic pathologists in identifying cause of death) are important.

Provision of body in optimal condition for post mortem

In its Background Paper the Commission noted problems experienced in the north-east of Western Australia where bodies had been transported by unrefrigerated vehicles in extremely hot conditions over long distances.²² 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. While transport in refrigerated vehicles is not a requirement of the coronial transport contract, there is 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. Although many of the regional cases coming to Perth for post mortem examination have causes of death that are evident from gross examination of the body²³ where limited deterioration does not impact the reliability of the findings, this is not the case where the death is caused by a subtle infection.²⁴ In those cases, findings can be significantly impaired by deterioration and provision of the body in optimal state is desirable.²⁵

The Commission's consultation with police in one regional area revealed a concerning practice in relation to transport of bodies to Perth for forensic post mortem examination. The Commission was told that, although the retrieval of bodies by body transport contractors was usually overseen by police, 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. The Commission is not aware how widespread this practice is, but it is important that this is addressed by police authorities at the earliest opportunity and the Commission therefore makes the following proposal.

PROPOSAL 35

Police to seal body bags

That the Western Australia Police take action to ensure that, where bodies are transported to Perth from regional areas by body transport contractors, retrieval of bodies should be overseen and body bags sealed by police to prevent tampering or contamination of evidence prior to post mortem examination.

19. See 'Seizure of Medical Records', above.

20. Roger Byard gives the example of similar forms consisting of a description as brief as 'found dead at home address': Byard RW, 'Forensic Pathology and Problems in Determining Cause of Death' (2008) 4 *Forensic Science, Medicine and Pathology* 73, 74.

21. Detective Inspector Mark Bordin, OIC Coronial Investigation Unit, consultation (11 March 2011).

22. LRCWA, *Review of Coronial Practice in Western Australia*, Background Paper (September 2010) 56. This issue has also been ventilated in the media: see 'Funeral Director Defends Using Ice Packs, Hire Cars', *The West Australian* (4 February 2010).

23. Eg, motor vehicle accidents, suicides and homicides.

24. PathWest, consultation (19 August 2008).

25. *Ibid.*

IMPACT OF DELAY IN DELIVERY OF POST MORTEM FINDINGS

As discussed in Chapter Three, delays in any part of the coronial process can impact negatively on families wishing to finalise the deceased's affairs.²⁶ Proposal 25, dealing with the provision of interim coronial determinations to the Registrar of Births, Deaths and Marriages to enable the issuing of a death certificate containing sufficient detail to facilitate insurance claims, requires the timely provision to the Office of the State Coroner of post mortem examination findings (whether complete or interim) that provide a cause of death.²⁷ Delays in the provision of post mortem examination findings can be caused by the requirement for and availability of specialised testing (such as neuropathology), backlog in other laboratories (such as ChemCentre, which undertakes forensic toxicological testing) and failure of investigators to provide forensic pathologists with medical notes or sufficient information regarding the circumstances of the death.²⁸ Delays can also be introduced by human resourcing issues, such as when a forensic pathologist takes leave when part of his or her caseload is not finalised.²⁹

Although a post mortem examination is usually performed as quickly as possible after finding the body of the deceased, the pathologist's interim findings are sometimes classified as 'undetermined' pending further investigations. During the Commission's consultations, a number of people commented that the incidence of undetermined cases (ie, where no interim cause of death has been given) had increased in recent years. This was confirmed by a search of Western Australian post mortem examination findings in 'closed' cases³⁰ on the National Coroners Information System, which revealed a substantial increase in the number

of post mortem examination findings listed in the interim stage as 'undetermined' with a significant jump from just 18 cases in 2001 to 637 cases in 2008.³¹ Of a possible total of 1,797 coronial cases in 2008 this represents at least 35% of coronial post mortem examinations as opposed to just over 1% of all coronial cases in 2001.³² The precise explanation for this remarkable increase in undetermined findings is unknown. The Commission understands that most (though certainly not all) post mortem examinations will enable the forensic pathologist to identify a probable cause of death, with tests such as toxicology and histopathology confirming the cause of death or adding detail to the finding. While there may be an understandable hesitancy to commit to a precise cause of death until results of all tests are available, this does not necessarily explain the increase in interim undetermined findings. In this regard, the Commission notes that all interim findings carry a qualifying clause which states: 'It may be necessary to modify this opinion as results of investigations undertaken as part of the post mortem examination become available'. For present purposes it is important to note that, where interim post mortem examination findings classify the cause of death as 'undetermined', an interim coronial finding cannot be provided to the Registrar of Births, Deaths and Marriages and an interim death certificate cannot be issued to facilitate the finalisation of a deceased's affairs.

While delays between interim 'undetermined' post mortem examination findings and completed findings are inevitable, the length of those delays can be managed. Since April 2010, at the instigation of the CIU, the State Coroner has been holding monthly meetings

26. Chapter Three, 'Impacts of Delay in Death Registration'.

27. It also requires timely disposition by the Office of the State Coroner.

28. The importance of such information to assist forensic pathologists to confirm their internal post mortem examination findings is noted in Byard RW, 'Forensic Pathology and Problems in Determining Cause of Death' (2008) 4 *Forensic Science, Medicine and Pathology* 73, 74.

29. This is inevitable where cases are undetermined pending further testing and the test results have not been returned before the staff member takes leave.

30. A closed case is one where a coroner's finding has been recorded. It is possible that not all 'undetermined' interim findings have been accounted for because a certain number of cases each year remain in open status (eg, homicides awaiting prosecutions and cases awaiting inquest or coronial administrative finding).

31. National Coroners' Information System (accessed 12 March 2011). The most significant increase in a single year was observed between 2003 and 2004 where undetermined interim findings jumped from 62 cases in 2003 to 304 cases in 2004. The number of undetermined interim cases appears to have increased steadily since that time to the figure of 637 in 2008. In 2009 this figure dropped to 556 cases; however, it is too early to obtain a reliable figure for that year as it likely that a number of cases remain open and are therefore not included in the results of closed cases available to the Commission.

32. The total number of coronial cases in 2001 was 1,505. It should be noted that the total coronial case figure is higher than the number of cases that were subject to post mortem examination, which could increase the ratio of undetermined to total cases. Although post mortem examinations are undertaken in the vast majority of coronial deaths some will be excluded because of an upheld objection to post mortem examination or because (in the case of suspected deaths) there is no body to examine.

with PathWest, ChemCentre and the CIU to advance the progress of undetermined cases in the coronial system. At these meetings the undetermined files are presented and explained by the pathologists and the source of delay is identified. Though the backlog in finalising interim undetermined post mortem examination findings is still significant, since these meetings began police have observed a reduction in delays. This is excellent practice and all parties are to be commended for their dedicated attention to resolving problems of delay in this area.

CENTRE FOR FORENSIC MEDICINE

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 (VIFM), 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 PathWest and the Coroners Court was both collegial and appropriate. Both the forensic pathologists and the coroners informed the Commission that they preferred to maintain the clear distinction between their roles and responsibilities including in regard to physical location.³³ In particular, forensic pathologists emphasised the benefits of their current co-location with a major public hospital and stressed the desirability of maintaining close professional relations with their clinical colleagues.

Having reviewed the matter the Commission has determined that the need for an 'all-in-one' centre for forensic medicine is not great in Western Australia. The monthly meetings outlined above are an example of cooperative practices between PathWest and the Coroners Court, and show that both parties are

dedicated to working together to benefit the coronial system in Western Australia. In the Commission's opinion, the trend identification and analysis of deaths function potentially undertaken by a centre for forensic medicine would be better housed within the Coroners Court, which has access to a greater range of investigation material about the circumstances of death than PathWest and is responsible for data input into the National Coroners Information System. This is discussed, along with the enhanced prevention role of the coroner, in Chapter Six. Having said this, it is clear from the Commission's consultations and viewing of the PathWest facility at QEII Medical Centre in Nedlands that there is a significant and urgent need for modernisation and enlargement of the entire facility. The Commission understands that the development of the new PathWest facility (located close to the existing site) is well underway with completion expected in 2012.³⁴

33. State Coroner and Deputy State Coroner, consultation (20 August 2008); PathWest, consultation (19 August 2008); PathWest, consultation (26 November 2009).

34. QEII Redevelopment, <<http://www.nmahs.health.wa.gov.au/BuildingProgram/QEII/RedevelopmentUpdate.html>> (accessed 13 March 2011).

Deaths in custody or police presence

As discussed in Chapter Three, the definition of reportable death includes a person held in care (relevantly defined as being held in custody, escaping from custody or being transported to or from custody) and a person whose death 'appears to have been caused or contributed to by any action of a member of the Police Force'.¹ These include deaths where police have obvious involvement (eg, a police shooting or a suicide in a police lockup) to those where the involvement of police is less clear (eg, a death caused by a motor vehicle accident where a pursuit by police was abandoned prior to the death). In each of these cases, an inquest must be held to examine the circumstances of the death in a public forum.² This section examines the current investigation models for these types of deaths and considers whether a new approach to death in custody or police presence investigations is warranted.

DEATHS IN PRISON CUSTODY

In Western Australia, death in custody³ investigations on behalf of the coroner are conducted by experienced police officers from the Major Crime Squad. This is in keeping with recommendations of the Royal Commission into Aboriginal Deaths in Custody (RCIADIC) which require that the most qualified death investigators be responsible for death in custody investigations.⁴ Deaths in custody can range from expected deaths from terminal illnesses⁵ to suicides or homicides and under s 22 of the *Coroners Act 1996* (WA) ('the Coroners Act') all such deaths must be inquested. The Department of Corrective Services Policy

Directive 30 governs how prison officers deal with a suspected fatality upon discovery.⁶ First they are required to raise the alarm, check for vital signs and administer CPR until ambulance officers attend to take over or certify life extinct. Meanwhile the superintendent must notify a number of people including the Major Crime Squad. Once the prisoner is confirmed deceased the scene of death must be preserved as a possible crime scene awaiting the attendance of police and forensic scene analysts. Those officers who discovered the deceased must remain at the prison to be questioned.⁷

Notification of the coroner

Section 17(5) of the Coroners Act provides that:

The death of a person who, immediately before death, was a person held in care must be reported immediately to a coroner by the person under whose care the deceased was held.⁸

Section 17(5) explicitly states that notification must be made to a coroner; this is different to the general obligation to report under s 17(1) which provides that notification can be made to either the coroner or a member of the police service.

Under the Department of Corrective Services Policy Directive 30 a long list of notifications is required to be made immediately upon the discovery of a deceased. These notifications are prioritised as follows:

1. *Coroners Act 1996* (WA) s 3.
2. *Coroners Act 1996* (WA) s 22. See further Chapter Five, 'Mandated Inquests'.
3. These include deaths in juvenile detention and deaths in prisoner transport, but do not include deaths in police transport or police custody. Those deaths are dealt with in 'Deaths Involving Police', below.
4. Royal Commission into Aboriginal Deaths in Custody, *National Report* (1991) vol 5, recommendation 34.
5. Often such prisoners will be in palliative care in a hospital but are still under the custody of the prison and therefore require a mandated inquest.

6. Policy Directive 30 provides a detailed procedure for prison officers upon discovering a death in custody including notification, security of the scene, recording of events, collation of records and exhibits and reporting, and includes a comprehensive action checklist. Regulations 74 and 75 of the *Prison Regulations 1982* also briefly deal with procedures on death of a prisoner.
7. Office of the Inspector of Custodial Services, *The Diminishing Quality of Prison Life: Deaths at Hakea Prison 2001–2003*, Report No 22 (2004) 81.
8. The current penalty for breach of this section is \$1,000, but it should be noted that Proposal 14 proposes increasing the penalty to \$10,000 or 12 months' imprisonment: see Chapter Three, 'Obligation to Report a Death'.

4.3 The designated superintendent shall immediately notify:

- Superintendent Custodial Operations
- The Director Health Services and on-call doctor for that site
- The police officer in charge at the nearest police station
- The Staff Psychologist to the department
- The Manager, Suicide Prevention
- The Manager, Aboriginal Visitors Scheme, if the prisoner was Aboriginal
- The site Staff Support Co-ordinator
- The relevant prison chaplain (where indicated on the reception history sheet, if the prisoner was of a particular religion)
- The Manager, Clinical Services (Offender Services)
- The Manager, Offender Services at the prison where the death occurred

In turn, paragraph 4.4 provides:

4.4 The Superintendent Custodial Operations shall immediately notify:

- The relevant Director
- Commissioner
- Deputy Commissioner Adult Custodial
- Assistant Commissioner Custodial Operations
- The Director Security Services
- The Police Prisons Team, Major Crimes Squad
- The Manager Standards and Review
- The Office of the Inspector of Custodial Services
- The Manager or Duty Officer, Public Affairs
- Assistant Commissioner Aboriginal Justice (where deceased is Aboriginal)

4.4.1 The Superintendent Custodial Operations shall comply with the Ministerial Notification (Critical and Major Incidents) Protocol, Adult Custodial Division, to facilitate the prompt notification of the Minister.

Paragraph 4.7 provides that 'the Deputy Commissioner shall within one working day provide written notification to ... the Coroner's Office – to provide additional information to that provided by the police, and an indication of information to follow'. It appears from this paragraph that the Department of Corrective Services have assumed that reporting the death to police satisfies its obligation to report

under s 17(5) of the Coroners Act. It does not. The Commission therefore proposes that Policy Directive 30 be amended to provide for immediate notification of the coroner at the same time as notification of Major Crime Squad police, which should be appropriately prioritised.

PROPOSAL 36

Department of Corrective Services Policy Directive 30

1. That the Department of Corrective Services amend its Policy Directive 30 to provide for immediate notification of the coroner upon the discovery of a death in custody.
2. That the Department of Corrective Services amend its Policy Directive 30 to provide for prioritisation of notification of Major Crime Squad police upon the discovery of a death in custody.

Guidelines for deaths in custody

Pursuant to the recommendations of the RCIADIC,⁹ the State Coroner has developed guidelines for the investigation of deaths of 'Prisoners in the Custody of the Ministry of Justice'.¹⁰ However, like the Guidelines for Police these have not been updated since they were established in 1997. The information provided within the guidelines is informational rather than directive and appears now to have been almost completely subsumed by the Department of Corrective Services Policy Directive 30.¹¹ The Commission therefore proposes that the State Coroner review and update the guidelines, placing particular emphasis on the obligations of custodial officers under the Coroners Act.

PROPOSAL 37

State Coroner's guidelines: deaths in custody

That the State Coroner review and update the guidelines for the investigation of deaths in custody.

9. Royal Commission into Aboriginal Deaths in Custody, *National Report* (1991) vol 5, recommendation 8.
10. State Coroner, 'Guidelines – Persons Held in Care – Prisoners in the Custody of the Ministry of Justice' (undated).
11. Department of Corrective Services, Policy Directive 30, 'Death of a Prisoner'.

Concurrent internal review

At the same time as the police investigation is being undertaken on behalf of the coroner, an internal review is undertaken by the Department of Corrective Services. The Custodial Standards and Review Team create a report for the department on the circumstances of the death which may contain recommendations for change to policies or procedures. The Critical Reviews Unit within the department provide to the coroner a Management Review Report which summarises the recommendations made by the department's Custodial Standards and Review Team and provides the department's response to those recommendations along with any further information that may be required by the coroner or counsel assisting leading up to inquest.¹² The Commission was told that the department's internal investigators were almost always called as witnesses at a death in custody inquest.¹³ Following the inquest the Critical Reviews Unit provide the coroner with a response to the coronial recommendations emanating from the inquest and has an ongoing role in monitoring implementation of the coronial recommendations (where supported by the department).

Coronial investigation delays

The Commission's consultations revealed some criticisms about investigations into prison deaths in custody. A primary concern was the delay between the date of death and the date of inquest. An evaluation of the process undertaken by the Office of the Inspector of Custodial Services in 2004 attributed the delay to the police investigation stage, stating that:

Despite the fact that the core work seems to have been done within a week – or at worst two – many months can then pass before the completion of the police investigation file. ... Whatever the explanation, the delays between the commencement and the completion of the police investigation report seem excessive.¹⁴

12. Sue Holt, Manager Critical Reviews Unit, Department for Corrective Services, consultation (24 September 2008).

13. Ibid.

14. Office of the Inspector of Custodial Services, *The Diminishing Quality of Prison Life: Deaths at Hakea Prison 2001–2003*, Report No 22 (2004) 81.

While the Commission does not have access to the dates on which police reports are provided to the coroner, a desktop analysis of death in prison custody cases in 2004 (at the time the Inspector of Custodial Services' report was written) and 2010 shows that the time elapsed between death and inquest has increased. In 2010 the average time for a death in custody to reach inquest was 31 months with almost all cases being natural causes deaths and some being the expected outcome of terminal illness. In contrast, in 2004 the average time for a death in custody to reach inquest was 21 months with the majority of cases being suicide deaths (with possibly more complex investigations). In the Commission's opinion, the Coroners Court should be striving for finalisation of a death in custody investigation and inquest (where no criminality is involved) within 12–18 months. Any longer than this and the circumstances of the death become historical and recommendations to prevent the occurrence of future deaths in similar circumstances are less meaningful. A number of respondents to the Commission's public survey who had been involved as witnesses in prison deaths also commented that the significant delays in the coronial process meant that it was difficult to recall events accurately and this made the experience of giving evidence very stressful.

Adequacy of investigations

An issue raised by the Aboriginal Legal Service was that traditional police investigations are

narrowly focussed on compliance with the law and criminality. By contrast, coronial investigations require a broader ambit that involves the identification of important thematic issues and consideration of all of the circumstances surrounding the death.¹⁵

This was a point also raised by others the Commission consulted in relation to deaths in custody. The Commission notes that while the Coronial Investigation Unit (CIU) has sought training to refocus its officers' investigations (once criminality is discounted) to the questions the coroner needs answered, the same training has not been undertaken

15. Aboriginal Legal Service of Western Australia (Inc), submission (December 2010) 7.

by investigators in Major Crime. If homicide detectives are to continue in the role of deaths in custody investigators, ideally they should be properly trained about the requirements of a coronial investigation in circumstances where the potential of criminality has been ruled out. The Commission believes that the CIU is best placed to provide such training to major crime officers. In addition, it is the Commission's view that an officer from the CIU should be in joint attendance with major crime detectives at every death in prison custody investigation. This will ensure that the coronial aspects of the investigation are immediately attended to and adequately addressed.

In making the proposals below the Commission notes that s 14 of the Coroners Act, which allows the appointment of independent coroner's investigators, could be invoked to ensure the integrity of coronial investigations into deaths in custody.¹⁶ However, the Commission does not see the same problem with potential conflict of interest in the police investigation of deaths in prison custody that it does with regard to police investigation into police-related deaths (dealt with below). While it is possible that independent coronial investigators could play an oversight role in relation to deaths in prison custody to ensure coronial matters are properly addressed, the Commission is of the opinion that the CIU is currently best placed and best resourced for this function.

PROPOSAL 38

Coronial training for Major Crime Squad

That the Coronial Investigation Unit develop a targeted training module for Major Crime Squad detectives to raise awareness about the coroner's requirements for investigations into deaths in custody where no actionable criminality is detected.

16. Such a role was envisaged by Parliament when debating the Bill; however, to the Commission's knowledge no independent investigator has ever been appointed under the *Coroners Act 1996* (WA) s 14: 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).

PROPOSAL 39

Joint attendance with Coronial Investigation Unit for deaths in custody

That the Major Crime Squad and Coronial Investigation Unit jointly attend the scene of a death in prison custody to ensure that the coronial aspects of the investigation are adequately addressed.

Collaboration with the Office of the Inspector of Custodial Services

In consultations with the former Inspector of Custodial Services, the Commission was invited to consider a different model for investigations into deaths in custody.¹⁷ In England and Wales, the Prisons and Probations Ombudsman (PPO) investigates deaths in custody (including immigration detainees) and complaints from prisoners, people on probation and people being held in immigration removal centres.¹⁸ PPO investigations run in tandem with coronial investigations and focus on systemic issues such as safety and governance of the institution. Reports from the PPO are provided to the coroner who conducts an inquest into each death in custody. Detailed anonymised reports are published online on the PPO's website and often provide recommendations for reform of policies and procedures.¹⁹ While the attractions of a PPO model are manifold, it must be remembered that the volume of work is significantly different between England and Western Australia. The PPO investigates an average of 200 deaths each year, while deaths in custody in Western Australia rarely exceed half a dozen. In these circumstances, an independent body dedicated to death in custody investigations running in tandem with coronial investigations into the same deaths is probably not a feasible option for Western Australia.

17. Richard Harding, Former Inspector of Custodial Services, consultation (21 August 2008).

18. See <<http://www.ppo.gov.uk>> (accessed 28 March 2011).

19. <<http://www.ppo.gov.uk/investigating-fatal-accidents.html>> (accessed 28 March 2011).

Nonetheless, the Commission believes there is scope and opportunity for the Coroners Court to improve its identification of systemic concerns and to better fulfil its prevention role. A brief analysis of Department of Corrective Services' responses to coronial recommendations shows that where coronial recommendations are not supported or unable to be implemented by the department the problem is primarily one of lack of systemic or practical knowledge of the prison system by the relevant coroner.²⁰ As noted earlier, the coroner receives some assistance in this respect from the Management Review Reports provided by the Critical Reviews Unit of the Department of Corrective Services; however, such advice while well informed is not independent. The Commission considers that the Office of the Inspector of Custodial Services should have a role in assisting the coroner to identify possible systemic issues and address those issues by developing more-informed recommendations. The Office of the Inspector of Custodial Services is well placed to offer such assistance: it has completed four inspection rounds of all Western Australian custodial facilities since 2000, and has a thorough understanding of the practices of each prison and the issues that impact across the system. The Office of the Inspector of Custodial Services also has the distinctly advantageous position of being able to follow up on the progress of implementation of coronial recommendations during its regular prison inspections, the reports of which are tabled in Parliament. In addition, the State Coroner should be aware of the recommendations of the Office of the Inspector of Custodial Services, which may provide a better evidence-base for future coronial recommendations. In the Commission's opinion, it is in the best interests of both the Office of the State Coroner and the Western Australian public for such collaboration to be actioned at the earliest opportunity.

20. For example, a recommendation by the coroner that all 'unlock' officers at a particular prison carry Hoffman knives (for the cutting of ligatures) was unable to be implemented because a knife carried as routine on the person would place officers at risk. Another recommendation for the dimming of lights in a secure unit was not supported because the physical infrastructure of the prison did not allow it: Sue Holt, Manager Critical Review Team, Department of Corrective Services, letter (31 December 2008).

PROPOSAL 40

Collaboration with the Office of the Inspector of Custodial Services

That the State Coroner develop a collaborative information sharing relationship with the Office of the Inspector of Custodial Services with a view to receiving independent information about Western Australian prisons and better informing coronial recommendations that impact systemically across the prison system.

DEATHS INVOLVING POLICE

A concern of a number of lawyers consulted by the Commission was the potential for an actual or perceived conflict of interest where police officers investigate deaths that may have been caused or contributed to by police.²¹ It is important to note at the outset that Western Australia is not alone in this regard. In all Australian jurisdictions police officers are involved in such investigations; the only difference is the level and independence of the oversight of investigations with some being oversighted by senior police and others being oversighted by an independent body or directly by the State Coroner. In Western Australia police-related deaths are investigated by the Major Crime Squad or the Major Crash Investigation Unit (for pursuit deaths) with oversight or joint investigation by Internal Affairs.

Police investigating police

There have been a number of very high profile inquests in Western Australia in which the investigations of police in police-related deaths have been criticised by the coroner and others. These include a 2008 inquest into the police shooting of a mentally ill man²² and a 2010 inquest into four motor vehicle fatalities following police pursuits.²³ In 2010 the State Coroner wrote to the Commission outlining his

21. The issue of police investigating police has been the subject of a recent article in Western Australia: see Alligham K & Collins P, 'Coronial Reform in Western Australia' (2008) 12 (SE2) *Australian Indigenous Law Review* 90, 90.
 22. Coroners Court (WA), *Inquest into the death of Daniel Rolph* (7 July 2008).
 23. See 'Coroner Questions Police Statements', *The West Australian* (24 August 2010); 'Coroner Criticises Top Cop on Chase Speeds', *The West Australian* (25 August 2010).

concerns regarding the police investigation of police-related deaths. He noted potential issues with the provision of transcripts of interviews with police witnesses where the information had been obtained by compulsion under a disciplinary demand. This issue is discussed in depth earlier in this chapter.²⁴ Another concern expressed by the coroner was that questioning of police in these cases 'differs from questioning of other witnesses and very often suggestions are made by the questioner which would provide an explanation for or otherwise reflect well on the conduct of the officers concerned'.²⁵ He suggested that 'it is difficult to imagine a system which would favour police officers concerned more than the current one'.²⁶

In its submission to the Commission following release of the Background Paper, the Aboriginal Legal Service commented that:

Key cultural and systemic issues within the police force may impact upon internal investigations into potential police misconduct related to a death in custody or police presence. It is possible that police investigations may not be conducted in as thorough, objective and independent manner as is required when a death in police presence and/or custody occurs. In addition to police officers being unwilling to be critical of individual police colleagues, investigating police officers may also be unwilling or unable to identify and criticise broad systemic issues within the police force that may have contributed to the death.²⁷

The Commission also heard some criticism from counsel during initial consultations that the focus of police investigations in all coronial cases, including police-related death cases, was too narrowly confined to criminal responsibility and that certain issues that should be canvassed in a coroners brief were left wanting.

Alternative models

The Commission is aware that similar concerns about the potential partiality of police have been raised in other states where investigation arrangements for deaths involving police are comparable to Western Australia, notably Queensland and Victoria. In Queensland's

24. See 'Provision of Information to the Coroner', above.
25. Alastair Hope, State Coroner, 'Matters for Consideration by the Law Reform Commission', letter (7 January 2010).
26. Ibid.
27. Aboriginal Legal Service of Western Australia (Inc), submission (December 2010) 7.

2010 Mulrunji Inquest involving the death of a man in a police lockup on Palm Island, Special Coroner Hine recommended that the Crime and Misconduct Commission take over the investigation of police-related deaths in that state.²⁸ The Commission is advised that several options are now being considered in that state for the investigation of police deaths, including the option of embedding police investigators in the Coroners Court reporting directly to the State Coroner. In Victoria, following the fatal police shooting of a 15-year-old boy, the Office of Police Integrity (OPI) 'commissioned research into the appropriateness of Victoria Police investigating deaths associated with police contact'.²⁹ The OPI has released an Issues Paper, which helpfully sets out five alternative models for investigation of police contact deaths, summarised below.³⁰

Investigation by another police service model: this is one model used in Canada and it is said to allow for 'a perception of independence and objectivity of the investigation and [minimises] the effects of internal loyalty and solidarity'.³¹ The OPI notes that 'the use of external police to investigate police-related deaths has received some criticism similar to that levelled at internal police investigations'.³²

Hybrid civilian/police model: this model is used in one province of Canada and is effectively an incident response team of mixed police and civilian investigators.³³ The OPI notes being a civilian controlled agency it has difficulty in attracting suitably qualified police investigators.³⁴

Civilian-managed investigation model: this is the model used in England and Wales under the auspices of the Independent Police Complaints Commission.³⁵ Under this model

28. Coroners Court (Qld), *Inquest into the death of Mulrunji* (14 May 2010) 150.
29. Office of Police Integrity Victoria, Terms of Reference, 'Investigations of Deaths Associated with Police Contact' (undated).
30. Office of Police Integrity Victoria, *Review of the Investigation of Deaths Associated with Police Contact*, Issues Paper (October 2010) 45 <<http://www.opi.vic.gov.au>>
31. Ibid 45.
32. Ibid.
33. Ibid 46.
34. Ibid.
35. These are called managed investigations and apply to cases where a completely independent investigation is not considered to be warranted. The Independent Police Complaints Commission can also undertake independent investigations.

the investigation is undertaken by police but directed and controlled by the civilian agency. One disadvantage of this model identified by the OPI is that the agency 'may be too remote to ensure the integrity of the investigation' and may not, for example, be able to ensure that all witnesses are identified and interviewed and that appropriate questions were asked.³⁶

Embedded civilian observer model: this is another model in use in Canada and Los Angeles and involves a person employed to 'oversee and assess the impartiality of police investigations' into a police death.³⁷ This model is said to 'improve confidence and strengthen the integrity of the investigation process', but it does not 'remove or address the issues associated with police conducting investigations'.³⁸ A variant of this model was suggested to the Commission by Internal Affairs police who raised the potential of independent investigators from the Corruption and Crime Commission being involved in an observation and oversight capacity at all stages of a police-related death investigation to maintain the integrity of the investigation.³⁹

Independent model: this model is used in Northern Ireland, South Africa, New Zealand, Chicago and Ontario. These agencies are institutionally separate from the police service and generally use a mix of police investigators seconded to the agency, ex-police officers and civilian investigators. The OPI noted that while the advantage of the independent model is that it provides 'maximum assurance to ... the public that the investigation will be objective, impartial and rigorous', such agencies require significant resources.⁴⁰ Despite the institutional independence from police, it is usual that police will be depended upon to secure a scene and provide certain forensic services such as ballistics with some agencies also utilising seconded police investigators.⁴¹ This may impact upon the public's perception of the

degree of independence from police. A further disadvantage identified by OPI is that police may not have sufficient confidence in or be willing to cooperate with a completely civilian-based service.⁴²

In addition to the five models identified by the OPI, the Commission notes a further model recently implemented in South Australia, which uses police detectives based in the Office of the State Coroner to investigate police-related deaths and deaths in custody. As discussed above in relation to deaths in custody, the current Coroners Act has facility in s 14 to appoint independent coroner's investigators and this provides yet another option to consider in relation to a **coroner-based model**. A model using coroner's investigators that are independent of police to investigate all coronial deaths was preferred by the Aboriginal Legal Service.⁴³

The Commission's preliminary view

In the RCIADIC report, Commissioner Elliot Johnson QC observed:

A death in custody is a public matter. Police and prison officers perform their services on behalf of the community. They must be accountable for the proper performance of the duties. Justice requires that both the individual interest of the deceased's family and the general interest of the community be served by the conduct of thorough, competent and impartial investigations into all deaths in custody.⁴⁴

The RCIADIC relevantly recommended that investigating officers should be the highest qualified investigators, independent of the officers allegedly or apparently involved in the death and also preferably independent from an internal affairs unit.⁴⁵ The current arrangement does meet these requirements, but questions remain about the independence of police investigators in police-related deaths. The Commission acknowledges there are advantages to police investigating such deaths and these include that they have the appropriate skills and expertise in death investigation and knowledge of police practices. However, it is

36. Office of Police Integrity Victoria, *Review of the Investigation of Deaths Associated with Police Contact*, Issues Paper (October 2010) 47.

37. Ibid 48.

38. Ibid.

39. Detective Superintendent Fred Zagami, *Deaths in Custody Investigations*, Western Australia Police, consultation (28 February 2008).

40. Office of Police Integrity Victoria, *Review of the Investigation of Deaths Associated with Police Contact*, Issues Paper (October 2010) 48.

41. Ibid 49.

42. Ibid.

43. Aboriginal Legal Service of Western Australia (Inc), submission (December 2010) 7-8.

44. Royal Commission into Aboriginal Deaths in Custody, *National Report* (1991) vol 1, 109.

45. Ibid, vol 5, recommendations 33 & 34.

clear that the conflict of interest (whether real or apparent) will continue to attract criticism of police-led investigations. In the interests of transparency of process and a full and frank coronial investigation into the cause and circumstances of a police-related death, the Commission believes that a new model warrants consideration.

Having considered the models set out above, the Commission is attracted to the model in which an independent observer is embedded with the police investigation from its earliest stage. The Commission considers that the Corruption and Crime Commission is well placed to supply experienced investigators for the purpose of overseeing a police investigation into a police-related death to ensure the integrity of the investigation and quality of investigation processes, while maintaining the confidence of police in the investigation process.⁴⁶ An advantage of this model and a distinct difference between Western Australia and the jurisdictions that have completely independent investigation agencies is that there are very few police-related deaths in Western Australia each year and probably not enough to warrant a separate agency for that purpose.⁴⁷ Another benefit is that this model requires very limited resourcing and can be deployed with immediate effect. Having said this, the Commission notes that the Final Report of the OPI, which should set out its recommendations for reform in that state, is expected to be tabled in the Victorian Parliament sometime this year. The Commission feels that it is prudent to wait for that report before making a concrete proposal for reform and therefore it simply invites submissions on the following model.

46. The Commission still sees a strong role for Internal Affairs in this model; the Corruption and Crime Commission would simply provide additional and clearly independent oversight.

47. Police estimate that there are around six police-related deaths per year in Western Australia. Places where independent agencies have been established usually investigate many more deaths. The most recent information available (for 2009–2010) shows that the Independent Police Complaints Commission in England and Wales investigated 86 police-related deaths <http://www.ipcc.gov.uk/Pages/reports_polcustody.aspx>; the Independent Complaints Directorate in South Africa investigated 1287 police-related deaths <http://www.icd.gov.za/documents/report_released/annual_reports/2008-2009/Part1.pdf>; and the Garda Ombudsman in the Republic of Ireland investigated 16 police-related deaths <<http://www.gardaombudsman.ie/GSOC/GSOC-Annual-Report-2009.pdf>> (accessed 28 March 2011). Each of these agencies also deal with complaints of misconduct and other police integrity matters.

QUESTION C

Oversight of police-related deaths by the Corruption and Crime Commission

Should police-related deaths be subject to independent oversight by the Corruption and Crime Commission? It is envisaged that such oversight would involve the embedding of Corruption and Crime Commission investigators from the beginning of a police-related death investigation to ensure the integrity of the investigation is monitored and that the requirements of the coroner are properly addressed.

It would preserve the role of senior police detectives in investigating the death on behalf of the coroner and of Internal Affairs providing internal and disciplinary oversight in relation to the investigation of police officers being investigated in relation to the death. The Corruption and Crime Commission investigators may, among other things, provide a separate report to the coroner about the integrity, depth and nature of the investigation.

Deaths in healthcare facilities

DEATHS IN HOSPITALS

According to coronial police, approximately 27% of deaths investigated by the Coronial Investigation Unit (CIU) are hospital deaths.¹ During consultations police confided some concerns about their capacity to investigate effectively deaths in medical settings.² The difficulties that attend police coronial investigation in relation to healthcare or medical treatment deaths are generally well known and have been discussed in detail elsewhere.³ In short, police are not medically trained and depend largely on the doctors involved in the deceased's care to volunteer the specific information required to evaluate the potential for errors or negligence in medical treatment. In addition, coroners in Australia generally have no medical training and have varying access to specialist advice on medical matters. As a result, it has been observed that 'the level and depth of investigations into medical treatment-related deaths in coronial practice appears from a medical perspective to be rather limited'.⁴ A small study of 14 coronial deaths in Victoria, where a panel of medical professionals had identified each death as being the subject of a preventable medical adverse event, showed that the subsequent coroner's investigation process was not very effective at identifying medical error.⁵

Examining the coronial findings in these cases revealed that in six cases, the Coroner's finding did not mention the fact that medical treatment had been given. In four of the 14 findings medical treatment was described as

being provided but no comment was made as to its efficacy or quality. In two of the 14 findings a detailed description of treatment was given ... but no finding of contribution of the medical treatment to death was made. In the final two cases the medical treatment was investigated in considerable detail by the Coroner and a number of issues identified, although the Coroner did not make any final legal determination regarding contribution.⁶

This problem is apparently exacerbated where the admission to hospital was trauma-related, because coroners tended to focus on the initial trauma rather than any potential subsequent adverse events in medical treatment.⁷

CURRENT INVESTIGATION PRACTICE

Coronial police

Following a reportable death in a hospital or healthcare facility police from the CIU attend at the scene to identify witnesses, take photographs and seize patient records.⁸ However, as discussed earlier, statements from doctors and nurses are often provided a significant time later. These are generally provided through the doctors' or nurses' legal counsel or the hospital's general 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. In evidence to the Victorian Parliamentary Law Reform Committee, this practice was criticised for allowing hospital lawyers effectively to control the identification of witnesses and the evidence to be presented at the inquest.⁹ A

1. Based on current case statistics as at 6 April 2011: Detective Sergeant Rohan Ingles, CIU, email (6 April 2011).
2. Because of this lack of medical expertise, most police reports to the coroner on healthcare-related deaths are qualified by a statement that police 'do not have the ability to comment on the medical treatment provided and suggest that further expert medical opinion is sought: Detective Sergeant Rohan Ingles, CIU, email (4 April 2011)
3. VPLRC, *Coroners Act 1985*, Final Report (2006) 201–2; Freckelton I & Ranson D, *Death Investigation and the Coroner's Inquest* (Melbourne: Oxford University Press, 2006) 735; Ranson D, 'How Effective, How Efficient' (1998) 23 *Alternative Law Journal* 284.
4. Ranson, *ibid.*
5. *Ibid* 286.

6. *Ibid.*
7. *Ibid* 285. The trauma study was a much larger study of 137 patients, the ultimate deaths of which 33% were identified as potentially preventable and 5% were identified as preventable. The bulk of medical errors in these cases were identified as being management-related.
8. In 2010 hospital deaths accounted for 56% of all Coronial Investigation Unit scene attendances: Detective Sergeant Rohan Ingles, CIU, email (4 April 2011)
9. VPLRC, *Coroners Act 1985*, Final Report (2006) 202.

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 issues that are 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.

Medical review

In Western Australia the State Coroner is fortunate to have the assistance of two in-house medical advisers¹⁰ on a part-time basis.¹¹ These doctors review healthcare-related death¹² case files and prepare advice for the coroner in relation to the adequacy of the medical management of the deceased.¹³ The Commission is informed that 'their advice sometimes obviates the need for an inquest and has dramatically reduced the need to obtain independent medical reports'.¹⁴ However, it appears their advice is focussed toward the pre-inquest stage of the investigation (after the investigation file has been completed by police and forwarded to the coroner) and rarely feeds into the initial investigation stage.¹⁵ This is supported by a 2005 practice direction from the State Coroner which states that the opinion of the medical advisers attached to the office are

10. The two medical advisers are experienced general practitioners from the same family practice. Both have an interest and considerable experience in mental health and one has experience in bariatric surgery. According to the Manager of the Office of the State Coroner, their 'combined experience covers most of the common causes of death that find their way to this office': Manager, Office of the State Coroner (WA), email (25 March 2011).
11. The doctors attend at the Office of the State Coroner for two-and-a-half days per week and invoice on an hourly basis: Manager, Office of the State Coroner (WA), email (25 March 2011).
12. Including deaths in mental health facilities or where medical or mental health treatment was a factor. The doctors also interpret post mortem examination findings and medical histories for the coroners or coronial police.
13. Dr Robert Turnbull, Medical Adviser, Office of the State Coroner (WA), consultation (19 August 2008).
14. Manager, Office of the State Coroner (WA), email (24 March 2011).
15. Although in some cases, the Commission is advised that following medical review of a file an additional request for further or clarifying information may be forwarded to the coronial investigators: Detective Inspector Mark Bordin, OIC Coronial Investigation Unit, consultation (11 March 2011).

'not to be treated as part of the investigation process but as part of the Coroner's file'.¹⁶

A USEFUL MODEL FOR REFORM

Noting the increased complexity of healthcare-related deaths, a clinical liaison service was established in the Coroners Court of Victoria (co-located with the Victorian Institute of Forensic Medicine) in August 2002. The service consists of five part-time practising doctors and nurses with a range of expertise¹⁷ working onsite with police investigators. The objectives of the service were to create collaborative partnerships between the coroner and the healthcare sector,¹⁸ to inform the use of the existing coroner's information and to clinically enhance the coroner's death investigation process.¹⁹

The reported outcomes of the service over its first six years of operation were 'improved appropriateness of cases that processed to investigation; improvements in the nature and depth of the investigation and self-reported changes to clinicians' practice'.²⁰ Other important outcomes included 'fast-track closure of cases that are due to natural disease', better identification of 'who should provide statements and the clinical questions to be addressed' and 'better selection of appropriate medical experts to refer cases to for independent opinions'.²¹

A NEW APPROACH

Healthcare-related death investigation

The Commission believes that a new approach is needed to enhance the coronial investigation of healthcare-related deaths in Western Australia. This is particularly important if the coroner is

16. Office of the State Coroner, 'Advice Provided by Dr Turnbull', Practice Direction 3/2005 (7 April 2005).
17. Including adult and paediatric emergency medicine, general and aged care medicine, critical care nursing, midwifery and pre-hospital acute care. Additionally members are trained in epidemiology, patient safety, quality improvement, education and forensic medicine: Ibrahim JE et al, 'The Impact of a Clinical Team Assisting the Coroner's Investigation of Healthcare-Related Deaths: Reflections on six years of service' (2010) 12 *Legal Medicine* 28, 29.
18. For discussion on this aspect of the role of the clinical liaison service, see 'Improving Relationships between Coroners and Healthcare Professionals', below.
19. Ibrahim JE et al, 'The Impact of a Clinical Team Assisting the Coroner's Investigation of Healthcare-Related Deaths: Reflections on six years of service' (2010) 12 *Legal Medicine* 28, 29.
20. *Ibid* 28.
21. *Ibid* 31.

to have any impact at all on identification and prevention of avoidable deaths in this area. The Commission has sought, in proposals throughout this paper, to address concerns about the efficacy and efficiency of coronial investigation of healthcare-related deaths. For example, in Chapter Three the Commission proposes a system whereby coroners may authorise the issuing of a cause of death certificate in certain circumstances where the coroner is satisfied that a reportable death requires no further investigation.²² This proposal will significantly reduce the number of healthcare deaths required to be investigated by coronial police and allow staff to commit more time to their investigations.²³ Other proposals that will assist the investigation of hospital deaths include the power to request medical history reports and prepared statements from treating doctors discussed earlier in this chapter.²⁴ These powers will hopefully address some of the issues of delay in provision of statements to police because the doctor will commit an offence if he or she does not provide the requested information without lawful excuse within the time specified by the coroner.²⁵

A complementary initiative is to establish a specialised team for the investigation of healthcare-related deaths. This idea received strong support from those consulted on the subject. The Commission's consultations revealed that there is a clear need for medical advice at the initial investigation stage to enable investigators to establish the circumstances of the death by more informed questioning of family members, medical practitioners and other health professionals. Ready access to

medical expertise at this early stage of the investigation should avoid unnecessary delays in healthcare-related death investigations, lessen the imposition on doctors who may be required to clarify or add to information provided in initial reports and statements several times, and ensure that the coroner receives useful and pertinent information at the earliest possible stage. This, in turn, will enable the early identification of cases not requiring in-depth investigation (eg, those that may be attributable to natural causes or non-preventable deaths) and focus the work of coronial investigators more effectively.

A number of possible locations for a specialist unit were mooted during consultations, including a team within the police Coronial Investigations Unit with access to medical specialists; a team within the Office of the State Coroner and utilising the coroner's own medical advisers; and a team within the Health Department. Having considered each option, it is the Commission's opinion that such a team would be best placed within the Office of the State Coroner capitalising on existing resources within that office and contributing to the prevention function of the Office of the State Coroner.

A specialist healthcare-related death investigation team might be comprised of the current medical advisers to the State Coroner (with perhaps a further part-time medical adviser with different expertise, eg, in emergency medicine and epidemiology),²⁶ a medical liaison administrative officer, and at least three investigators. The investigators could be either specialist investigators appointed pursuant to s 14 of the *Coroners Act 1996* (WA) or police detectives placed within the Office of the State Coroner. The former has the advantage of being under the sole direction of the State Coroner, as well as potentially longer tenure (given that police are generally required to be reassigned after a two-year period in one position), which would ensure that corporate knowledge is maintained within the Office of the State Coroner. However, the Commission observes that, under

22. See Chapter Three, 'Authorising Issue of Cause of Death Certificate' and Proposals 21, 22 & 23. The system requires the doctor to fax the admission notes to the coroner and to seek the family's input before submitting the case for authorisation for a coroner to issue a cause of death certificate. Under the Commission's proposals the cause of death must be sufficiently certain and the death cannot be a death of a person held in custody or care under the Coroners Act.

23. The Commission was advised that of the 506 files being investigated by CIU as at 6 April 2011, only 261 had been allocated to an investigator. While preliminary essential investigation work had been completed on all 506 files, finalisation of the unassigned files must wait until an investigator becomes available. A substantial number of the unassigned files are cases of deaths of an elderly person in hospital following a fall at home or in care where no suspicious circumstances exist and where family have no complaints about the care: Coronial Investigation Unit, consultation (14 March 2011); Detective Sergeant Rohan Ingles, CIU, email (6 April 2011).

24. See 'Powers of Coroner's Investigators', above.

25. See 'Power to Request Documents and Prepared Statements', above.

26. The Commission notes that the Clinical Liaison Service at the Victorian Coroners Court consists of five practising clinicians (doctors and nurses) with a total FTE status of 1.5. Because the volume of coronial work to be investigated in Western Australia would be far less than that in Victoria, the FTE status of the medical advisers will be similarly reduced.

its structural reforms which propose dedicated regional coroners,²⁷ the existing in-house police who perform a largely administrative role in quality assurance of coronial files from country areas will have less work as this assessment function is taken over by regional registrars.²⁸ In those circumstances, it is possible that detectives²⁹ could be placed within the Office of the State Coroner to work with the in-house medical advisers to improve the quality of healthcare-related death investigations.³⁰ Ultimately, the Commission believes this is a matter to be negotiated by the State Coroner, the Department of the Attorney General and the Commissioner of Police: the proposal below is therefore worded to encompass both possible options.

Improving relationships between coroners and healthcare professionals

An important part of the role of the clinical liaison service at the Victorian Coroners Court is the development of collaborative partnerships between the Coroners Court and the healthcare sector in that state. Practically this is achieved by the production of a 'Coronial Communiqué' – a quarterly newsletter providing a précis of selected coronial cases with the aim of improving 'the awareness of clinicians and those in positions of governance about adverse events resulting from systems failures'.³¹ The clinical liaison service also conducts training and holds open days for clinicians to provide an insight into the legal investigation of healthcare-related deaths conducted by the coroner.³²

Consultations with legal representatives of healthcare professionals, representatives of hospitals and comments provided to the Commission via its public survey by medical witnesses show that there is much work to be done to forge collaborative relationships

between the Coroners Court and the healthcare profession in Western Australia. It appears that there is very little understanding of the coronial system by healthcare professionals on the one hand and a concomitant lack of understanding and consideration of the position of healthcare professionals by the Coroners Court on the other. The Commission heard many comments that the inquest process was becoming very adversarial in nature and it observed that witnesses were sometimes treated in a quite hostile manner by counsel assisting the coroner. Such an approach does not foster cooperative relationships between the court and healthcare professionals in achieving the ultimate aim of the inquest; that is, the truth about the circumstances and cause of the death. The Commission believes that immediate action should be taken to improve communication between the Coroners Court and the healthcare sector to enhance the reporting and investigation process, and to ensure that the best possible outcomes for families of deceased are achieved.

In making the proposal below the Commission notes that actions are already being undertaken by both the healthcare sector and the Coroners Court to seek to educate healthcare professionals about the role of the coroner. For example, the Commission's consultations with the principal medical adviser to the coroner revealed that he considered education of clinicians to be an important part of his role that could be usefully enhanced.³³ At the time of consultation, he was in the process of producing a handbook for clinicians and medical students educating them about the role of the coroner and their obligations under the Coroners Act. The Commission also notes that Western Australia has an established clinical coronial feedback system. The reports on medical management issues provided to the coroner by the medical advisers attached to that office are also provided to the Office of Safety and Quality in Healthcare for the purposes of education and quality improvement.³⁴ These reports provide the background for de-identified case studies delivering key messages for clinicians and featured in an annual Department of Health

27. See Chapter Two, 'A New Structure'.

28. The Commission notes that the previous role of counsel assisting the coroner performed by these officers has now been taken out of the position description as a result of the Office of the State Coroner receiving funding for up to three full-time legal counsel assisting: Detective Inspector Mark Bordin, OIC, CIU, consultation (11 March 2011).

29. One of which should be of the rank of sergeant or above.

30. It is also noted that the experience that detectives could gain from such a placement would be of considerable use to the Western Australia Police in future death investigation placements within the service.

31. See <<http://www.vifm.org/communique.html>> (accessed 25 March 2011).

32. Ibid.

33. Dr Robert Turnbull, Medical Adviser, Office of the State Coroner (WA), consultation (19 August 2008).

34. Ibid; Dr Tom Hitchcock, Office of Safety and Quality in HealthCare, consultation (26 November 2009).

publication: *From Death We Learn: Lessons from the Coroner*.³⁵

While these efforts are admirable, more could and should be done to effect change to the attitudes of all participants in the process to achieve an effective coronial system. It is the Commission's belief that a dedicated specialist healthcare-related death investigation team is an important step to achieving that change of attitude, and improving cooperation and communication between healthcare professionals and the Coroners Court.

PROPOSAL 41

Specialist healthcare-related death investigation team

That a specialist healthcare-related death investigation team comprising of the current medical advisers to the State Coroner, a medical liaison administrative officer, and at least three investigators be established within the Office of the State Coroner. The functions of this team should include:

- investigation of deaths in hospitals;
- provision of medical advice to the coroner including an initial assessment of whether a case may warrant further investigation at inquest;
- assistance in informing the coroner about the appropriateness and formulation of proposed recommendations impacting the healthcare sector; and
- development, in collaboration with the Office of Safety and Quality in Healthcare in the Department of Health, of education and other strategies to improve health professionals' understanding of the coronial system and enhance cooperation between the Coroners Court and the healthcare sector.

DEATHS IN MENTAL HEALTH FACILITIES

Most investigations into deaths in mental health facilities in the metropolitan area are now conducted by officers from the Coronial Investigation Unit (CIU), but these are sometimes investigated by local detectives and, on occasion, by officers of the Major Crime Squad. During consultations, the Commission heard that there had been instances where insufficient regard was paid by police to the special nature of the environment where the death occurred. One example involved the death of a patient (who had previously been under restraint) at a major mental health facility. The deceased was apparently left in a cordoned-off corridor in full view of patients and staff for many hours awaiting forensic examiners, and distraught staff were required to strip down and provide their clothes to police. The Commission is not aware of all the details in this case and appreciates that this approach may have been appropriate in the circumstances; however, it appears that a number of patients were unable to enter their rooms for over 24 hours and became extremely distressed by the presence of police.

While events such as these are probably rare, it would be useful for police to receive guidance about the best way to approach a death in a mental health facility. The Commission has described the new internal training regime in place for CIU officers earlier in this chapter, as well as the training initiatives that CIU has developed for operational officers in regional areas and for cadets at the police academy. The recent advancements in the training of police in coronial investigations are both substantial and impressive; however, it is noted that the training initiatives do not yet include guidance in relation to investigating deaths in mental health facilities and, in particular, protocols for scene attendance at such deaths. In the Commission's opinion it is important that police investigators are conscious that vulnerable patients may be unduly distressed by interruptions to institutional routines caused by an investigation. The Commission therefore suggests that CIU consult with the Office of the Chief Psychiatrist to determine ways of diminishing patient distress in cases of deaths

35. Available at <<http://www.safetyandquality.health.wa.gov.au/policies/index.cfm>> (accessed 26 March 2011).

in mental health facilities. It is hoped that investigation protocols can be developed and, where possible, be communicated to police officers through CIU-run training.

PROPOSAL 42

Investigation of deaths in mental health facilities

That the Western Australia Police Coronial Investigation Unit, in consultation with the Office of the Chief Psychiatrist, develop protocols for police investigation of deaths in mental health facilities.

Cross-jurisdictional assistance

Coronial investigations may require access to information and assistance from coroners and coronial investigators in other jurisdictions. This is particularly the case where witnesses have moved across borders or where 'events that commence in one state ... result in deaths in another'.¹ Section 31 of the Coroners Act currently deals with aid or assistance to coroners from other jurisdictions and provides:

- (1) The State Coroner may use any of the powers of a coroner under this Act to help a coroner of another State or a Territory to investigate a death.
- (2) If the Attorney General so directs, the State Coroner must use any of the powers of a coroner under this Act to help a coroner of another State or a Territory to investigate a death.

This section has similar counterparts in all other Australian jurisdictions.² In 2007, in the context of discussions on cross-border disaster inquests, the Standing Committee of Attorneys-General (SCAG) agreed to implement 'a draft model provision for the giving of aid by one coroner to another'.³ It appears that, to date, only two jurisdictions – Queensland and New South Wales⁴ – have implemented the model provision. An advantage of the model provision is that it makes clear that both the provision of assistance to other jurisdictions and the request for assistance from other jurisdictions is contemplated. This is useful where coroners in two jurisdictions are investigating deaths that arise from the same incident (eg, a tsunami striking the east coast of Australia and causing multiple casualties in Queensland and

New South Wales) or where a single coroner is investigating a cross-border disaster with casualties in two or more jurisdictions. Further, it sets up a process for the seeking of assistance via a written request. The Commission notes that the model provision is supported by the State Coroner⁵ and makes the following proposal.

PROPOSAL 43

Assistance to and from coroners in other jurisdictions

That the following provision be inserted in the Coroners Act (in place of the present s 31):

- (1) The State Coroner may request in writing that the person holding a corresponding office in another state or a territory provide assistance in connection with the exercise by the State Coroner or another coroner of any power under this Act.
- (2) The State Coroner, at the written request of the person holding a corresponding office in another state or a territory, may provide assistance to that person or a coroner of that state or territory in connection with the exercise of a power under the law of that state or territory.
- (3) For the purpose of providing assistance, the State Coroner or a coroner may exercise any of his or her powers under this Act irrespective of whether he or she would, apart from this section, have authority to exercise that power.
- (4) If the Attorney General so directs, the State Coroner must use any of the powers of a coroner under this Act to help a coroner of another state or a territory to investigate a death.

1. Barnes M, *Review of the Coroners Act 1996 (WA)* (August 2008) 27.
2. See, eg, *Coroners Act 1995 (Tas)* s 33; *Coroners Act 1997 (ACT)* s 17; *Coroners Act (NT)* s 18; *Coroners Act 2003 (SA)* s 31; *Coroners Act 2008 (Vic)* s 51; *Coroners Act 2003 (Qld)* s 71A; *Coroners Act 2009 (NSW)* s 102.
3. Standing Committee of Attorneys-General (SCAG), *Annual Report 2006–2007* (2007) 2–3. There is no reproduction of the model provision in any of the documents publicly available from SCAG; however, the explanatory notes to the Queensland amendment make clear that its provision implements the model provision agreed to by SCAG.
4. *Coroners Act 2003 (Qld)* s 71A (inserted 2009); *Coroners Act 2009 (NSW)* s 102.

5. Alastair Hope, State Coroner, 'Review of the Coroners Act 1996 – Possible Issues', correspondence (12 June 2007) 2.

(5) For the purposes of this section, this Act applies as if the matter that is the subject of the request or direction was the subject of an investigation under this Act.

ASSISTANCE TO CORONERS IN OTHER COUNTRIES

While Victoria has been through a reform process since the SCAG decision, that state's corresponding section is not in the same terms as the model provisions found in the Queensland and New South Wales legislation. The Victorian provision stipulates that:

The State Coroner may use any of the powers of a coroner under this Act to assist a coroner, or a person who performs a role that substantially corresponds to that of a coroner, of another country or of another State or Territory to investigate a death as if that death were a reportable death.⁶

While it is not as detailed as the model provision it does extend to providing assistance to coroners in other countries. This may be useful where a Western Australian resident dies overseas and his or her medical records are required for the overseas coroner's investigation or where a citizen of another country dies in Western Australia and the overseas coroner wishes to also investigate the death. Although this is not included in the model provision it appears to the Commission to be a useful extension of the power; however, before making this proposal, the Commission seeks submissions from interested parties.

QUESTION D

Assistance to coroners in other countries

Should the provision for assistance to other coroners set out in Proposal 43 extend to coroners (or someone who performs a role that substantially corresponds to that of a coroner) in another country?

6. *Coroners Act 2008* (Vic) s 51.

Chapter Five

Coronial Findings and Inquests



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Introduction

Coroners' findings are contained in the formal 'record of investigation into death'.¹ A record of investigation is produced by the coroner in every coronial case, whether it is disposed of by way of an administrative finding (on the papers) or by an inquest (public hearing).² Effectively it sets out the coroner's determination as to the identity of the deceased, the cause of death, the circumstances surrounding the death and the particulars necessary to register the death (collectively known as 'the findings'). Sometimes a record of investigation may contain comments about matters of public safety or the administration of justice and in certain circumstances (eg, a death in custody) the coroner must comment on the quality of the supervision, treatment and care of the deceased.³

As noted in the Commission's Background Paper, the majority of coronial cases are disposed of by way of administrative findings.⁴ Only 35–40 cases go to inquest each year. Approximately half of these cases are mandated by the *Coroners Act 1996* ('the Coroners Act'),⁵ while the remaining are held at the discretion of the coroner investigating the death.⁶

This chapter begins by examining the nature of findings and comments under the Coroners Act and the existing right of review of a coroner's findings at inquest. It makes proposals to confine the coroners' comment function, provide for an initial right of internal review of findings and expand the right of superior court review to include review of administrative findings.

It then examines the character of administrative findings, mandated inquests and discretionary inquests, and makes proposals for reform in relation to each of these categories of coronial determination. Finally, this chapter discusses matters relating to inquest practice and procedure, the rights of interested persons and the powers of coroners in relation to inquest proceedings.

1. See *Coroners Regulations 1997* (WA) Form 3.
2. *Coroners Act 1996* (WA) s 26.
3. Coroners' findings may also contain recommendations for changes to policies or procedures or other actions to be taken to prevent future deaths in similar circumstances. Coroners' recommendations are discussed in Chapter Six.
4. See 'Administrative Findings', below.
5. See 'Mandated Inquests', below. These include deaths in custody, police-related deaths, suspected deaths and deaths of involuntary mental health patients.
6. See 'Discretionary Inquests', below.

Coronial findings and comments

Section 25 of the *Coroners Act 1996* (WA) ('the Coroners Act') provides that a coroner must make certain findings and he or she may make comments in respect of a death for which a coronial investigation is undertaken.¹ What constitutes a finding or a comment under the Act is dealt with below.

FINDINGS

As noted above, the coroner's findings in relation to a reportable death are contained in the formal record of investigation.² Section 25(1) of the Coroners Act provides:

A coroner investigating a death must find if possible—

- (a) the identity of the deceased;
- (b) how death occurred;
- (c) the cause of death; and
- (d) the particulars needed to register the death under the *Births, Deaths and Marriages Registration Act 1998*.

The standard of proof applicable to the findings to be made by a coroner pursuant to s 25 is the balance of probabilities.³ As can be seen from s 25(1) there are four specified findings that a coroner is obliged to make under the Coroners Act. The first of these—the identity of the deceased—is generally uncontroversial and usually straightforward. Although, there will be rare situations where the identity of the deceased cannot be established on the balance of probabilities in which case the finding under this subsection will be expressed as 'unknown male' or 'unknown female'.

1. As noted below, where the deceased was a 'person held in care' the coroner is *required* to comment 'on the quality of the supervision, treatment and care of the person while in that care': *Coroners Act 1996* (WA) s 25(3).
2. Section 26(1) of the *Coroners Act 1996* (WA) requires a coroner or coroner's registrar to keep a record of each coronial investigation in the form prescribed by regulation. Regulation 6 and Form 3 of the *Coroners Regulations 1997* (WA) set out the prescribed form which requires the coroner to state his or her name, the identity of the deceased person, the date and place of death, the cause of death and the circumstances in which the death occurred.
3. *Re the State Coroner; Ex parte the Minister for Health* [2009] WASCA 165, [21] (Buss J, Martin CJ and Miller JA agreeing).

The second finding that a coroner is obliged to make is how the death occurred. In practice, a finding by a Western Australian coroner as to how death occurred is expressed in the record of investigation through the narrative of the circumstances surrounding the death. This narrative usually culminates in the coroner's 'verdict' which ascribes the manner in which the deceased died. In Western Australia there are seven verdicts commonly used by coroners: suicide, unlawful homicide, lawful homicide (eg, a shooting in self-defence), natural causes, misadventure (eg, an error in medical treatment), accident and open.⁴ Coroners 'verdicts' are expressed in terms of an explicit finding; for example, 'I find that death arose by way of accident'. While it might be thought that such a verdict would constitute the finding under s 25(1)(b), the court in *Re the State Coroner; Ex parte the Minister for Health* held that a finding as to 'how death occurred' included the manner in which the deceased died and extended to 'the circumstances attending the death'.⁵ It may therefore encompass those parts of the narrative contained in the record of investigation that constitute 'an ultimate finding or decision as to the circumstances in which the death occurred'.⁶

The third finding that a coroner must, where possible, make in a coronial case is the cause of death. There is some debate as to the extent to which a coroner is permitted to inquire into the facts surrounding a death so as to determine a cause of death and this is discussed later in this chapter.⁷ For now, it can be said that in finding the cause of death a coroner is not restricted by the legal concepts of direct cause

4. The 'open' verdict is used where the coroner cannot ascribe a manner of death; for example, in relation to a suspected maritime death where it cannot be reliably determined whether the deceased died as a result of drowning or being taken by a shark.
5. *Re the State Coroner; Ex parte the Minister for Health* [2009] WASCA 165, [42] (Buss J, Martin CJ and Miller JA agreeing). See also, *Atkinson v Morrow* [2005] QCA 353 [13]–[14] (McPherson JA, Cullinane and Jones JJ agreeing).
6. *Re the State Coroner; Ex parte the Minister for Health* [2009] WASCA 165, [66] (Buss J, Martin CJ and Miller JA agreeing).
7. See 'Purpose and Scope of an Inquest', below.

or proximate cause.⁸ In practice, however, the specific finding of a cause of death under s 25(1)(c) is generally stated in the coroner's record of investigation into the death as the medical cause (or causes) of death and these are usually taken directly from the forensic pathologist's report of the post mortem examination. For example, a single medical cause might be 'pneumonia complicating head and neck injuries' and a number of identified medical causes may be 'ischaemic heart disease and coronary arteriosclerosis with thrombosis'. In some cases a forensic pathologist's finding as to cause of death may be expressed in less equivocal terms; for example, 'consistent with electrocution'. In such cases the coroner must determine by examination of all the circumstances of the death whether the cause of death was indeed electrocution or whether some other factor was involved.

The fourth and final finding that a coroner is required to make under s 25 relates to the particulars required for registration by the Registrar of Births, Deaths and Marriages. The relevant particulars are not specified by legislation; instead, s 48 of the *Births, Deaths and Marriages Registration Act 1998* (WA) leaves the decision as to what particulars are required to the Registrar. In addition to the deceased's full name (identity) and cause of death, the particulars that are usually required of a coroner's determination will include the date and place of the deceased's death.⁹

COMMENTS

As well as the specific findings set out in s 25(1), a coroner is permitted under s 25(2) to make comment 'on any matter connected with the death including public health or safety or the administration of justice'.¹⁰ In circumstances where the deceased was a 'person held in care' as defined in s 3 of the Coroners Act, the coroner is *required* to comment 'on the quality of the supervision, treatment and care of the person while in that care'.¹¹ While most

8. *Re the State Coroner; Ex parte the Minister for Health* [2009] WASCA 165, [44] (Buss J, Martin CJ and Miller JA agreeing); *WRB Transport v Chivell* [1998] SASC 7002, [20] (Lander J, Mullighan J agreeing).

9. Other particulars necessary for registration of the death (eg, date and place of burial or cremation) are required to be provided by the funeral director.

10. *Coroners Act 1996* (WA) s 25(2).

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

jurisdictions require coroners to comment on the care of those who die in custody,¹² not all jurisdictions give coroners the power to make discretionary comments.¹³ However, where the power to make such comments exists, it is generally in the same terms as s 25(2) of the Coroners Act.¹⁴

Comments made under s 25(2) will often (but not always) form the basis of the discussion leading to coronial recommendations (discussed in Chapter Six) for the purposes of prevention of similar deaths. In these circumstances, the Commission has considered whether the power to make discretionary comments serves any useful purpose. The Commission's review of inquests undertaken by coroners over the past decade shows that discretionary comments made independently of recommendations are generally made to alert individuals or authorities to matters for consideration which do not warrant a formal recommendation or to acknowledge that steps have already been taken to implement appropriate changes in response to the death. In light of the Commission's proposals in Chapter Six to mandate public responses by entities the subject of recommendations, the Commission considers that the discretionary comment function in s 25(2) remains a useful means of raising awareness of matters connected with the death which do not warrant such specific attention. However, in the Commission's opinion, coroners would benefit from legislative guidance in the matters that should be considered when exercising powers under the Coroners Act to make recommendations and comments, and a proposal to this effect is made in Chapter Six.¹⁵

During initial consultations for this reference some lawyers suggested to the Commission that the power to comment 'on any matter connected with the death' in s 25(2) of the Coroners Act was too wide and that it should be

12. Coroners are generally required by legislation to investigate and comment on the adequacy or quality of the treatment and care received by the deceased pursuant to the Royal Commission into Aboriginal Deaths in Custody, *National Report* (1991) vol 5, recommendations 12 & 13.

13. South Australia and New South Wales only specify a power to make recommendations within their Coroners Acts. The power of coroners to make recommendations is discussed in detail in Chapter Six.

14. See, eg, *Coroners Act* (NT) s 34(2); *Coroners Act 1995* (Tas) s 28(3); *Coroners Act 2008* (Vic) s 67(3); *Coroners Act 1997* (ACT) s 52(4).

15. See Proposal 82.

legislatively confined to matters directly arising from the death. In 2009 the Western Australian Court of Appeal held that the coroner's role to comment under s 25(2) was ancillary to his or her role under s 25(1) and that the 'ultimate findings or decisions under s 25(1) circumscribe the matters connected with the death ... in respect of which the coroner may comment'.¹⁶ While this effectively confines the coroner's comment function in the manner suggested, in the Commission's view the matters upon which a coroner may comment should be specifically provided for in the Coroners Act. In this regard the Commission is attracted to the formulation in s 46 of the *Coroners Act 2003* (Qld), which provides:

- (1) A coroner may, whenever appropriate, comment on anything connected with a death investigated at an inquest that relates to—
 - (a) public health or safety; or
 - (b) the administration of justice; or
 - (c) ways to prevent deaths from happening in similar circumstances in the future.

Having regard to the Commission's review of inquests discussed above, it is the Commission's opinion that this formulation adequately recognises the current (and appropriate) role and use of comments in the Western Australian coronial system and the Commission, therefore, proposes that it be adopted in this state.¹⁷ It will be evident from the Queensland provision that a coroner may only make comment on such matters in the context of an inquest, while the current Coroners Act does not confine the coroner's comment function in this way. However, the Commission has been advised by the Registry Manager of the Coroners Court (WA) that comments are never made pursuant to s 25(2) outside the context of an inquest.¹⁸ This is not surprising given that administrative findings are not public documents and comments would not necessarily reach the intended parties. In light of the fact that comments may

not be reviewed by a superior court (discussed immediately below), the Commission believes it is appropriate that the discretionary comment function is confined to inquest. The Commission, therefore, makes the following proposal.

PROPOSAL 44

Coroners' discretionary comment function

That the power of coroners to make discretionary comments (currently s 25(2)) be confined to any matter connected with a death investigated at an inquest that relates to—

- (a) public health or safety;
- (b) the administration of justice; or
- (c) the prevention of future deaths in similar circumstances.

As noted, in contrast to findings, comments made by a coroner under the powers contained in ss 25(2) and 25(3) are not susceptible to review by the Supreme Court.¹⁹ Some lawyers consulted by the Commission expressed confusion about distinguishing findings from comments in a coroner's record of investigation. The confusion appears to stem from the fact that the circumstances of the death are (necessarily) expressed in narrative form, only parts of which may be considered to be an ultimate finding as to how death occurred as required by s 25(1) with other parts being viewed as 'commentary'. While this confusion is understandable (particularly since in the case referred to by the lawyers no comments under the Act were made),²⁰ the Commission notes that where a coroner is exercising the power to comment under ss 25(2) or 25(3) he or she must do so in the form prescribed by the *Coroners Regulations 1997* (WA) reg 6.²¹ Form 3, which is appended to the Regulations,

16. *Re the State Coroner; Ex parte the Minister for Health* [2009] WASCA 165, [52] (Buss J, Martin CJ and Miller JA agreeing).

17. Under s 6 of the *Coroners Act 2003* (Qld) 'comment' is defined to include recommendations and the Commission agrees that the power to make recommendations should be similarly confined in this jurisdiction. Proposals regarding the power to make recommendations are contained in Chapter Six.

18. Registry Manager, Office of the State Coroner (WA), email (27 April 2011).

19. For discussion of this power of review see 'Review of Findings by Superior Court', below.

20. Lawyers were referring to the inquest into the death of Daniel Paul Rolph, which became the subject of an application for review to the Supreme Court in *Re the State Coroner; Ex parte the Minister for Health* [2008] WASC 250 and was later appealed to the Court of Appeal in *Re the State Coroner; Ex parte the Minister for Health* [2009] WASCA 165.

21. *Re the State Coroner; Ex parte the Minister for Health* [2008] WASC 250, [13]–[16] (Templeman J).

requires that comments be set out at the end of the record of investigation under a separate heading using the word 'comments'. Comments made under ss 25(2) or 25(3) may, therefore, be readily distinguished from the narrative that contains the findings made under s 25(1) and the Commission observes that Western Australian inquest findings over the past decade appear to conform to the requirements of Form 3.

LIMITATION ON FINDINGS AND COMMENTS

As discussed in Chapter Two, the coronial jurisdiction is inquisitorial and the coroner's function is a fact-finding one.²² It is not the coroner's task to attribute or apportion blame. This is made clear by s 25(5) of the Coroners Act, which states:

A coroner must not frame a finding or comment in such a way as to appear to determine any question of civil liability or to suggest that any person is guilty of any offence.

Similar limitations on coronial findings and comments exist in all Australian jurisdictions.²³ It should, however, be noted that this limitation does not prohibit the exploration of facts that may have a bearing on criminal or civil liability.²⁴ In the event that the circumstances of the death lead a coroner to believe that an offence has been committed in connection with the death, the coroner may report that belief to the Director of Public Prosecutions (DPP) (for an indictable offence) or the Commissioner of Police (for a simple offence).²⁵ In addition, under s 50 of the Coroners Act, the coroner may refer evidence to a disciplinary body in certain circumstances.²⁶

22. See Chapter Two, 'An Inquisitorial Jurisdiction'; see also *Perre v Chivell* [2000] SASC 279 [54]; *Keown v Khan* [1998] VSC 297 [15] (Callaway JA, Ormiston and Batt JJA agreeing).

23. Having said that, the Coroners Act clearly contemplates that an adverse finding may be made against an 'interested person' at an inquest. Under s 44(2) of the Act, in circumstances where the coroner is contemplating the making of such a finding, he or she must give the person the opportunity to present submissions against the making of such a finding. The rights of interested persons are discussed in more detail later in this chapter: see 'Rights of Interested Persons: Procedural Fairness', below.

24. See, eg, *R v Coroner for North Humberside & Scunthorpe; Ex parte Jamieson* [1995] QB 1, 24.

25. *Coroners Act 1996* (WA) s 27(5).

26. The Commission discusses below the possibility of extending the protection of certificates issued under s 47 to disciplinary proceedings: see 'Inquest Practice and Procedure: Statements made by witnesses', below.

In his 2008 review Michael Barnes recommended that coroners be authorised to include in the record of investigation an indication as to whether a referral to the DPP has been made.²⁷ There is no supporting argument stated by Barnes, but the Commission notes that it is currently the practice of Western Australian coroners (at least in some cases) to make a statement in the record of investigation regarding referral. There is precedent in s 69 of the *Coroners Act 2008* (Vic) for authorising such a statement of referral. That section provides:

- (1) A coroner must not include in a finding or comment any statement that a person is, or may be, guilty of an offence.
- (2) Subsection (1) does not apply to prevent the inclusion in a comment of a statement relating to a notification to the Director of Public Prosecutions under section 49.

The Commission sees some attraction in legislatively authorising the current practice of making such statements in the interests of transparency of the coronial function. However, it is clear that coroners currently tread a very fine line to ensure that they do not breach the limitation on findings and comments in s 25(5). The Commission considers that any such statement should not form part of the findings or comments or be an exception to the limitation in s 25(5) as the Victorian provision appears to be. In the Commission's opinion, the public interest in transparency may be simply served by a short statement of fact at the end of the record of investigation; for example, 'This matter has been referred to the DPP/ Commissioner of Police for consideration as to whether an offence may have been committed in respect of the death of the deceased'. The position of such statement should be prescribed by amendment to Form 3 of the record of investigation pursuant to reg 6 of the *Coroners Regulations*. The Commission notes that there is no requirement in the Coroners Act that the coroner identify a person or persons who may be responsible for an offence committed in relation to the death²⁸ and the Commission does not see any reason why an individual or individuals should be named in the referral statement. It is enough, in the Commission's opinion, that a

27. Barnes M, *Review of the Coroners Act 1996* (WA) (August 2008) 28.

28. See *Coroners Act 1996* (WA) s 27(5) and Inquest No 2/2003.

referral is clearly made and relevant evidence is forwarded to prosecuting authorities. Avoiding the naming of a person the subject of a referral will protect and enhance the coroner's role as an independent fact-finding tribunal and not one that attributes blame or adjudicates legal responsibility for a death.

PROPOSAL 45

Statement of referral in record of investigation

That the Coroners Act authorise the coroner to make a short statement of fact as to whether the death the subject of an inquest has been referred to the Director of Public Prosecutions or the Commissioner of Police for consideration as to whether an offence may have been committed in respect of the death of the deceased.

That the statement must not name an individual or individuals who may be implicated in a possible offence.

That the relevant form for the record of investigation (currently Form 3) make clear that the position of such a statement be at the end of the record before the signature of the coroner.

REVIEW OF FINDINGS BY CORONER

The Coroners Act is silent about internal review of administrative findings (that is, the findings of a coroner following an investigation without inquest). There is nothing in the Coroners Act to authorise such review, but also nothing to prevent it. There is, however, a prohibition on the internal review by a coroner of findings following an inquest. Such review must be undertaken by the Supreme Court under s 52 of the Coroners Act (see discussion below). Western Australia is one of only two Australian jurisdictions in which a coroner is not permitted to re-open an inquest either on his or her own initiative or following application.²⁹ It is worth

29. Tasmania is the only other jurisdiction where it appears a coroner may not re-open an inquest; however, the Chief Magistrate (who is ex officio Chief Coroner) may re-open an investigation on his or her own volition or on application by any person with sufficient interest: *Coroners Act 1995* (Tas) s 58.

noting that both jurisdictions have the oldest coronial legislation in the country.

Mechanisms for the internal review of administrative findings now exist in many Australian jurisdictions.³⁰ Such review is activated by an application or by the coroner on his or her own initiative.³¹ The primary (and in some cases only) ground for re-opening an investigation is the discovery of new evidence, facts or circumstances. A consideration is then required to be made as to whether it is desirable or appropriate to re-open the investigation. Some provisions (eg, Victoria) leave silent the basis on which a coroner may judge it appropriate to re-open the investigation, while others (eg, the Australian Capital Territory and Queensland) require consideration of whether re-opening the investigation is desirable in the public interest or in the interests of justice. Having examined the terms of all available provisions, the Commission is of the view that a combination of the Victorian and Queensland provisions is suitable for Western Australia. This combines the clarity of the Queensland requirement that the new information must cast doubt on the original findings with the flexibility of the Victorian provision under which a coroner may determine on what basis it is or is not appropriate to re-open an investigation. In addition, as noted above, with the exception of Western Australia and Tasmania, all Australian jurisdictions also permit a coroner to re-open an inquest and the Commission proposes that this facility be extended to Western Australia, both in response to an application and on the coroner's own initiative.³²

30. See, eg, *Coroners Act 2003* (Qld) s 50B; *Coroners Act 2008* (Vic) s 77; *Coroners Act 1995* (Tas) s 58; *Coroners Act 1997* (ACT) s 68.

31. The Coroners Acts of the Australian Capital Territory and Tasmania permit a coroner to re-open an investigation on his or her own initiative or on application, while Queensland permits re-opening of an investigation on a coroner's initiative and Victoria permits re-opening of an investigation following an application.

32. See, eg, *Coroners Act 2003* (Qld) s 50A; *Coroners Act 2003* (SA) s 26; *Coroners Act 1997* (ACT) s 68; *Coroners Act 2009* (NSW) s 83; *Coroners Act* (NT) s 44A; *Coroners Act 2008* (Vic) s 77.

PROPOSAL 46

Re-opening of investigation or inquest on coroner's initiative

That a section be inserted into the Coroners Act to provide:

1. That the State Coroner or a coroner who conducted an investigation or inquest into a death may, on his or her own initiative, re-open the investigation or inquest into the death if satisfied that there is new information that casts doubt on the earlier findings and that it is appropriate to re-open the investigation or inquest.
2. That the State Coroner, or another coroner, who has re-opened an investigation or inquest under this section may treat any of the evidence given at the earlier investigation or inquest as being given in the re-opened investigation or inquest.

PROPOSAL 47

Application to coroner to re-open investigation or inquest

That a section be inserted into the Coroners Act to provide:

1. That a person may apply to the Coroners Court (in a form prescribed by regulation) for an order that some or all of the findings of a coroner after an investigation or inquest be set aside and, if the court considers it appropriate, that the investigation or inquest into the death of the deceased be re-opened.
2. That the Coroners Court may only make such an order if it is satisfied that there is new information that casts doubt on the earlier findings and that it is appropriate to re-open the investigation or inquest.
3. That for the purposes of such an application the Coroners Court must be constituted by the coroner who conducted the original investigation or inquest, unless that coroner no longer holds office or there are special circumstances.

4. That the decision of the Coroners Court in respect of such an application must be in writing.

PROPOSAL 48

Form of application to coroner to re-open investigation or inquest

That the Coroners Regulations prescribe the form in which an application to a coroner for the re-opening of an investigation or inquest should be made and that such form be prominently featured and made available for download on the Coroners Court website.

REVIEW OF FINDINGS BY SUPERIOR COURT

One of the defining characteristics of the coronial jurisdiction throughout Australia is the limited guidance provided by superior courts in the interpretation of coronial legislation.³³ An examination of the case law in Western Australia reveals that very few applications have been made to the Supreme Court under the various provisions for review of coroners' decisions in the Coroners Act.³⁴

Section 52 of the Coroners Act provides a mechanism for any person to apply to the Supreme Court for a declaration that some or all of the findings of a coroner at an inquest are void and to seek that the inquest be re-opened or a new inquest be held. Only the 'findings' of an inquest made under s 25(1) may be challenged by application to the Supreme Court under s 52.³⁵ As discussed earlier, these have been held to be the 'ultimate findings or decisions' made by a coroner in respect of the identity of the deceased, how death occurred

33. Freckelton I & Ranson D, *Death Investigation and the Coroner's Inquest* (Melbourne: Oxford University Press, 2006) 745.

34. In addition to the power of review under s 52 (which is discussed below) the *Coroners Act 1996* (WA) also provides for superior court review of decisions to order a post mortem examination (s 37) and to exhume a body (s 38). These rights are discussed in Chapter Seven. A further right to apply to the Supreme Court for an order that an inquest be held (s 24) is discussed later in this chapter: see 'Discretionary Inquests', below.

35. *Re Inquest into the death of Romauld Todd Zak: Ex parte Zak* [2006] WASC 186 [28]. In contrast, as noted earlier, comments made by a coroner under the powers contained in ss 25(2)–(3) are non-justiciable.

and cause of death.³⁶ There is no time limit for commencing proceedings to have the findings of an inquest declared void and under s 52(3) such an order may be made if the Supreme Court is satisfied that:

- (a) it is necessary or desirable because of fraud, consideration of evidence, failure to consider evidence, irregularity of proceedings or insufficiency of inquiry;
- (b) there is a mistake in the record of the findings;
- (c) it is desirable because of new facts or evidence; or
- (d) the findings are against the evidence or the weight of the evidence.

An identical provision to s 52 exists in the *Coroners Act* (NT)³⁷ and until the recent reform process in Victoria, the same provision existed in the *Coroners Act 1985* (Vic).³⁸ Prior to its repeal in Victoria, the provision had been the subject of judicial criticism in the Victorian Supreme Court. In particular, the phrase 'consideration of the evidence' (see s 52(3)(a) above) had been described as 'unclear and somewhat incomprehensible'.³⁹ Further, the ground that 'the findings are against the evidence or the weight of the evidence' (see s 52(3)(d) above) has been criticised as being extremely wide and requiring the court to consider the whole of the evidence given before the coroner.⁴⁰ However, the Victorian Court of Appeal⁴¹ has since found (and the Western Australian Court of Appeal has accepted)⁴² that s 52(3)(d) should be read to require that an applicant establish that the finding was perverse in the sense that 'it was a finding for which there was no evidence or that no reasonable coroner could make'.⁴³ In this regard, Buss JA has observed that:

36. See 'Findings', above and *Re the State Coroner; Ex parte the Minister for Health* [2009] WASCA 165, [52] (Buss J, Martin CJ and Miller JA agreeing). The particulars of the death required by the Registrar of Births, Deaths and Marriages to register the death is a further finding.

37. *Coroners Act* (NT) s 44. It appears that this provision has never been judicially considered in the Northern Territory.

38. *Coroners Act 1985* (Vic) s 59.

39. *Anderson v Blashki* [1993] 2 VR 89, 92 (Gobbo J); see also *Chief Commissioner of Police v Hallenstein* [1996] 2 VR 1, 12 (Hedigan J).

40. *Ibid.* It has been remarked by one Western Australian judge that such a task 'may be an onerous one': *Re Inquest into the Death of Romauld Todd Zak: Ex parte Zak* [2006] WASC 186 [30] (Murray J).

41. *Keown v Khan* [1998] VSC 297 [20] (Callaway JA, Ormiston and Batt JJA agreeing); *Khan v Keown* [2001] VSCA 137 [28] (Batt JA, Ormiston JA agreeing).

42. *Re the State Coroner; Ex parte the Minister for Health* [2009] WASCA 165, [56]–[57] (Buss J, Martin CJ and Miller JA agreeing).

43. *Ibid* [55].

The mere fact that the evidence at the inquest reasonably supported possible findings different from the coroner's findings is not sufficient to justify the setting aside of the coroner's findings if those findings are also reasonably supported by the evidence.⁴⁴

In 2008, Victoria replaced its review provision (which was in the same terms as s 52 of the *Coroners Act*) with a general appeal provision exercisable on a question of law.⁴⁵ The primary aim of the Victorian reforms in this regard was to simplify and clarify the review process.⁴⁶ An appeal must generally be lodged in the Supreme Court within six months of the date of the coroner's findings.⁴⁷ However, the court may grant an extension of time to institute proceedings if it is of the opinion that the failure to commence proceedings was due to exceptional circumstances or if it is satisfied that the granting of leave is in the interests of justice.⁴⁸ In addition, people may also make an application to the Supreme Court seeking judicial review of decisions made by a coroner.⁴⁹

The Commission's view

It is rare for the findings of a coroner to be the subject of review by the Supreme Court in Western Australia and this is also the case in other Australian jurisdictions. The Commission has heard comments from lawyers indicating confusion about how to file and proceed with Supreme Court reviews of coroner's findings under s 52 and other review sections contained in the *Coroners Act*. The Commission has also received comments from families that the cost of seeking review of a coroner's decisions in the Supreme Court is prohibitive because of the perceived need for legal representation.⁵⁰

The Commission has considered whether the Supreme Court remains the appropriate body to review decisions made by coroners. Given

44. *Ibid* [57].

45. *Coroners Act 2008* (Vic) ss 83 & 87.

46. Victoria, *Parliamentary Debates*, Legislative Council, 2 December 2008, 5263 (Mr Dalla Riva).

47. *Coroners Act 2008* (Vic) s 83.

48. *Coroners Act 2008* (Vic) s 86.

49. See Victorian Parliament, *Coroners Bill 2008*, Explanatory Memorandum, 16. It is noted that all appeals in which judgments had been delivered at the date of writing had been taken on the basis of judicial review by application for an order in the nature of certiorari under the *Supreme Court Rules* (Vic) O56, or jointly as an appeal proceeding and a proceeding under O56.

50. Although it must be noted that these comments were not related to reviews of coroner's findings under s 52, but rather to review of a coroner's refusal to hold an inquest or refusal to uphold an objection to post mortem examination.

the Commission's proposal to restructure the coronial jurisdiction so that the State Coroner is drawn from the District Court, the Commission believes it is appropriate that any review of coroners' decisions continue to be heard by the Supreme Court. However, the Commission believes that the Western Australian coronial jurisdiction would benefit from legislative clarification of the review process and, therefore, it has made various proposals in this section and elsewhere in this Paper to achieve this objective. In addition, the Commission makes a number of proposals to assist family members and legal representatives to navigate the review process. These include the provision of legal aid funding for the legal representation of the family of a deceased at inquest, and the provision of publicly available forms and precedents for internal and Supreme Court review of coroners' decisions.

The proposals above for internal review of the findings of an investigation or inquest by the original coroner will represent the first step in the review process for many parties interested in a review of findings. However, it will be noted that such review is confined to cases in which new facts or circumstances have been discovered which cast doubt on the original findings. The following proposal deals with applications to the Supreme Court for an order that findings be set aside, and that an investigation or inquest be re-opened whether or not a person has previously applied to the Coroners Court and been refused on the basis of the same or substantially the same grounds or evidence. In formulating its proposal the Commission has examined the superior court review provisions in all Australian jurisdictions, including the current Victorian provisions which confine appeals against all decisions of a coroner to questions of law. In this regard the Commission notes that the only application that has succeeded to date under s 52 of the Coroners Act has been on the ground of 'new facts or evidence' under s 52(3)(c)⁵¹ and that

51. *Re Inquest into the Death of Romauld Todd Zak: Ex parte Zak* [2006] WASC 186 [32]. In *Zak*, the family of the deceased succeeded in their application to quash the coroner's finding of suicide and for an order that the inquest be re-opened on the basis of new evidence (gathered by the family) which cast significant doubt on the findings made as to cause and manner of death. Past successful cases also on fresh evidence under the *Coroners Act 1920 (WA)* s 14 include *Re Zappelli: The Attorney General for the State of Western Australia* [2000] WASC 183 where the Attorney General successfully applied

all Australian jurisdictions other than Victoria recognise new evidence as a ground of appeal or review.⁵² Therefore, in order to ensure that coroners' findings can be reviewed on the basis that there are new facts or evidence or evidence not previously considered by the coroner during the investigation, the Commission proposes that this should remain as a ground of review.

The Commission notes that several jurisdictions permit superior court review of findings following a coroner's investigation as well as findings following an inquest.⁵³ Given that a person may apply to the Coroners Court for the re-opening of either an inquest or an investigation under the above proposals, the Commission believes it is appropriate that superior court review of findings also extend to investigations. It therefore makes the following proposal.

PROPOSAL 49

Superior court review of coroner's findings

1. That, whether or not an application based on the same or substantially the same grounds or evidence has been refused by the Coroners Court, any person may apply to a single judge of the Supreme Court (in respect of the findings of a coroner or Deputy State Coroner) or to the Court of Appeal (in respect of the findings of the State Coroner) for an order that some or all of the findings of a coroner's inquest or investigation be set aside.
2. That the superior court may set aside a finding and order that the inquest or investigation be re-opened to re-examine the finding or order a new inquest or investigation if satisfied that the coroner has made an error of law in making the findings or there was evidence not adduced at the inquest or considered by the coroner during the investigation which casts doubt on the correctness of the findings.

for the findings of an inquest into the death of a young woman to be quashed and a new inquest ordered on the basis of a deathbed confession to her murder.

52. While the South Australian Coroners Act does not specify the grounds on which an appeal may be made, it does expressly state that the court may re-hear witnesses and receive fresh evidence: *Coroners Act 2003 (SA)* s 27(5).

53. See, *Coroners Act 2008 (Vic)* s 83; *Coroners Act 1997 (ACT)* s 93; *Coroners Act 1995 (Tas)* s 58.

POWER TO CORRECT THE RECORD OF INVESTIGATION

As part of the research for this reference all inquest records from 2000 to 2010 were examined by the Commission. During this process a large number of clerical errors and inconsistencies were discovered. In many cases the errors were typographical, but in others the mistakes were more significant. These included errors in the identification of key witnesses and inconsistencies in the evidence relied upon in different parts of the inquest record. In one case, the Commission found that two separate places of death had been recorded for one individual: one in the body of the finding and one in the lead-in paragraph.⁵⁴ The Commission was also told by one family member that the coroner recorded the wrong date of death on her relative's administrative finding.

The ability of the Coroners Court to internally correct typographical errors in records of investigations (including inquests) is unclear and is an area that could benefit from legislative clarification. The Commission notes that those jurisdictions in which recent reform processes have been undertaken provide for coroners to correct the record of findings in certain circumstances.⁵⁵ Section 76 of the *Coroners Act 2008* (Vic) provides a useful model for reform in this respect:

The Coroners Court may correct any finding, recommendation or comment of a coroner that contains—

- (a) a clerical mistake; or
- (b) an error arising from an accidental slip or omission; or
- (c) a material miscalculation of figures or a material mistake in the description of any person, thing or matter referred to in the findings, recommendations or comments; or
- (d) a defect of form.

The Commission proposes that a similar provision be introduced in Western Australia.

PROPOSAL 50

Power to correct errors in records of investigation

That a section modelled on s 76 of the *Coroners Act 2008* (Vic) enabling the correction of clerical errors and defects of form in a coroner's record of investigation be inserted into the Coroners Act.

54. Inquest No 9/10.

55. See, eg, *Coroners Act 2003* (Qld) s 51(3); *Coroners Act 2008* (Vic) s 76.

Administrative findings

As noted in the introduction to this chapter, a coroner in Western Australia is required to produce a record of investigation into death in all coronial cases. This record must contain all the findings required to be made under s 25(1) of the *Coroners Act 1996* (WA) ('the Coroners Act'); that is, the identity of the deceased, how the death occurred, the cause of death and the particulars necessary to register the death. As discussed above, s 25(1)(b) has been held to confer upon the coroner an obligation to find not only the manner by which the death occurred, but also the circumstances attending the death.¹ In practice, this means that all records of investigation should contain a narrative setting out the circumstances of the death, whether the death is the subject of an inquest or an administrative finding. There are both benefits and disadvantages in this requirement. The primary benefit is that coronial records contain more-detailed information about deaths which may be of interest to future generations within a family.² However, this must be weighed up against the fact that such records take time to produce and this can result in delays in registration of a death which may be an impediment to relatives wishing to finalise the deceased's financial affairs and to obtain emotional 'closure'.³

As discussed in the Commission's Background Paper, there is currently a significant backlog in the coronial system in Western Australia.⁴ In his submission retired Senior State Pathologist Dr Derek Pocock observed that the current delays in the coronial process appeared to be impacting on the 'public view of the coroner and

his function in society'.⁵ The reduction of delays in all facets of the coronial process is a major impetus behind the Commission's proposed reforms in this Paper.⁶ In respect of streamlining the process for making coronial administrative findings, the Commission is attracted to two initiatives of the *Coroners Act 2008* (Vic).

NON-NARRATIVE FINDINGS

There are a large number of sudden deaths each year where the cause of death is identified by the examining forensic pathologist as being attributable to natural causes. Some of these deaths, though sudden, will not be wholly unexpected and the only reason some such deaths are referred to the coroner is that the deceased's regular doctor is on leave or away for the weekend and cannot sign a death certificate within the required short period before the coroner assumes jurisdiction over the death. Presently the administrative findings in natural causes cases are drafted by very junior clerks and contain nothing but the details required by the Registrar of Births, Deaths and Marriages to register the death.⁷ The finding as to how the death occurred in these cases is limited to a coroner's verdict of 'natural causes'. As can be seen from the appellate law discussed earlier, this is not adequate to satisfy the obligation conferred upon the coroner under s 25(1)(b) of the Coroners Act.⁸

A number of jurisdictions permit non-narrative, limited findings (of the type just described) in respect of all non-inquested deaths;⁹ however,

1. *Re the State Coroner; Ex parte the Minister for Health* [2009] WASCA 165, [42] (Buss J, Martin CJ and Miller JA agreeing); see also *Atkinson v Morrow* [2005] QCA 353 [13]–[14] (McPherson JA, Cullinane and Jones JJ agreeing).
2. Barnes M, *Review of the Coroners Act 1996 (WA)* (August 2008) 12.
3. The impact of delay in death registration is discussed above in some detail: see Chapter Three, 'Death Registration'.
4. LRCWA, *Review of Coronial Practice in Western Australia*, Background Paper (September 2010) 38–9; 47–8.

5. Pocock DA, Senior Pathologist (ret.), correspondence (27 December 2010).
6. See Chapter One, 'Objectives of Reform'.
7. That is, the name and age of deceased, the date and place of death and the cause of death.
8. That is, a finding as to the manner by which the death occurred and the circumstances attending the death: *Re the State Coroner; Ex parte the Minister for Health* [2009] WASCA 165, [42] (Buss J, Martin CJ and Miller JA agreeing); see also *Atkinson v Morrow* [2005] QCA 353 [13]–[14] (McPherson JA, Cullinane and Jones JJ agreeing).
9. For example, New South Wales and the Australian Capital Territory require only a finding as to cause and manner of death, while South Australia requires only a finding as to cause of death.

Western Australia has always required a finding as to how death occurred.¹⁰ This was also the case in Victoria, but following the recent reforms in that jurisdiction a coroner may refrain from making a finding about the circumstances of the death. Section 67 of the *Coroners Act 2008* (Vic) provides that:

- (1) A coroner investigating a death must find, if possible—
 - (a) the identity of the deceased; and
 - (b) the cause of death; and
 - (c) unless subsection (2) applies, the circumstances in which the death occurred; and
 - (d) any other prescribed particulars.
- (2) Whether it is possible or not, a coroner need not make a finding with respect to the circumstances in which a death occurred if—
 - (a) an inquest into the death was not held; and
 - (b) the coroner finds that—
 - (i) the deceased was not, immediately before the person died, a person placed in custody or care; and
 - (ii) there is no public interest to be served in making a finding regarding those circumstances.

From the above it can be seen that while the same findings are required to be made under both the Western Australian section and the Victorian section, the necessity of making a finding about the circumstances of the death (as distinct from the manner and cause of death) may be avoided in certain circumstances at the discretion of the coroner. In practical terms, this means that some administrative findings may be constituted by a statement of the relevant particulars (including a coronial verdict as to manner of death) without the need to set out a full narrative as to the circumstances surrounding the death. The Commission suggests that a similar provision to that found in Victoria should be enacted in Western Australia. Not only will this legitimate the current practice of the Coroners Court in regard to natural causes deaths, it will be a useful tool to enable the swift registration of deaths following a coronial investigation, particularly in respect of non-controversial sudden deaths.

10. *Coroners Act 1920* (WA) s 11(3).

PROPOSAL 51

Non-narrative findings

1. That the Coroners Act contain a section modelled on s 67 of the *Coroners Act 2008* (Vic) enabling a coroner to make an administrative finding consisting of the identity of the deceased, the manner and cause of death and the particulars required to register the death (that is, excluding the narrative of circumstances attending the death).
2. That the above section only applies in cases where no inquest has been held, where the deceased was not a person held in care or a person held in custody (under Proposals 54 and 55), and where the coroner determines that there is no public interest to be served in including in the finding a narrative as to the circumstances attending the death.

NATURAL CAUSES FINDINGS

In addition to the facility to make non-narrative findings in certain cases, s 17 of the *Coroners Act 2008* (Vic) provides that in cases where a forensic pathologist has examined the body of a deceased and has determined that the death was due to natural causes, a coroner may discontinue the coronial investigation into the death and report the particulars required to register the death to the Registrar of Births, Deaths and Marriages. The relevant section provides:

- (1) A coroner is not required to continue an investigation into a reportable death if—
 - (a) the coroner determines that the death was not a death referred to in section 4(2)(b); and
 - (b) a medical investigator conducts a medical examination on the deceased person and provides a report to the coroner that includes an opinion that the death was due to natural causes; and
 - (c) the coroner determines that, other than the fact that the death of the person was unexpected, the death is not a reportable death; and
 - (d) the coroner determines that the death is not a reviewable death.

- (2) If a coroner determines under this section not to continue an investigation, the principal registrar must notify the Registrar of Births, Deaths and Marriages, without delay, of the prescribed particulars.

The only exceptions to dealing with unexpected deaths by natural causes in this way in Victoria are in respect of deaths during or following a medical procedure (where the death is causally related to the procedure)¹¹ and reviewable deaths.¹² Deaths in care or custody are not expressly excluded from s 17; however, s 52 of the *Coroners Act 2008* (Vic) dictates that an inquest must be held into such deaths.

In Western Australia natural causes deaths are usually attended by local police¹³ who fill out the necessary paperwork for admission of the deceased's body to the mortuary. If the death is in the metropolitan area, the Coronial Investigation Unit will then assume the police investigation and, if necessary, will request medical reports from the deceased's medical practitioner. In regional areas the investigation is carried through by local police. Following post mortem examination the pathologist submits a report setting out, if possible, the cause of death. Once this is provided to police (and simultaneously to the coroner), the police file is submitted to the coroner for a finding to be made.¹⁴ The Commission is advised that the time for a forensic pathologist's report on a natural causes death can vary greatly from one week to over 12 months (depending on the circumstances of the death, the requirement for testing of blood and tissue samples, and the pathologist's workload).¹⁵

As noted earlier, there are significant delays in all coronial findings in Western Australia. The Commission has been told that, although the current non-narrative findings in natural

causes deaths (described above) are generated by administrative staff soon after receipt of the post mortem examination report from the forensic pathologist (and accompanying police file), there can be further substantial delays in closure of natural causes cases as they await a coroner to sign off on the findings. In a submission in response to the Commission's Background Paper, retired Senior State Pathologist Dr Derek Pocock stated that 'most coronial cases are natural causes and require minimal enquiry before certification. Finalisation should be days only in settlement.'¹⁶ While this is unlikely to be achieved given the current backlogs in both PathWest and the Office of the State Coroner, the aim of substantially reducing delays in natural causes cases should be embraced by both entities and strategies to improve outcomes in this area should be put in place.

In the Second Reading Speech in Victorian Parliament, Attorney-General Rob Hulls noted that the introduction of the s 17 process was specifically aimed at reducing delays in delivery of coronial findings in natural causes deaths. He explained:

The bill creates a streamlined process for dealing with deaths which were only reportable because they were unexpected or where there was no medical certificate of cause of death. This is a discretionary process and the coroner can determine that, in a particular case, it would be appropriate to conduct a full investigation of the death. The requirement to conduct an investigation into the circumstances of deaths that were due to natural causes is a major reason for delays in the coronial system, which causes unnecessary stress for the families of the deceased. These investigations also divert resources away from investigations that need to be made. This new process will allow the coronial system to target its resources more effectively and end a prolonged process for grieving families, where possible.¹⁷

So far as the Commission is concerned, the option to discontinue coronial investigation into certain natural causes deaths should be available to coroners in Western Australia and a provision similar to s 17 of the *Coroners Act 2008* (Vic) is proposed for this purpose.

11. *Coroners Act 2008* (Vic) s 4(2)(b).

12. That is, deaths of children where more than one child of the same parent has previously died in reportable circumstances.

13. The exception is for natural causes deaths in metropolitan hospitals at which officers from the Coronial Investigation Unit attend.

14. For a natural causes death the police file will usually consist of the Certificate of Life Extinct, the mortuary admission form (P98), the identification form, the police report (P100), the St John's Ambulance patient care record (if applicable), and a report from the deceased's general practitioner or from the hospital in which the deceased died. Statements are not always taken or required in a natural causes death case, but any collected by police attending are also forwarded to the coroner: Detective Sergeant Rohan Ingles, CIU, email (19 April 2011).

15. *Ibid.*

16. Pocock DA, Senior Pathologist (ret.), correspondence (27 December 2010).

17. Victoria, *Parliamentary Debates*, Legislative Assembly, 9 October 2008, 4306 (Mr R Hulls, Attorney General).

The Commission believes that the power to discontinue an investigation under this provision should be capable of being delegated by the State Coroner to the Principal Registrar.¹⁸ Under the Commission's Proposal 10 the position of Principal Registrar must be filled by a suitably qualified person who is eligible to be appointed to the Magistrates Court of Western Australia and determinations of the Principal Registrar of the nature contemplated by this provision are reviewable by the State Coroner.¹⁹ The Commission suggests that such delegation will impact considerably upon the length of time between the receipt of post mortem examination findings and the signing off of prepared findings by a coroner. However, for this provision to effectively reduce delays, the forensic pathologist must express an opinion that the death was due to natural causes. This does not appear to be current practice in Western Australia. In Victoria such opinions are expressed following either external or internal post mortem examination in a comment after the cause of death. Examples of post mortem reports viewed by the Commission indicate there is no 'prescribed' method of expressing an opinion for the purposes of s 17. Such statements might include that 'all evidence would suggest that this was a natural cause of death' and 'death would appear due to natural cause'.

In order to ensure that a power to discontinue investigations is effective in practice it would be desirable for forensic pathologists to express, where possible and appropriate, an opinion that the death was or appeared to be due to natural causes.

PROPOSAL 52

Power of coroner to discontinue investigation in certain cases

1. That a provision modelled on s 17 of the *Coroners Act 2008* (Vic) be inserted into the Coroners Act to provide that in cases where a forensic pathologist has examined the body of a deceased and has expressed an opinion that the death was due to natural causes and the coroner determines that, other than the fact that the death of the person was unexpected, the death is not a reportable death, a coroner may discontinue the coronial investigation into the death and report the particulars required to register the death to the Registrar of Births, Deaths and Marriages.
2. That a coroner may not discontinue a coronial investigation in cases where the deceased was a person held in care or a person held in custody or where the death was during or following and causally connected to a medical procedure.
3. That the power to discontinue a coronial investigation into a death in the circumstances described above may be delegated by the State Coroner to the Principal Registrar.

18. In consultations with the State Coroner he stated that he saw no reason why a coroner was required to sign off on natural causes deaths, suggesting that someone with the necessary qualifications could remove this task from coroners: State Coroner, consultation (20 August 2008).

19. See Chapter Two, Proposal 10.

Mandated inquests

An inquest is a public hearing into the circumstances of a reportable death conducted to establish the findings that a coroner is obliged, if possible, to make under s 25(1) of the *Coroners Act 1996* (WA) ('the Coroners Act').¹ Under the Coroners Act inquests may be mandatory or discretionary. Section 22 sets out the circumstances under which a coroner must hold an inquest into a death ('mandated inquest'). Section 22(1) provides that:

- (1) A coroner who has jurisdiction to investigate a death must hold an inquest if the death appears to be a Western Australian death and—
 - (a) the deceased was immediately before death a person held in care;
 - (b) it appears that the death was caused, or contributed to, by any action of a member of the Police Force;
 - (c) it appears that the death was caused, or contributed to, while the deceased was a person held in care;
 - (d) the Attorney General so directs;
 - (e) the State Coroner so directs; or
 - (f) the death occurred in prescribed circumstances.²

The phrase 'person held in care' in s 22(1)(a) is defined in s 3 of the Coroners Act to mean:

- (a) a person under, or escaping from, the control, care or custody of—
 - (i) the CEO as defined in section 3 of the *Children and Community Services Act 2004*;
 - (ii) the Chief Executive Officer of the department of the Public Service principally assisting the Minister administering the *Prisons Act 1981* in its administration; or
 - (iii) a member of the Police Force;

- (aa) a person for whom the CEO as defined in the *Court Security and Custodial Services Act 1999* is responsible under section 10, 13, 15 or 16 of that Act, whether that person is at a custodial place as defined in that Act, is being moved between custodial places or escapes, or becomes absent, from a custodial place or during movement between custodial places;
- (b) a person admitted to a centre under the *Alcohol and Drug Authority Act 1974*;
- (c) a person who is an involuntary patient within the meaning of the *Mental Health Act 1996*, or who is apprehended or detained under Part 3 of that Act;³ or
- (d) a person detained under the *Young Offenders Act 1994*.

Table 6 in Appendix B shows the number of mandated inquests undertaken by Western Australian coroners over the 10-year period 2000 to 2009. These data show that the percentage of total inquests that are mandated by the Coroners Act has increased over the past decade from 35% in 2000 to 52% in 2009. As observed in the Commission's Background Paper, 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.⁴ The latter figure has remained relatively steady over the past decade with small peaks in 2000 and 2004.

DEATH OF A 'PERSON HELD IN CARE'

Currently the definition of 'person held in care' in Western Australia includes a person held in, escaping from or being transported to or from a prison, juvenile detention or police custody; an involuntary inpatient at a mental health facility; a person on a community treatment

1. See 'Coronial Findings and Comments', above.
2. Under the *Coroners Act 1996* (WA) s 3, 'prescribed' means prescribed by regulation. As at the date of writing there are no prescribed circumstances under the *Coroners Regulations 1997* (WA).

3. This includes a person on a community treatment order under the *Mental Health Act 1996* (WA).
4. LRCWA, *Review of Coronial Practice in Western Australia*, Background Paper (September 2010) 34.

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.⁵ Under s 22(a) of the *Coroners Act* all such deaths are subject to mandatory inquest.

Each year a number of inquests are held into deaths that the coronial investigation has established are non-controversial (eg, natural causes deaths or accidental deaths) because they concern a deceased who was a person held in care. Although these inquests are a mere formality to comply with the Act and the only witness called is the investigating officer (who simply reads his or her report into evidence), the court must nevertheless be convened with its full complement of staff.⁶ A courtroom must be booked and the proceedings must be recorded. From the Commission's analysis of inquest data it appears that many such inquests are held over until there is a critical mass (perhaps to justify the booking of a courtroom) – this can result in needless delay for families. In the Commission's opinion this represents an unnecessary drain on resources in circumstances where there are no concerns relating to the care of the deceased person and where the matter can be adequately dealt with by an administrative finding.

While the Commission accepts that following the Royal Commission into Aboriginal Deaths in Custody, deaths in prison, police custody or detention (including escape from, and transport to and from custody) must be subject to public inquest regardless of whether the death was controversial or not, that reasoning does not necessarily apply to all deaths in care.⁷ In Queensland, deaths in care and deaths in custody are separated.⁸ Deaths in custody are mandatorily inquested, while deaths in care are only subject to mandatory inquest if the circumstances of the death raise issues about the deceased person's care.⁹ The coroner retains discretion to hold an inquest into any

5. *Coroners Act 1996* (WA) s 3.

6. Including at least a coroner, counsel assisting and a coroner's associate.

7. Deaths in custody and deaths in care are separated in many Australian jurisdictions, three of which (Queensland, New South Wales and South Australia) provide for discretion as to whether a death in care requires a public inquest. Deaths in custody are subject to mandatory inquest in all Australian jurisdictions.

8. *Coroners Act 2003* (Qld) ss 9 & 10.

9. *Coroners Act 2003* (Qld) s 27(1)(a)(ii).

death regardless of the circumstances.¹⁰ The Commission believes this is a sensible approach and, therefore, makes the following proposal.¹¹

PROPOSAL 53

Two categories: persons held in custody and persons held in care

1. That the definition of 'person held in care' in the *Coroners Act* be separated into two categories: 'person held in custody' and 'person held in care'.
2. That deaths of persons falling within the definition of 'person held in custody' (defined in Proposal 54) and that deaths of persons falling within the definition of 'person held in care' (defined in Proposal 55) be reportable deaths for the purposes of the *Coroners Act*.
3. That deaths of persons falling within the definition of 'person held in custody' (defined in Proposal 54) be the subject of a mandatory inquest.
4. That deaths of persons falling within the definition of 'person held in care' (defined in Proposal 55) be the subject of a mandatory inquest only if, in the coroner's opinion, the circumstances of the death raise issues about the deceased person's care.

Proposed definition of 'person held in custody'

All 'in custody' aspects of the current definition of 'person held in care' under s 3 of the *Coroners Act* are reproduced in the Commission's proposed definition of 'person held in custody'. These aspects concern a person held in, escaping from or being transported to or from prison, juvenile detention or police custody. As discussed above, deaths of persons in these

10. *Coroners Act 2003* (Qld) s 28. In Queensland the discretion is exercisable where the coroner is satisfied that it is in the public interest to hold an inquest.

11. It is noted that consequential amendments must be made to other provisions as a result of splitting 'person held in care' into two categories. For example, the *Coroners Act 1996* (WA) s 17(5) will need to be amended to refer to 'a person held in care' or a 'person held in custody'.

circumstances will continue to be the subject of mandatory inquest under the Commission's proposals.¹² In this section the Commission clarifies the position of people detained under the *Criminal Law (Mentally Impaired Accused) Act 1996* (WA) ('the CLMIA Act') and examines whether mentally ill people involuntarily detained in an authorised hospital and persons held in custody in Western Australia under an Act of the Commonwealth should be included in the definition of 'person held in custody'.

Deaths of mentally impaired accused

A mentally impaired accused is defined in Part 5 of the CLMIA Act as 'an accused in respect of whom a custody order has been made and who has not been discharged from the order'.¹³ A person the subject of a custody order under the CLMIA Act may be 'detained in an authorised hospital, a declared place, a detention centre or a prison, as determined by the [Mentally Impaired Accused Review] Board, until released by an order of the Governor'.¹⁴ The major determining factor in placement of a mentally impaired accused is whether the accused has a mental illness that is 'treatable'.¹⁵ If an accused has a treatable mental illness then he or she will be held in an authorised hospital.¹⁶ If the accused has no treatable mental illness then he or she will be held in a 'declared place' or a prison. Currently there are no declared places in Western Australia; therefore, all adult mentally impaired accused who do not have a treatable mental illness are sent to prison.¹⁷

Under the current definition of 'person held in care' a mentally impaired accused would be in the 'control, care or custody of the Chief Executive Officer of the department of the Public Service principally assisting the

Minister administering the *Prisons Act 1981*' if the person was being detained in a prison.¹⁸ Likewise, if the person was being detained in an authorised hospital and was, at the time the custody order was made, admitted as an involuntary patient under the *Mental Health Act* he or she would most likely come within the current definition of 'person held in care'.¹⁹ However, if the person was being detained in an authorised hospital or 'declared place' and was not, at the time the custody order or hospital order was made, admitted as an involuntary patient under the *Mental Health Act*, it is not clear whether the current definition of 'person held in care' in the Coroners Act applies. In light of the Commission's Proposal 53 to introduce separate categories for persons held in care and persons held in custody, it is important to make clear that, under the Commission's proposals, persons detained under the authority of the CLMIA Act come within the definition of 'person held in custody'. As such, the death of a person the subject of a hospital order or a custody order, or the death of a person who has been granted a leave of absence²⁰ under the CLMIA Act will be subject to mandatory inquest.

Deaths of persons detained under the Mental Health Act

Under the current definition of 'person held in care' a person who is an involuntary patient within the meaning of the *Mental Health Act 1996* (WA), or who is apprehended or detained under Part 3 of that Act is subject to mandatory inquest. As noted earlier, this includes an involuntary inpatient at an authorised hospital as well as an involuntary patient who is on a community treatment order under the *Mental Health Act*. In addition, it includes persons

12. See Proposal 53.

13. Under Part 2 of the *Criminal Law (Mentally Impaired Accused) Act 1996* (WA) a judicial officer may also make a 'hospital order' for a person charged with an offence who has or is suspected to have a mental illness requiring treatment and is denied bail. Such a person is not a 'mentally impaired accused' under the terms of the Act but is nonetheless someone to whom the definition of person held in care should apply.

14. *Criminal Law (Mentally Impaired Accused) Act 1996* (WA) s 26(1).

15. *Criminal Law (Mentally Impaired Accused) Act 1996* (WA) s 24.

16. Currently the Frankland Centre or Plaistowe Ward of Graylands Hospital.

17. Mentally Impaired Accused Review Board, *Annual Report 2008-2009* (2009) 5. A mentally impaired accused who is under the age of 18 years and who does not have a treatable mental illness will be sent to a juvenile detention centre.

18. It is noted that the *Prisons Act 1981* (WA) is administered by the Minister for Corrective Services, while the *Criminal Law (Mentally Impaired Accused) Act 1996* (WA) ('the CLMIA Act') is administered by the Attorney General. Whether a person subject to a custody order under the CLMIA Act who is detained in a juvenile detention centre (because he or she does not have a treatable mental illness) comes within the category of 'a person detained under the *Young Offenders Act 1994*' is unclear. The Commission's Proposal 54 will remove any doubt that such a person is to be considered a 'person held in custody' for the purposes of the *Coroners Act 1996* (WA).

19. That is, as 'a person who is an involuntary patient within the meaning of the *Mental Health Act 1996*, or who is apprehended or detained under Part 3 of that Act': *Coroners Act 1996* (WA) s 3(c) 'person held in care'.

20. Under the *Criminal Law (Mentally Impaired Accused) Act 1996* (WA) Pt 5 Div 3 the Mentally Impaired Accused Board may, under certain circumstances, grant a leave of absence to a person detained on a custody order under the Act.

apprehended or detained for the purpose of assessment as to whether the person should be made an involuntary patient.

In the Commission's opinion, there is no practical difference between persons involuntarily detained at an authorised hospital under the *Mental Health Act* and persons detained in an authorised hospital under the CLMIA Act.²¹ Both categories should reflect the fact that detention is involuntary and the deaths of such persons should be subject to mandatory inquest. Therefore, the Commission has proposed that the death of a person who is an involuntary patient within the meaning of the *Mental Health Act* and is detained in an authorised hospital under Part 3, Division 2 of that Act should be included in the proposed definition of 'person held in custody' under the Coroners Act. In addition, the Commission has proposed that a person who is apprehended or detained under Part 3, Division 1 of *Mental Health Act* (that is, for the purposes of assessment as to involuntary status) should also be included in the proposed definition of 'person held in custody'. In recognition of their freedom to move about the community, involuntary patients on a community treatment order under the *Mental Health Act* will be included in the proposed definition of 'person held in care' and therefore subject to mandatory inquest only if the circumstances of the death raise issues about the deceased person's care in the community while on the treatment order.

Deaths in Commonwealth detention

In a letter to the Commission, the State Coroner raised the concern that the current Coroners Act does not include persons in Commonwealth detention in the definition of 'person held in care'. He recommended that:

The definition of 'a person held in care' in section 3 should be amended to include person in Commonwealth custody. This is important because otherwise a Coroner may not be permitted to make observations about the quality of the supervision, treatment and care of the person while in the custody

21. Under s 3 of the *Mental Health Act 1996* (WA) authorised hospital means (a) a public hospital, or part of a public hospital, that is for the time being authorised under section 21; and (b) a private hospital whose licence is endorsed under section 26DA of the *Hospitals and Health Services Act 1927* (WA).

of Commonwealth officers (eg, Immigration, Fisheries).²²

This concern was reiterated by a number of people consulted for this reference and by Michael Barnes in his 2008 review of the Coroners Act.²³

Western Australia has more immigration detention and processing facilities than any other state in Australia, making this issue particularly pertinent.²⁴ The Western Australian coroner also deals with deaths in the Commonwealth Territory of Christmas Island, which is home to a major immigration detention centre and two community detention facilities.²⁵ However, while the State Coroner has been permitted in the past to investigate deaths in Commonwealth custody on Christmas Island it is unclear whether the coroner is permitted to comment specifically on the quality of supervision, treatment and care of the deceased in those cases.²⁶ In the Commission's opinion, persons held in Commonwealth care or custody should be included in the Commission's proposed definition of 'person held in custody' in the Coroners Act. This will mandate the holding of an inquest in the case of a death in such circumstances and will clarify the position of the coroner to comment on the supervision, treatment and care of the deceased. The Commission notes that such provision currently exists in Queensland²⁷ and South Australia.²⁸

22. Hope A, State Coroner of Western Australia, 'Review of the Coroners Act 1996 – Possible Issues', correspondence (12 June 2007) 2.

23. Barnes M, *Review of the Coroners Act 1996* (WA) (August 2008) 28.

24. Eg, Perth Immigration Detention Centre, Perth Immigration Residential Housing, Curtin Immigration Detention Centre and Leonora Alternative Place of Detention. In addition, there is a proposal to open a further detention centre in Northam by mid-2011.

25. Coronal jurisdiction over deaths on Christmas Island is conferred by the *Christmas Island Act 1958* (Cth) s 14B and the *Indian Ocean Territories (Application of Laws) Act 1992* (WA) s 11. The provisions of the *Coroners Act 1996* (WA) (CI) mirror those in the current Western Australian Coroners Act and so do not include people in Commonwealth detention within the current definition of 'person held in care'.

26. That is, under the *Coroners Act 1996* (WA) s 25(3). However, it is arguable that the coroner can do so under s 25(2) which permits the coroner in all cases to comment on 'any matter connected with the death including public health or safety or the administration of justice'.

27. *Coroners Act 2003* (Qld) s 10(2)(d).

28. *Coroners Act 2003* (SA) s 3 'Death in custody' (b)(ii) defines a death in custody as including a person who 'was in the process of being apprehended or was being held ... at any place within the State – by a person authorised to do so under the law of any jurisdiction'.

In making the below proposal, the Commission is conscious that there may be room for debate as to the authority of a state Parliament to authorise the exercise of at least some coronial powers in immigration detention centres. Immigration detention centres are generally located on land acquired by the Commonwealth and the Commonwealth Parliament has exclusive power²⁹ to make laws with respect to places acquired by the Commonwealth for public purposes.³⁰ To avoid a legislative vacuum the *Commonwealth Places (Application of Laws) Act 1970* (Cth) s 4(1) effectively applies the provisions of state law to Commonwealth places;³¹ however, where a state law is inconsistent with a Commonwealth Act, it is invalid to the extent of that inconsistency.³² This is of potential significance for the inspection of immigration detention centres³³ for the purposes of a coronial investigation because the provisions of the Coroners Act will not operate to the extent that they are inconsistent with those of the *Migration Act 1958* (Cth) or other relevant Commonwealth law.³⁴

Notwithstanding these constitutional questions, the Commission is of the view that the Coroners Act should be amended to provide for mandatory inquests where a person dies while detained under the authority of a Commonwealth Act. As a matter of policy, the desirability of such a provision appears uncontroversial. In those circumstances, the state should legislate as far as it is constitutionally able to do so.

29. *Australian Constitution* (Cth) s 52(i).

30. The effect of that section is to exclude the power of state Parliament, even by a law of general application, to regulate the conduct of persons engaged in activity in the acquired place: *Worthing v Rowell & Muston Pty Ltd* (1970) 123 CLR 89; *R v Phillips* (1970) 125 CLR 93; *Attorney-General (NSW) v Stocks and Holdings (Constructors) Pty Ltd*; *Allders International Pty Ltd v Commissioner of State Revenue (Vic)* (1996) 186 CLR 630.

31. Therefore, in Commonwealth places state laws will continue to operate, but will operate by force of Commonwealth law.

32. *Australian Constitution* (Cth) s 109.

33. Immigration detention centres are established by the Minister for Immigration pursuant to the *Migration Act 1958* (Cth) s 273(1).

34. The legislative framework for the management of, and entry to, detention centres is surprisingly sparse. Notwithstanding that lack of detail, it may be arguable that provisions purporting to authorise a state coronial investigator to enter and inspect an immigration detention centre would be inconsistent with the *Migration Act 1958* (Cth) s 273.

PROPOSAL 54

Definition of person held in custody

That the definition of *person held in custody* include:

- (1) a person under, or escaping from, the control, care or custody of—
 - (a) the Chief Executive Officer of the department of the Public Service principally assisting the Minister administering the *Prisons Act 1981* in its administration; or
 - (b) a member of the Western Australia Police;
- (2) a person for whom the CEO as defined in the *Court Security and Custodial Services Act 1999* is responsible under section 10, 13, 15 or 16 of that Act, whether that person is at a custodial place as defined in that Act, is being moved between custodial places or escapes, or becomes absent, from a custodial place or during movement between custodial places;
- (3) a person detained under the *Young Offenders Act 1994*;
- (4) a person who is the subject of a hospital order or a custody order or who has been granted a leave of absence under the *Criminal Law (Mentally Impaired Accused) Act 1996*;
- (5) a person who is an involuntary patient within the meaning of the *Mental Health Act 1996* and is detained in an authorised hospital under Part 3, Division 2 of that Act or a person who is apprehended or detained under Part 3, Division 1 of that Act;
- (6) a person detained under the authority of an Act of the Commonwealth.

Proposed definition of 'person held in care'

All 'in care' aspects of the current definition of 'person held in care' under s 3 of the Coroners Act are reproduced in the Commission's proposed definition of 'person held in care'. These are:

- a person under, or escaping from, the control, care or custody of the CEO as defined in s 3 of the *Children and Community Services Act 2004* (WA);³⁵
- a person admitted to a centre under the *Alcohol and Drug Authority Act 1974* (WA); and
- a person who is an involuntary patient within the meaning of the *Mental Health Act 1996* (WA), or who is apprehended or detained under Part 3 of that Act.

These categories reflect the special vulnerability of children who are subject to care and protection orders or government placement, people who are admitted to a drug or alcohol rehabilitation centre and people who are involuntary inpatients or on community treatment orders under the *Mental Health Act*.

As discussed earlier, the Commission believes that these cases should only be subject to mandatory inquest if the coroner believes that the circumstances of the death raise issues about the deceased person's care.³⁶ In all other cases the coroner retains the discretion to hold an inquest.³⁷ In addition, the Commission has examined whether the deaths of persons in residential facilities for the disabled should be included in the definition of 'person held in care'.

35. Section 30 of the *Children and Community Services Act* defines a child in the CEO's care as a child who is in provisional protection and care; is the subject of a protection order; is the subject of a negotiated placement agreement; or is provided with placement services after determination by the CEO that action is required to safeguard the child's wellbeing.

36. See 'Death of a 'Person Held in Care', above. It should be noted that sudden or unexpected deaths of children known to the Department for Child Protection in Western Australia are also subject to investigation and review by the Ombudsman's office. This function involves reviewing, investigating and making recommendations to the Department for Child Protection and other public authorities in relation to preventable deaths of children. Further, deaths of persons in mental health facilities are investigated and reviewed by the Office of the Chief Psychiatrist, as discussed in Chapter Four, 'Specialist Investigators'.

37. See 'Discretionary Inquests', below.

Deaths of persons admitted to alcohol and drug treatment centres

As noted above, the current Coroners Act provides that a person 'admitted to a centre under the *Alcohol and Drug Authority Act 1974* (WA)' ('the ADA Act') is a person held in care for the purposes of the Coroners Act. 'Centre' is defined under s 4 of the ADA Act as: 'premises maintained by the Authority for the assessment, treatment, management, care, or rehabilitation of persons suffering from alcohol or drug abuse'. The Drug and Alcohol Office runs a number of centres in the metropolitan area under the name 'Next Step' which provide assessment, treatment and counselling to persons suffering from drug or alcohol abuse. Clients are based in the community and attend centres to receive services on a voluntary basis.³⁸ There is only one residential centre run by the authority, which is located in East Perth.³⁹

Because there is no definition of 'admitted' in the ADA Act, the reach of the Coroners Act is potentially quite wide and could include persons receiving drug treatment or counselling through a Next Step centre in the community. This would place an unreasonable burden on the Coroners Court because every death of a person who was receiving services from a centre under the ADA Act would be subject, under the current regime, to mandatory inquest.⁴⁰ In the Commission's opinion the Coroners Act was only intended to apply to patients admitted to treatment at the residential withdrawal unit.⁴¹ The Commission believes that the definition of person held in care should be made clearer by referring to admission 'for residential treatment'.

38. Robyn Miller, Drug and Alcohol Office, consultation (21 October 2010).

39. Drug and Alcohol Office, 'Inpatient Withdrawal Services' <<http://www.dao.health.wa.gov.au/tabid/83/Default.aspx>> (accessed 21 October 2010).

40. It is noted that the *Alcohol and Drug Authority Act 1974* (WA) s 26 requires that the Authority hold an inquiry into any 'death or injury caused to any person in a centre while he is there for assessment, treatment, management, care, or rehabilitation'.

41. It should be noted that such patients are admitted on a voluntary basis.

Deaths in residential facilities for the disabled

Another group of vulnerable people are people with profound or severe disabilities living in supported residential facilities. The Commission notes that in Western Australia most individuals in residential disability accommodation have profound intellectual disabilities and/or severe functional needs, and require support for daily living including mobility, communication and eating.⁴² This group of people often have significant health concerns that require ongoing management and regular review. Western Australians requiring this level of care usually receive funding for accommodation support through the Disability Services Commission (DSC).⁴³ Care may be provided in the community in residential facilities operated by the DSC or by specialist disability service providers who are funded either directly by the DSC or indirectly by the money provided to the residents by the DSC.⁴⁴

Following public release of the Background Paper, the Commission was contacted by a family member of a person with profound physical disabilities requiring full-time care who had died while in a residential facility for the disabled. The family member was concerned that deaths of people with profound physical disabilities may not be investigated as thoroughly as other deaths and that deaths may wrongly be attributed to the natural progression of the disabled person's underlying disease or disorder.⁴⁵ This is a particular possibility if such a death is not reported to the coroner because it is accepted by the treating doctor as an expected death in light of the presence of an underlying disease or disorder.

42. Data collected for 2003, shows that over 70,000 people resident in Perth had profound or severe core activity limitation and 96,000 people with disabilities required accommodation support in the Perth area: Disability Services Commission, *Profile of Disability - Perth Statistical Division* (undated) tables 2 & 7.

43. Disability Services Commission, *Eligibility Policy for Specialist Disability Services* (February 2010).

44. *Ibid.*

45. The Commission was also referred to the following reports in the United Kingdom which have found that people with severe intellectual disabilities experience inequality in physical health care, sometimes leading to death: Disability Rights Commission (UK), *Equal Treatment: Closing the Gap. A formal investigation into the physical health inequalities experienced by persons with learning disabilities and/or mental health problems* (2006); MENCAP (UK), *Death by Indifference* (March 2007) <<http://www.mencap.org.uk>>.

Submissions to the Victorian Parliamentary Law Reform Committee (VPLRC) review of the *Coroners Act 1985* (Vic) supported extending the definition of person held in care to people being cared for in residential facilities for the disabled.⁴⁶ Legal Aid Victoria submitted to the VPLRC that:

People with disabilities who reside in institutions live outside the public gaze. They have less control over their lives and their choices are usually limited. Because they must rely on others, they are particularly vulnerable to inadequacies in the standard of care they receive.⁴⁷

The VPLRC recommended that the definition of 'person held in care' be appropriately extended to encompass people receiving residential services operated, or wholly or partly funded by government.⁴⁸ Recognising their special vulnerability, the Coroners Acts of Victoria, New South Wales, South Australia and Queensland include deaths of disabled persons residing in supported residential facilities as either a category of reportable death⁴⁹ or as a death of a person held in care.⁵⁰ The Commission agrees with the approach of New South Wales, Victoria and Queensland, which include such persons within the definition of person held in care. The Commission also notes that the Acts of these three jurisdictions are the most recently reviewed in Australia and that it is highly likely that the acts of other jurisdictions will follow the trend of recognising the special vulnerability of disabled people in residential care.

The Commission, therefore, proposes that a new definition of 'person held in care' be inserted in the Coroners Act. The Commission invites people commenting on the following proposal to consider the appropriate wording to ensure that it captures persons residing in residential facilities for the disabled.

46. VPLRC, *Coroners Act 1985 - Final Report* (2006) 130.

47. *Ibid.*

48. *Ibid.*, recommendation 23. In Victoria the Department of Human Services handles such funding. The Disability Services Commission is its counterpart in Western Australia.

49. *Coroners Act 2003* (SA) s 3 'Reportable death' (f)(iv).

50. *Coroners Act 2009* (NSW) s 24; *Coroners Act 2003* (Qld) ss 8(3)(f) & 9 (1)(a); *Coroners Act 2008* (Vic) s 3 'Person placed in custody or care' (d).

PROPOSAL 55

Definition of 'person held in care'

That the definition of *person held in care* include:

- (1) a person under, or escaping from, the control, care or custody of the CEO as defined in section 3 of the *Children and Community Services Act 2004*;
- (2) a person admitted for residential treatment to a centre under the *Alcohol and Drug Authority Act 1974*;
- (3) a person who is the subject of a community treatment order under Part 3, Division 3 of the *Mental Health Act 1996*; and
- (4) a person who is living in a residential care facility operated by or wholly or partly funded either directly or indirectly by the Disability Services Commission.

Education for persons obliged to report or investigate a death in custody or care

The legislative definition of 'person held in care' may not necessarily be readily accessible to persons who are obliged to report such deaths under the Coroners Act. For example, the Commission found that some people who were intimately involved with the coronial system were not aware that the current definition of 'person held in care' included persons who were on community treatment orders under the *Mental Health Act*. Others did not know that children who were residing with extended family pursuant to a negotiated placement agreement under the *Children and Community Services Act* fell within the definition of person held in care. The Commission found that this lack of knowledge also extended to some coroners and, as a result, some cases that required mandatory inquest under the Coroners Act may have escaped the notice of these coroners. While the latter situation should be remedied by the appointment and training of dedicated regional coroners under Proposals 4 and 12,⁵¹ there remains a need to educate persons who are obliged to report or investigate a

51. See Chapter Two.

death of a person held in custody or care. The Commission, therefore, makes the following recommendations.

PROPOSAL 56

State Coroner's guidelines: person held in custody and person held in care

That the State Coroner produce guidelines that specify by example the types of cases that fall into the definition of 'person held in custody' and 'person held in care' in the Coroners Act.

PROPOSAL 57

Informing people about relevant changes to the definitions of person held in custody and person held in care

That the Office of the State Coroner should work together with relevant departments or agencies (including the Department of Corrective Services, the Department for Child Protection, the Mental Health Commission, the Drug and Alcohol Office, the Disability Services Commission and the Western Australia Police) to develop ways of appropriately delivering information about any relevant changes to their obligations under the Coroners Act.

SUSPECTED DEATHS

As discussed in Chapter Three, s 23 of the Coroners Act 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'. Where a suspected death is investigated by the coroner an inquest must be held into the circumstances of the suspected death.⁵² It is, therefore, classified as a mandated inquest.

52. *Coroners Act 1996* (WA) s 23(2).

Only one other Australian jurisdiction mandates that an inquest must be held in these circumstances.⁵³ Having reviewed the inquest findings into suspected deaths over the past decade, the Commission observes that, while inquest hearings may be desirable in some cases of suspected death, in others the fact of death is incontrovertible, the cause of death is uncontroversial and the hearing is a mere formality to comply with the Act. In the Commission's opinion the coroner should have discretion whether to hold an inquest into a suspected death or to determine the case administratively.

PROPOSAL 58

Removal of mandatory inquest for suspected deaths

That the requirement that a suspected death be the subject of an inquest hearing be removed from the Coroners Act.

In his 2008 review of the Coroners Act, Michael Barnes recommended that the standard of proof of 'beyond reasonable doubt' required under s 23(2) for a coroner to establish that a missing person is dead should be repealed. In support of this, Barnes argued that:

The standard of proof for a coroner to find a missing person dead should be regulated by the general law, rather than the Act. The presumption of life and the *Briginshaw* principle⁵⁴ will ensure that a finding of death [is] only made when the evidence is sufficiently persuasive.⁵⁵

53. *Coroners Act 2009* (NSW) s 27. While the *Coroners Act 1997* (ACT) s 13 appears to require an inquest into each death within the coronial jurisdiction, the coroner may decide not to conduct a hearing into the death (s 14).

54. *Briginshaw v Briginshaw* (1938) 60 CLR 336. The *Briginshaw* principle refers to the fact that the nature and strength of the evidence required to meet the civil standard of proof (ie, the balance of probabilities) will change depending on the nature and seriousness of the allegation.

55. Barnes M, *Review of the Coroners Act 1996 (WA)* (August 2008) 24. It is noted that in *Re the State Coroner; Ex parte the Minister for Health*, the Court of Appeal (WA) approved *Briginshaw* and held that the applicable standard of proof for coroner's findings under s 25 of the Coroners Act was the balance of probabilities: [2009] WASCA 165, [21] (Buss J, Martin CJ and Miller JA agreeing).

The Commission notes that no other Australian jurisdiction requires the coroner to find that the fact of death be established beyond reasonable doubt and agrees with Barnes that this requirement should be removed from the Coroners Act.⁵⁶

PROPOSAL 59

Removal of standard of proof for suspected deaths

That the requirement that the coroner be satisfied that the death of the person has been established beyond reasonable doubt be removed from the Coroners Act.

56. The State Coroner has indicated his support for this amendment: State Coroner (WA), correspondence (12 June 2007).

Discretionary inquests

Section 22(2) of the *Coroners Act 1996* (WA) ('the Coroners Act') provides that a 'coroner who has jurisdiction to investigate a death may hold an inquest if the coroner believes it is desirable'. Therefore, apart from those inquests that are mandated under the Coroners Act (discussed above), a coroner has discretion to choose what cases he or she wishes to investigate at an inquest.¹ As discussed in Chapter One, very few coronial cases each year are the subject of an inquest.² In a typical year, around 35 inquests are held in Western Australia, at least half of which are mandated under the Coroners Act.³ Over the past decade, almost all inquests in Western Australia (including in regional areas) have been performed by either the State Coroner or Deputy State Coroner.⁴

PURPOSE AND SCOPE OF AN INQUEST

Section 3 of the Coroners Act defines an inquest as 'a formal hearing by the court'. As discussed in Chapter Two, the nature of an inquest is inquisitorial; that is, it is considered a fact-finding tribunal rather than one which apportions blame.⁵ The functions of an inquest are set out effectively under s 25 (discussed above).⁶ These are to make findings as to the identity of the deceased, how death occurred and the cause of death, and to make comment, where appropriate or required, on matters connected with the death including public safety and the administration of justice. However, the function of an inquest is distinct from its purpose⁷ and the Act is silent as to what is the

purpose of an inquest. This issue was raised before the Shipman Inquiry where Dame Janet Smith observed that:

Historically, the purpose of the coroner's inquest was to determine whether there was criminal involvement in the death. That was plainly a 'public interest' purpose. Nowadays, such investigation is the province of the police. Today, the purpose of the public investigation of [reportable deaths] is unclear. The coroners who gave evidence stressed the need for the purposes of the coronial inquest to be clearly stated in future. I have the impression that they feel that *the fact that the inquest has no defined purpose which the public can understand leads to difficulty and unrealistic expectations*.⁸

The Victorian Parliamentary Law Reform Committee (VPLRC) considered this issue in its 2006 report on the *Coroners Act 1985* (Vic) and found that the purposes of an inquest were:

- (a) to conduct a public investigation into a death which occurred in contentious circumstances in order to provide public accountability for the death;
- (b) to provide an effective mechanism for eliciting and challenging evidence; and
- (c) to provide a forum for interested persons to contribute to the development of coronial recommendations for the prevention of similar deaths.⁹

The VPLRC concluded that the purposes of an inquest should be clearly stated in the Act to enable 'coroners, family members and the community [to] have a better understanding of why an inquest is or is not taking place'.¹⁰ While the Commission agrees that the understanding of family members and the management of a family's expectations of the coronial investigation could be usefully improved, it does not agree that a statement, such as that recommend by the VPLRC, should be included in coronial legislation. In particular, the Commission does

1. 'Mandated Inquests', above.

2. See Chapter One, 'Coronial Process Snapshot'.

3. Table 3 in Appendix B shows the number of inquests undertaken by Western Australian coroners over the 10-year period 2000 to 2009, while Table 6 shows the number of mandated inquests as a percentage of total inquests for the same period.

4. See Tables 5 & 8, Appendix B.

5. See Chapter Two, 'An Inquisitorial Jurisdiction'. See also *Annetts v McCann* [1990] HCA 57; (1990) 170 CLR 596, 616 (Toohey J).

6. 'Coronial Findings and Comments', above.

7. United Kingdom, *Death Certification and the Investigation of Deaths by Coroners* ('the Shipman Inquiry'), Third Report (Cmd 5854, July 2003) 214 (emphasis added).

8. *Ibid* 213 (emphasis added).

9. VPLRC, *Coroners Act 1985 - Final Report* (2006), recommendation 52.

10. *Ibid* 229.

not agree that there should be a legislative statement that the purpose of an inquest is to provide 'public accountability for a death'. In the Commission's opinion, and on the basis of its consultations with members of the public, this may lead people to believe that the inquest will identify a person or entity as being responsible for the death and that person or entity will be held criminally or civilly accountable as a result of the inquest.¹¹ In the Commission's view, this is precisely what Dame Janet Smith meant when she referred (in the quote above) to the public having 'unrealistic expectations' about the outcome of an inquest.

Ultimately, the Victorian legislative reforms declined to include a section setting out the purposes of an inquest. Though there is nothing in the public realm to indicate why, the Victorian Act appears to rely instead on the general purposes clause of the legislation which includes reference to the prevention role of the coroner and the making of recommendations.¹² In the Commission's opinion a similar approach should be adopted in Western Australia. The Commission's proposed objects clause (Proposal 1), which acts as a guide to interpreting the Coroners Act, expressly states the following objects that are relevant in this context:

- to contribute to a reduction in the incidence of preventable deaths and injury by the findings and recommendations made by coroners and by the timely provision by coroners of relevant data to appropriate authorities and research bodies;
- to facilitate the timely provision of relevant information to family members of a deceased person the subject of a coronial investigation; and
- to provide a counselling service to family members, friends and others associated with a death the subject of a coronial investigation.

The prevention and recommendation function of coroners, discussed in detail in the following chapter, is what will ultimately provide a form of 'public accountability' for a death, in the sense of a public examination of and response

11. A number of respondents to the Commission's call for public comments expressed frustration and bewilderment that the inquest did not find anyone to blame for the death of their relative. This has also been expressed in newspaper articles following inquests: see, eg, 'Parents Disappointed After Baby Death Inquest', *The West Australian* (28 February 2011).
12. *Coroners Act 2008* (Vic) s 1.

to the circumstances that led to the death. And it is this, in the Commission's opinion, that truly characterises the purpose of an inquest.

Having said that, there are clearly limits to the scope of inquiry that a coroner may take at inquest. The inquiries a coroner may make must be causally related to the death under investigation.¹³ In *R v Doogan; Ex parte Lucas-Smith* the Full Court of the Supreme Court of the Australian Capital Territory held that the Coroners Act

does not provide a general mechanism for an open-ended inquiry into the merits of government agencies or private institutions, or the conduct of individuals, even if apparently related in some way to circumstances in which the death ... occurred.¹⁴ ... As Nathan J said in *Harmsworth v the State Coroner*, such discursive investigations might never end and hence never arrive at the findings actually required by the Act.¹⁵

Doogan was recently cited with approval by the Western Australian Court of Appeal in the recent case of *Re the State Coroner; Ex parte the Minister for Health* where the court observed that:

Section 25(1)(c) [cause of death] does not, however, authorise a coroner to undertake a roving Royal Commission for the purpose of inquiring into any possible causal connection, no matter how tenuous, between an act, omission or circumstance on the one hand and the death of the deceased on the other. ... It will be necessary, in each inquest, to delineate those acts, omissions and circumstances which are, at least potentially, to be characterised as causing or a cause of the death of the deceased. This is to be undertaken by applying ordinary common sense and experience to the facts of the particular case.¹⁶

From the above statement it can be seen that the Western Australian Court of Appeal has embraced the position elsewhere in Australia that an inquest is not an inquiry without limits.¹⁷ As discussed in the Background Paper, the fact that inquests had become more wide-

13. *Harmsworth v State Coroner* [1989] VR 989, 995 (Nathan J).
14. *R v Doogan; Ex parte Lucas-Smith* [2005] ACTSC 74, [15] (Higgins CJ, Crispin and Bennet JJ).
15. *Ibid* [28].
16. *Re the State Coroner; Ex parte the Minister for Health* [2009] WASCA 165, [46]-[47] (Buss J, Martin CJ and Miller JA agreeing) (citations omitted).
17. See, eg, *R v Doogan; Ex parte Lucas-Smith* [2005] ACTSC 74; *Musumeci v Attorney General of New South Wales* [2003] NSWCA 77, [34] (Ipp JA, Beazley JA agreeing); *Harmsworth v State Coroner* [1989] VR 989, 996 (Nathan J); *Conway v Jerram* [2010] NSWSC 371, [54] (per Barr J).

ranging in Western Australia since the passage of the Coroners Act was noted by a number of people consulted for this reference.¹⁸ While a role for the coroner that is wider than that of simply finding the matters required under s 25(1) and embracing a prevention function was strongly supported by most people, significant concern was expressed about the fact that the issues explored at some inquests were seemingly unfettered and not justified by the circumstances.

An example widely cited by respondents as going beyond the 'acceptable' scope of an inquest was the 'Kimberley Inquest':¹⁹ an inquest 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.²⁰ 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, both in terms of the breadth of the inquiry and by making certain recommendations that were insufficiently connected with the deaths being investigated.²¹ 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 presented at the inquest to support the making of informed recommendations about such broad social policy matters.

The Commission shares these concerns and believes that in addition to specifying the matters upon which a coroner may make comments or recommendations (see Proposals 44 and 81) the jurisdiction would benefit from legislative clarification in respect of how a coroner's power under the Coroners Act to make recommendations and comments should be exercised. Such an approach, while not unnecessarily constraining the prevention function of the coroner, would oblige the coroner to consider certain matters in determining whether to make a recommendation or comment, including whether the proposed comment or recommendation had sufficient connection to the particular circumstances of the death under investigation. The Commission's proposals in this respect and discussion of the coroner's prevention function can be found in Chapter Six.²²

GUIDANCE TO CORONERS CONSIDERING WHETHER TO HOLD A INQUEST

As mentioned above, s 22(2) of the Coroners Act gives the coroner wide discretion as to whether or not to hold an inquest in a particular case. There is no guidance in the Act to assist a coroner in the exercise of this discretion: s 22(2) merely provides that a 'coroner who has jurisdiction to investigate a death may hold an inquest if the coroner believes it is desirable'. The website of the Coroners Court of Western Australia makes the following comment on when an inquest might be held:

Only a small number of investigations by the Coroner end with an Inquest. There is always an Inquest if the deceased was held in care or the death was caused or contributed to by any action of a member of the Police Force. There may be an Inquest in other cases if the Coroner believes it is necessary or desirable in all the circumstances. This will usually be because the facts are unclear or there is some

18. LRCWA, *Review of Coronial Practice in Western Australia*, Background Paper (September 2010) 45.

19. Inquest No 37/07.

20. 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>.

21. The Commission notes that, if such a discursive approach to inquest were taken now, it would be likely to transgress the permissible limits to such inquiry set down by the Court of Appeal in *Re the State Coroner; Ex parte the Minister for Health* [2009] WASCA 165.

22. See Chapter Six, Proposal 82.

issue of public importance (ie, public health and safety).²³

However, during discussions with the State Coroner and Deputy State Coroner and others in the Office of the State Coroner, it emerged that the primary catalyst to a decision to hold an inquest in a particular case was family pressure. The State Coroner described the system as being 'reactive in this respect rather than proactive'.²⁴ This also appeared to be the view of people outside the Office with some stating that there should be criteria to guide coroners in making decisions whether or not to inquest. This was urged upon the Commission in order to identify a rationale for holding an inquest for the benefit of families and legal representatives, and to protect coroners from having to bow to family pressure where an inquest is unlikely to answer the questions the family has or where there is no discernible public benefit to holding an inquest.

Queensland is the only Australian jurisdiction to give any express legislative guidance to coroners in regard to exercising their discretion whether or not to hold an inquest into a particular reportable death. Section 28 of the *Coroners Act 2003* (Qld) provides:

- (1) An inquest may be held into a reportable death if the coroner investigating the death is satisfied it is in the public interest to hold the inquest.
- (2) In deciding whether it is in the public interest to hold an inquest, the coroner may consider—
 - (a) the extent to which drawing attention to the circumstances of the death may prevent deaths in similar circumstances happening in the future; and
 - (b) any guidelines issued by the State Coroner about the issues that may be relevant for deciding whether to hold an inquest for particular types of deaths.

The Queensland State Coroner's Guidelines provide that the 'discretion to hold an inquest

23. Coroners Court of Western Australia, 'When an Inquest Might be Held', <http://www.coronerscourt.wa.gov.au/W/when_an_inquest_might_be_held.aspx?uid=2920-5147-2656-136> (accessed 21 April 2011).

24. State Coroner & Deputy State Coroner, consultation (20 August 2008). It was, however, made clear to the Commission that this situation was significantly influenced by lack of resources and that there were many more cases the coroners would like to inquest that they were not in a position to do.

should be exercised with reference to the purposes of the Act and with regard to the superior fact finding characteristics of an inquest compared to the fault attributing role of criminal and civil trials'.²⁵ It provides a non-exhaustive list of categories of cases in which an inquest should usually be held:

- Any death where there is such uncertainty or conflict of evidence as to justify the use of the judicial forensic process
- Any death in which there is a likelihood that an inquest will uncover important systemic defects or risks not already known about
- Any deaths in which the views of the family or other significant members of the public are such that an inquest is likely to assist [to] maintain public confidence in the administration of justice, health services or other public agencies
- Any death that when grouped with others that have occurred in similar circumstances indicates that there may be an unexpected increase in danger in a particular location, area, family, industry or activity
- Any workplace death in which industrial processes or activity is implicated
- Any disasters involving multiple deaths
- Any death from self harm in which it is not possible to exclude the involvement of a third party procuring the death or in failing to prevent it.²⁶

In the Commission's opinion, the Queensland approach provides useful guidance to coroners exercising the discretion whether or not to hold an inquest while not being unnecessarily prescriptive. The State Coroner's Guidelines, which are contained in a publicly available document, also assist family members to understand in what circumstances the holding of an inquest might be considered. The Commission, therefore, proposes that a similar section be inserted in the Coroners Act. However, having regard to the fact that in Western Australia an application to the Supreme Court for an order that an inquest be held²⁷ is referable to the interests of justice rather than the public interest, the Commission proposes that the same interests of justice test inform

25. Queensland State Coroner's Guidelines (December 2003) [8.1].

26. Ibid.

27. See 'Application for Inquest', below.

the coroner's consideration of whether or not to hold an inquest.

PROPOSAL 60

Guidance for coroners on when an inquest should be held

That the following provision be inserted into the Coroners Act:

- (1) An inquest may be held into a reportable death if the coroner investigating the death is satisfied it is necessary or desirable in the interests of justice to hold the inquest.
- (2) In deciding whether it is necessary or desirable in the interests of justice to hold an inquest, the coroner may consider—
 - (a) the extent to which drawing attention to the circumstances of the death may prevent deaths in similar circumstances happening in the future; and
 - (b) the extent to which the powers of a coroner at inquest would facilitate the investigation as to justify the use of the judicial forensic process; and
 - (c) any guidelines issued by the State Coroner about the issues that may be relevant for deciding whether to hold an inquest for particular types of deaths.

PROPOSAL 61

State Coroner's guidelines: when inquest should be held

That the State Coroner issue guidelines for coroners to assist them in the exercise of their discretion as to whether or not to hold an inquest.

APPLICATION FOR INQUEST

Coroner

With the exception of South Australia, all Australian jurisdictions provide a mechanism for persons to apply to the coroner or a superior court (or both) requesting that an inquest be held in respect of a reportable death. In Western Australia, such applications are governed by ss 24(1) and 24(1a) of the Coroners Act, which provide:

- (1) If a person asks a coroner to hold an inquest into a death which a coroner has jurisdiction to investigate, the coroner may—
 - (a) hold an inquest or ask another coroner to do so; or
 - (b) refuse the request and give reasons in writing for the refusal to the person and to the State Coroner within a reasonable period after receiving the request.
- (1a) A request under subsection (1) is to—
 - (a) be made in writing; and
 - (b) contain reasons for the request.

As can be seen from s 24, a request that an inquest be held into a particular case is first made by application to the coroner who has jurisdiction to investigate the death. The request must be in writing and contain the reasons for the request. In practice, the Commission was told that families generally write to the coroner requesting an inquest in ignorance of s 24.²⁸ The State Coroner said that in many cases families do not appreciate the difference between an inquest and an investigation, and are simply seeking an answer to a specified question.²⁹ In such cases, the State Coroner advised that he writes to the family inviting them to view the information on the file and discuss the case with a counsellor after which many requests for inquest simply drop away.³⁰ However, in cases where the application is clearly made under s 24 and the coroner considers and refuses the request, the coroner will give written reasons (as required by the Act) and advise the applicant of his or her right to apply to the Supreme Court for an order that an inquest be held.³¹

28. State Coroner & Deputy State Coroner, consultation (20 August 2008).

29. Ibid.

30. Ibid.

31. Ibid.

Two things must be noted in this regard. Firstly, while the Coroners Court website refers to the ability to request an inquest, no reference is made to s 24 making it particularly difficult for laypersons to frame their request in terms of the right under the Coroners Act.³² And secondly, the Commission heard from some lawyers that coroners do not always make a clear reviewable decision even where an application is expressed to be under s 24; instead, the Commission was told, applications often result in return correspondence inviting further information and this may be repeated several times over a long period. The Commission notes that a number of Australian jurisdictions have formal application forms for a request to hold an inquest which are downloadable from their website.³³ In the Commission's opinion, such a form would be useful in Western Australia, both to assist family members of a deceased to make an application for an inquest, and to signify formally to the coroner that the application is made under s 24 and requires a clear decision and reasons for refusal. In the Commission's opinion, all applications that are refused by a coroner should be accompanied by a statement about the applicant's right to apply for review of the decision to the Supreme Court, specifying the time in which such an application can be made.

PROPOSAL 62

Application to coroner for inquest

That an application for inquest form be developed and made available for download from the Coroners Court website. The form should provide clear fields for the information required by a coroner to make a decision pursuant to the Coroners Act whether or not to hold an inquest.

Supreme Court

Section 24(2) of the Coroners Act provides an avenue for a person whose application for an inquest has been refused by a coroner to

apply to the Supreme Court for an order that an inquest be held.

- (2) Within 7 days after receiving notice of the refusal, or if a reply to a request for an inquest to be held has not been given within 3 months after the request was made, the person may apply to the Supreme Court for an order that an inquest be held.
- (3) 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.

There is very little guidance as to what 'the interests of justice' means in the coronial context. The Commission is aware of three applications³⁴ brought under s 18 of the now repealed *Coroners Act 1985* (Vic),³⁵ of which the most recent noted that 'no test ... has been laid down' for the interpretation of the phrase and 'nor has there been a clear statement of what principles apply'.³⁶ In the context of an application for a fresh inquest, the New South Wales Court of Appeal held that the phrase 'necessary or desirable in the interests of justice' enlivened a 'discretionary judgment', with Kirby P noting that 'there could scarcely be a wider judicial remit'.³⁷

The Commission is aware of only one Western Australian case where a person has applied under s 24 to the Supreme Court following a refusal by a coroner to hold an inquest. In *Veitch v State Coroner*, Beech J stated that 'in determining what is encompassed by "the interests of justice" regard is to be had to the evident policy and objects of the legislation'³⁸ and the 'scope and focus of an inquest when one is held'.³⁹ More recently, the New South Wales Supreme Court has held that 'when considering where the interests of justice lie the courts should be guided by the statutory functions of the Coroner'.⁴⁰ It is also apparent that some regard to the 'public interest in ascertaining the truth about the manner and cause of the person's death' is required by a court considering

32. Coroners Court of Western Australia, 'Requesting an Inquest' <<http://www.coronerscourt.wa.gov.au>> (accessed 21 April 2011).

33. See, eg, Victoria <<http://www.coronerscourt.vic.gov.au>> (Form 26); Queensland <<http://www.courts.qld.gov.au/1709.htm>> (Form 15).

34. *Clancy v West* [1996] 2 VR 647; *Rouf v Johnstone* [1999] VSC 396; *Chiotelis v Coate* [2009] VSC 256.

35. *Coroners Act 1985* (Vic) s 18(3).

36. *Chiotelis v Coate* [2009] VSC 256, 20.

37. *Herron v Attorney General for New South Wales* (1987) 8 NSWLR 601, 613.

38. *Veitch v State Coroner* [2008] WASC 187 [36].

39. *Veitch v State Coroner* [2008] WASC 187 [38].

40. *Conway v Jerram* [2010] NSWSC 371, 35 citing *Minister for Aboriginal Affairs v Peko-Wallsend Limited* [1986] HCA 40; (1986) 162 CLR 24, 39 (Mason J).

an application whether or not to order that an inquest be held.⁴¹ While it is noted that the *Coroners Act 2003* (Qld)⁴² has adopted 'the public interest' as its touchstone rather than 'the interests of justice', the Commission notes that that jurisdiction has experienced similar issues arriving at a satisfactory interpretation of that phrase.⁴³ In the circumstances, and considering the wide usage of 'the interests of justice' test in the coronial context throughout Australia⁴⁴ and the potential for further useful judicial consideration of the term, the Commission has determined that it should remain as the test in Western Australia. The Commission also notes that the Supreme Court will be informed in its deliberations under this section by Proposal 1, which sets out the objects of the Act to which (according to the authorities)⁴⁵ a superior court should have regard when assessing whether it is in 'the interests of justice' that an inquest be held.

During consultations it was observed that s 24(2) provided a very limited window of opportunity (seven days) in which a person may apply to the Supreme Court for an order under s 24(3) that an inquest be held. Western Australia is the most restrictive jurisdiction in this regard, with most other jurisdictions providing between 14 and 30 days and others providing longer⁴⁶ or no limitation.⁴⁷ Unlike reviews by the Supreme Court of decisions regarding post mortem examination, the Commission can see no reason for such a strict time limitation for review of a coroner's decision in cases dealing with a request to hold an inquest. Having regard to the provisions of other jurisdictions, the Commission believes that 30 days is an appropriate time limit in which an applicant may seek superior court review and makes the following proposal.

41. *Herron v Attorney General for New South Wales* (1987) 8 NSWLR 601, 617 (McHugh JA).

42. *Coroners Act 2003* (Qld) s 30(8).

43. See *Gentner v Barnes* [2009] QDC 307, [19] where Robertson DCJ also refers to the lack of information as to why Parliament in that state adopted the public interest as its touchstone rather than the interests of justice 'as is the case in all the other states'.

44. See, eg, in the context of applications for an order that an inquest be held, *Coroners Act 2009* (NSW) s 84; *Coroners Act 1995* (Tas) s 44(3); *Coroners Act 1997* (ACT) s 91; and *Coroners Act 2003* (SA) s 27 (in the context of appeals from findings made on inquest).

45. See, eg, *Veitch v State Coroner* [2008] WASC 187, [36]; *Gentner v Barnes* [2009] QDC 307, [38].

46. See, eg, *Coroners Act 2008* (Vic) s 82 which provides a three-month period in which to appeal to the Supreme Court.

47. See, eg, *Coroners Act 2009* (NSW) s 84.

PROPOSAL 63

Superior court review of coroner's decision to refuse inquest

1. That where an application to hold an inquest has been refused by a coroner the person who made the application may, within 30 days of receiving the notice of refusal, apply to a single judge of the Supreme Court (in the case of a decision of a coroner or Deputy State Coroner) or the Court of Appeal (in the case of the State Coroner) for an order that an inquest be held.
2. That where a reply to an application for an inquest to be held has not been given within three months after the application was made, the person who made the application may apply to a single judge of the Supreme Court (in the case of a decision of a coroner or Deputy State Coroner) or the Court of Appeal (in the case of the State Coroner) for an order that an inquest be held.
3. That the Supreme Court may make such an order if it is satisfied that it is necessary or desirable in the interests of justice that an inquest be held.

JOINT INQUESTS

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 inquest⁴⁸ 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;⁴⁹
- an inquest into five suicide deaths in Oombulgarri, a remote Aboriginal community over a 12-month period;⁵⁰

48. Sometimes called 'cluster investigations'.

49. Inquest No 31/03.

50. Inquest No 13/08.

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

In other Australian jurisdictions there have been joint inquests into lap-band surgery deaths, immigrant drowning deaths, SIDS deaths, all-terrain vehicle fatalities, rock fishing deaths, level crossing deaths and motor vehicle accidents on a particular stretch of highway. Each of these joint inquests resulted in recommendations aimed at preventing future deaths in similar circumstances. The vehicle of the joint inquest allows coroners to explore more systemic recommendations and provides a unique opportunity to influence public health and safety outcomes in relation to deaths occurring in similar circumstances.

Section 40 of the Coroners Act provides that 'the State Coroner may direct that more than one death be investigated at one inquest'. In other jurisdictions the power to hold an inquest into two or more deaths is not confined in this way. For example, Victoria, the Northern Territory and South Australia permit any coroner to initiate a joint inquest.⁵⁴ In the professionalised jurisdiction that the Commission contemplates with its proposals there appears little reason to confine the holding of joint inquests to matters directed by the State Coroner. Instead the Commission suggests that the Coroners Act provide that any coroner may hold a joint inquest into two or more deaths and that the State Coroner issue a guideline pursuant to s 58 of the Coroners Act stating the matters to be considered by coroners in the exercise of their discretion whether or not to hold a joint inquest.

PROPOSAL 64

Joint inquests

1. That the Coroners Act provide that any coroner may hold a joint inquest into two or more deaths arising from the same incident or from separate incidents with apparently similar circumstances.
2. That the State Coroner issue guidelines stating the matters to be considered by coroners in the exercise of their discretion as to whether or not to hold a joint inquest.

51. Inquest No 13/04.

52. Inquest No 37/07.

53. 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.

54. *Coroners Act 2008* (Vic) s 54; *Coroners Act* (NT) s 14; *Coroners Act 2003* (SA) s 21(3).

Appearance at an inquest

INTERESTED PERSONS

Section 43 of the *Coroners Act 1996* (WA) ('the Coroners Act') expressly provides for the Attorney General to 'appear or be represented at an inquest, examine or cross-examine witnesses and make submissions'. The rights of other people to appear at an inquest are governed by s 44:

- (1) An interested person may appear, or be represented by an Australian legal practitioner (within the meaning of that term in the *Legal Profession Act 2008* section 3), at an inquest and examine or cross-examine witnesses.
- (2) Before a coroner makes any finding adverse to the interests of an interested person, that person must be given the opportunity to present submissions against the making of such a finding.
- (3) There may be prescribed a list of persons who are interested persons for the purpose of this section, but such a list is not a conclusive list of interested persons.
- (4) A coroner may disallow any question which in the coroner's opinion is not relevant or otherwise not a proper question.

Regulation 17 of the *Coroners Regulations 1997* (WA) ('the Coroners Regulations') provides a list of interested persons for the purposes of s 44(3).

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, 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*.

Regulation 17 provides the most detail of any Australian jurisdiction as to who may be considered an interested person with the right to appear at an inquest; however, it must be noted that under s 44(3) this list is not conclusive. Most Australian jurisdictions provide that a person or organisation may be an interested party if, in the opinion of the coroner or the Coroners Court, that person or organisation has a 'sufficient interest' in the subject matter of the proceedings.¹ This appears to be the threshold test in all Australian jurisdictions except Western Australia which has no specified test.

In his 2008 Review of the Coroners Act, Queensland State Coroner Michael Barnes recommended that the Commission consider 'who should be granted leave to participate in inquests and whether a limited right should be accorded those who do not have a direct personal interest in the death'.² In this regard, the Commission notes that the Queensland equivalent to s 44 limits the appearance rights of persons satisfying the sufficient interest test in the absence of a direct personal interest in the death to examining witnesses only with the courts leave and to confining submissions at the inquest to the matters on which a coroner may comment.³ These matters are specified in the Act as being public health or

1. *Coroners Act 2009* (NSW) s 57(1); *Coroners Act 1997* (ACT) s 42(b); *Coroners Act 2009* (NT) s 40(3); *Coroners Act 2003* (SA) s 20(1). The *Coroners Act 2003* (Qld) s 36 and the *Coroners Act 2008* (Vic) s 56 also provide that 'sufficient interest' is the threshold test.

2. Barnes M, *Review of the Coroners Act 1996* (WA) (August 2008) 29.

3. *Coroners Act 2003* (Qld) s 36(2).

safety, the administration of justice, and ways to prevent deaths from happening in similar circumstances in the future.⁴ Persons (or organisations) that fall into such a category are those who satisfy the sufficient interest test 'only because it is in the public interest'⁵ and are generally 'special interest advocacy groups' or government or community entities which have no direct connection with the particular death. The involvement of such persons in an inquest can usefully inform the comments and recommendations that coroners might make.

In Western Australia, such bodies might include regulatory bodies (such as WorkSafe, EnergySafety and Department of Mines), the Office of the Inspector of Custodial Services, the Commissioner for Children and Young People, the Ministerial Taskforce on Suicide Prevention, the Public Advocate, the Mental Health Law Centre and the Royal Lifesaving Society, among others. The Commission is also aware of one Western Australian case⁶ where the Human Rights and Equal Opportunity Commission has sought and been granted leave to make submissions at inquest. In a recent ruling in Victoria on whether certain entities⁷ should be granted leave to appear as interested parties at an inquest into the police shooting death of a 15-year-old boy, Coate J observed that:

The newly defined prevention role of the coroner, the Preamble and purposes set out in the Act and the mandatory response to coroners' recommendations widens the pool of those likely to express an interest in being granted interested party status.⁸

The Commission notes that this may well be the position in Western Australia if its proposals (to similar effect) are implemented. In these circumstances, and in order that inquest

proceedings are assisted but not unnecessarily protracted by the involvement of interested persons without a direct connection to the death, the Commission believes it is appropriate to limit the rights of interested persons to making submissions on the matters on which a coroner may comment or make recommendations and examining or cross-examining witnesses with the court's leave.

As noted earlier, s 44 does not specify a test by which a coroner may identify interested persons. However, s 42 which is titled 'rights of interested persons' states that a 'coroner may make available any statements that the coroner intends to consider to any person with a sufficient interest'. This suggests that identification is referable to the sufficient interest test which is used in all other Australian jurisdictions. In the Commission's opinion this should be made clear in the section governing who may appear at inquest (s 44). The Commission observes that currently interested parties under s 44 may examine and cross-examine witnesses, but may not make submissions except in circumstances where a coroner gives notice that an adverse finding or comment may be made under s 44(2). It is understood that in practice, interested persons are often invited to make submissions and in the Commission's opinion this should be a right of an interested person as a matter of course. The Commission therefore makes the following proposal.

PROPOSAL 65

Interested persons

1. That the section of the Coroners Act governing who may appear at an inquest (currently s 44) include those persons who the Coroners Court considers have a sufficient interest in the inquest or those persons prescribed by regulation and that the rights of appearance of those persons include the right to examine or cross examine witnesses and make submissions.
2. That where the Coroners Court considers a person to have sufficient interest in an inquest solely because it is in the public interest (eg, a special interest advocacy group or a government or community

4. *Coroners Act 2003* (Qld) s 46(1). The Commission adopts this formulation in Proposals 44 (comments) and 81 (recommendations).

5. *Coroners Act 2003* (Qld) s 36(2).

6. For example, the Human Rights and Equal Opportunity Commission (HREOC) was granted leave to appear in Inquest 29/02, which concerned the deaths of two Afghanistani asylum seekers at sea. While there is no detail as to any limitations placed on the participation of HREOC, it appears that submissions concerned matters directly relating to the human rights of the asylum seekers and the responsibilities of the Australian government under particular international rights conventions.

7. Specifically, Legal Aid Victoria, the Human Rights Law Resource Centre and Youthlaw.

8. Coroners Court of Victoria, Inquest into the Death of Tyler Cassidy, Ruling on applications to be granted leave to participate as interested parties (4 March 2010).

entity which has no direct connection with the death being investigated), the rights of appearance are limited to making submissions on the matters on which a coroner may comment or make recommendations and examining or cross-examining witnesses with the court's leave.

RIGHTS OF INTERESTED PERSONS

In support of the rights to examine or cross-examine witnesses and make submissions, certain procedural rights and courtesies must extend to interested persons who have been granted leave to appear at an inquest. One such right is found in s 42 of the Coroners Act which states that a 'coroner may make available any statements that the coroner intends to consider to any person with a sufficient interest'. The Act and Regulations are otherwise silent on what should be provided by the Coroners Court to interested persons appearing at an inquest. However, the Commission notes two internal practice directions made by the State Coroner in 2004 that have a bearing on what may be made available to interested persons pursuant to s 42. The first directs that 'a complete set of copies' of statements and reports (the 'inquest brief') prepared from a 'master copy' should be available for purchase by interested parties as soon as a 'firm date has been set for inquest';⁹ while the second makes clear that exhibits (eg, photographs) should not be provided to or accessed by interested persons except with the express consent of the coroner following a written request setting out the reasons for seeking access.¹⁰

Inquest brief

Unlike other courts in the Western Australian system, the Coroners Court cannot proceed on the basis of briefs prepared by parties because there are no parties to an inquest. As an inquisitorial court, it must produce its own brief consisting of the evidence collected during the

investigation stage that has a bearing upon the matters to be inquired into at the inquest and that brief should be provided to those people who are considered interested persons under s 44. During consultations a number of lawyers complained that, although the coroner granted access to the statements and some (but not all)¹¹ reports on the inquest file, there was not always an inquest brief prepared for the purposes of the inquest that was available to interested persons or their representatives. The Commission was told that lawyers were often required to attend at the offices of the coroner to view the file and request copies of statements and reports (for which they are charged a fee per page).¹² There were also reports of additions of evidence (such as statements and expert reports) to the file after notification that an inquest was to be held, so that some parties arrived at the inquest without relevant statements that were in the possession of counsel assisting or other interested persons. In some cases the Commission heard that, where an inquest brief was prepared, copies were not always made of all the pages in a statement or report (in particular, in the case of hospital notes), especially where the originals were double sided. Further, the Commission was told that at inquest it was sometimes found that people were working with different (ie, earlier or later) versions of the same documents on the file.

Whether the deficiencies referred to above are due to lack of human resources or otherwise, the situation is clearly unacceptable. In the Commission's opinion, once an inquest has been set down for hearing the file on the matter should be complete and an inquest brief consisting of everything to be referred to or considered by the coroner to be relevant to

9. Office of the State Coroner, Practice Direction 3/2004, 'Provision of Copies of Statements and Reports to Interested Persons for the Purpose of Inquest Hearings'.

10. Office of the State Coroner, Practice Direction 2/2004, 'Access to Inquest Files Prior to Inquest and at the Conclusion of an Inquest Hearing'.

11. The Commission is aware that the reports provided by the medical advisers to the State Coroner are considered privileged and do not form part of the inquest brief or the public file. It is noted, however, that such reports are generally prepared to assist the coroner to determine whether or not an inquest is required and the relevant medical issues that might arise. In contrast, expert reports on specific medical matters to be explored at inquest that are requested by the coroner (usually upon recommendation by the medical adviser) do form part of the inquest brief.

12. This is a substantial improvement on practice 15 years ago where it was reported that solicitors were required to gain permission to bring their own photocopying equipment into the coroner's office to copy documents in situ: Roberts-Smith L, 'The Conduct of Coronial Inquiries in Western Australia: A Practitioners Guide' (1994) 23 *University of Western Australia Law Review* 172, 177.

the inquest should be prepared for interested persons and charged at a rate per page specified in the Regulations.¹³ If there are additions to the file after the inquest date is set,¹⁴ they should immediately be made available to all interested persons as addenda to the inquest brief. It is the Commission's view that such an important matter as the preparation and provision of an inquest brief must be provided for in the Coroners Act.

Section 115(1)(b) of the *Coroners Act 2008* (Vic) provides a useful model for statutory reform in this area. That section requires the Principal Registrar to provide an interested party with an inquest brief, unless otherwise ordered by the coroner. An inquest brief is defined in s 115(7) as 'a brief of evidence that is prepared for an inquest and contains the following (if available)'—

- (a) a statement of identification by an appropriate person;
- (b) any reports given to a coroner as a result of a medical examination;
- (c) reports and statements that the coroner investigating the death or fire believes are relevant to an inquest;
- (d) other evidentiary material that the coroner investigating the death or fire believes is relevant to the inquest;
- (e) any material prescribed by the rules or the regulations.¹⁵

Under s 115(8), if the coroner considers part of the medical file to be irrelevant to the inquest he or she may direct that it not be included in the inquest brief. The Commission makes the following proposal for reform modelled on s 115 of the *Coroners Act 2008* (Vic), but including a clear legislative direction that unless leave is given for another purpose, information provided as part of the inquest brief shall only be used for proceedings under the Coroners Act.

13. In the Commission's opinion, families and their representatives should not be required to pay for a copy of the inquest brief.

14. For example, supplementary statements provided by interested persons.

15. *Coroners Act 2008* (Vic) s 115(7).

PROPOSAL 66

Inquest brief to be provided by Coroners Court

1. That, unless otherwise ordered by the coroner, the Principal Registrar must provide an interested party with a copy of the inquest brief being a brief of evidence that is prepared for an inquest and contains the following (if available) —
 - (a) a statement of identification by an appropriate person;
 - (b) any reports given to a coroner as a result of a medical examination;
 - (c) reports and statements that the coroner investigating the death believes are relevant to an inquest;
 - (d) other evidentiary material that the coroner investigating the death or believes is relevant to the inquest;
 - (e) any material prescribed by the regulations.
2. That an inquest brief does not include any part of a medical file that the coroner considers to be irrelevant to the inquest.
3. That, unless leave is given for another purpose, information provided as part of the inquest brief shall only be used for proceedings under the Coroners Act.

Notification of inquest

The Commission was told by counsel (both in private practice and in government) that the Coroners Court regularly failed to notify interested persons appearing at inquest about important events in the inquest process. Of particular concern was the late notification, firstly, of cases identified for inquest and, secondly, of the dates set down for inquest. It was suggested that in many cases counsel only learned that a case was proceeding to inquest a matter of weeks before the listing date. In some cases, counsel only learned of an inquest through the notice required to be placed by the

Coroners Court in the newspaper 14 days prior to inquest.¹⁶

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). In the Commission's view, these people should be identified at the earliest opportunity and kept informed of developments in the inquest process. These people may have interests to protect, both in respect of potential disciplinary proceedings or criminal charges that may follow from an inquest, and will often require legal representation. Counsel for interested persons need sufficient time to prepare their case, to examine the coroner's inquest brief, 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, especially in circumstances where inquests are called some years after the death. 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.¹⁷ It is important also to note that family members are among the interested persons who may appear at inquest under the Coroners Regulations. An experienced lawyer often engaged as counsel assisting the coroner told the Commission that more notice of the inquest was required by family members, particularly those who live in rural and remote Western Australia and who may have difficulty arranging transport at relatively short notice. He stated that this was one of the complaints that he heard most often from families.

The Commission is aware that many jurisdictions set dates for inquest hearings between four and six months in advance. In the Commission's opinion, in most cases this will constitute an adequate length of time to enable interested persons to prepare for inquest. As soon as a matter is set down for inquest those dates should be published on the Coroners Court

16. Section 39 of the *Coroners Act 1996* (WA) provides that 'Unless the State Coroner otherwise directs, a coroner must, at least 14 days before an inquest, publish in a daily newspaper circulating generally in the State, the date, time, place and subject of the inquest'.

17. See 'Procedural Fairness', below.

website. The Commission notes that, despite reference to the infrequent updating of the Coroners Court website in its Background Paper (published in September 2010),¹⁸ when viewed in April 2011 the court lists portion of the website still featured inquest listings for January and February of the previous year. Updating the court lists webpage would appear to be a relatively simple matter that should not impact heavily on human resources and since it is a pertinent public source of information about forthcoming inquests it is suggested that this be immediately rectified by the Office of the State Coroner. In addition, the Commission proposes that the timeframe for placing a notice of inquest in the newspaper at least 14 days under s 39 of the Coroners Act should be increased to 28 days prior to inquest in keeping with the proposals for notice for pre-inquest hearings (discussed below).

PROPOSAL 67

Notification and publication of inquest dates

1. That reasonable notice (between 4 and 6 months) is given to interested persons of dates set down for the hearing of an inquest.
2. That as soon as dates are set for the hearing of an inquest they are immediately published on the Coroners Court website.
3. That unless the State Coroner otherwise directs, a coroner must, at least 28 days before an inquest, publish in a daily newspaper circulating generally in the state, the date, time, place and subject of the inquest.

Pre-inquest hearings

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

18. LRCWA, *Review of Coronial Practice in Western Australia*, Background Paper (September 2010) 50.

jurisdiction. 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. In other jurisdictions, the Commission notes it is usual to have preliminary hearings otherwise known as directions hearings or pre-inquest conferences to assist the listing process for inquests. At such hearings the likely scope of the inquests is outlined by the coroner, possible interested persons are identified, applications for leave to appear as an interested person are heard and hearing dates are set in conjunction with key witnesses. An example of a notice for such a hearing (taken from the Queensland Coroners Court website) follows:

An inquest into the death of [Mr X]¹⁹ will be held in the Coroners Court at Court 4, Level 1, Brisbane Magistrates Court Building, 363 George Street, Brisbane on Thursday 11 February 2010 at 3:30pm. Applications for leave to appear and the date and place for hearing evidence will be considered and the issues to be investigated determined. Please note no evidence will be heard on this day.

The issues to be investigated at the inquest are:

- findings required by s.45(2) of the Coroners Act 2003; namely the identity of the deceased, when, where and how he died and what caused his death
- whether [Mr X]'s declining nutritional status with secondary aspiration pneumonia was adequately managed by the staff at the PAH
- whether [Mr X]'s jejunostomy tube was adequately maintained by the staff at the PAH
- whether the feeding tube was placed in the ileum at the time of the initial surgery in December 2004, and if not when and how it came to be positioned
- whether the displacement of the feeding tube ought to have been identified prior to the surgery in June 2005
- why a number of the radiology reports did not identify which part of the small bowel the feeding tube was positioned in.

Those intending to seek leave to appear or wanting further information should contact Daniel Grice, assistant to State Coroner Michael Barnes on 07 3247 5858.²⁰

19. The Commission has omitted the name of the deceased for the sake of privacy.

20. Coroners Court (Qld), 'Current Sitings' <<http://www.courts.qld.gov.au>> (accessed 26 April 2011).

The greater use of pre-inquest hearings in the Coroners Court was supported by all counsel consulted for this reference, including counsel assisting the coroner. One experienced counsel assisting suggested that it would be useful if there was a statutory basis for the holding of directions hearings, especially in long and complex cases. The Commission was referred to s 34 of the *Coroners Act 2003* (Qld) which provides for the holding of 'pre-inquest conferences' for the following purposes:

- (1) The Coroners Court investigating a death may hold a conference before holding an inquest—
 - (a) to decide—
 - (i) what issues are to be investigated at the inquest; or
 - (ii) who may appear at the inquest; or
 - (iii) which witnesses will be required at the inquest; or
 - (iv) what evidence will be required at the inquest; or
 - (b) to work out how long the inquest will take; or
 - (c) to hear any application under section 17;²¹ or
 - (d) to otherwise ensure the orderly conduct of the inquest.
- (2) The Coroners Court may publish, in a daily newspaper circulating generally in the State, a notice of—
 - (a) the matter to be investigated at the inquest; and
 - (b) the proposed issues to be investigated at the inquest; and
 - (c) the date, time and place of the conference set by the coroner.
- (3) If the Coroners Court decides to publish a notice as mentioned in subsection (2), the notice must be published at least 28 days before the conference is to be held.
- (4) The Coroners Court may order a person concerned with the investigation to attend the conference.

Given the significant level of support for such pre-inquest hearings and in light of the obvious difficulties experienced by both the Coroners Court and counsel in matters listed for inquest hearing in Western Australia, it is clear that provision for such hearings is both warranted and overdue. The Commission is particularly attracted to the Queensland provision because

21. *Coroners Act 2003* (Qld) s 17 relates to disclosure of confidential information to the coroner.

it permits the publication of a notice at least 28 days in advance of the hearing. In cases where the coroner is examining issues that are in the public interest such publication will be useful to alert special interest advocacy bodies of the intention to inquest at which they may, if granted leave, provide useful assistance to the coroner in the making of recommendations and comments.

PROPOSAL 68

Pre-inquest hearings

1. That a section modelled on s 34 of the *Coroners Act 2003* (Qld) be inserted into the Coroners Act to provide for pre-inquest hearings for the purposes of deciding the issues to be investigated at the inquest; the witnesses who will be required; the evidence that will be required; the interested persons who may appear at the inquest; whether it is appropriate that a specialist adviser be appointed to sit with a coroner at inquest;²² how long the inquest will take; and, where appropriate, the dates for the hearing of the inquest.
2. That interested persons and witnesses identified by the Coroners Court be advised in writing of the date for the pre-inquest hearing and the issues the coroner intends to investigate at the inquest.
3. That the Coroners Court may publish a notice of a pre-inquest hearing at least 28 days in advance of the hearing to notify potential interested persons of the inquest. Such notice should be published in a daily newspaper circulating generally in the state, as well as on the Coroners Court website.
4. That Coroners Court may order a person concerned with the investigation to attend the pre-inquest hearing.

22. See 'Inquest Practice and Procedure: Expert advice to coroners at inquest', below.

Procedural fairness

As discussed earlier, s 44(2) requires a coroner to give an interested person the opportunity to present submissions against the making of an adverse finding. This is an important recognition of the High Court decision in the Western Australian case of *Annetts v McCann*,²³ where the court found that a coroner carrying out an inquest is bound to observe the rules of natural justice and could not lawfully make an adverse finding against the interests of an interested person without first giving that person the opportunity to present submissions.²⁴

To satisfy the obligation in s 44(2), persons against whom an adverse finding may be made must have sufficient notification of the risk of such a finding.²⁵ A submission through counsel from the Medical Defence Association noted that, although in some cases counsel assisting sent doctors a letter in advance of inquest warning of the potential of an adverse finding, it was their experience that not all doctors at risk of such a finding receive notification. Further, the Commission heard that sometimes notice is only given of the possibility that an adverse finding may be made after all evidence has been heard and prior to closing submissions. This has meant that in some cases witnesses who had no reason to think that they may need legal representation have been effectively denied the opportunity to make effective submissions through counsel. One lawyer who regularly appears in the Coroners Court noted that it was 'quite common to get half way through an inquest and then find that a witness who isn't represented needs to be represented'. It was stated that counsel appearing for another party is often alerted to the potential of an adverse finding against a witness through the nature of the questioning by counsel assisting and that it is left to them to suggest to the person that he or she should seek legal representation (although this may be after the person's evidence is completed).

The Commission is of the view that a witness, who has previously provided a statement

23. *Annetts v McCann* (1990) 170 CLR 596.

24. *Ibid* 601.

25. This is effectively acknowledged by the State Coroner in Practice Direction 2/2005, 'Listing Issues in the Coroners Court'.

or report to the coroner detailing his or her involvement in the circumstances surrounding a death, should wherever possible be made aware of the risk of an adverse finding before submissions are being discussed at the close of an inquest. It will be a rare occasion where counsel assisting or the coroner will not be in a position to identify such risk prior to the inquest. In the Commission's opinion it is fundamentally important that such persons are identified at the earliest possible stage to enable them to gain legal representation for the inquest proceedings and, if necessary, seek their own expert reports. The Commission, therefore, makes the following proposal and also notes that the proposals above regarding early notification and publication of inquest hearing dates²⁶ and for pre-inquest hearings²⁷ at which persons may seek leave to appear as an interested person at an inquest will significantly improve the likelihood that the requirements of s 44(2) are satisfied.

PROPOSAL 69

Identifying interested parties

That reasonable efforts be made by the Coroners Court to identify and notify persons whose interests may be affected by the conduct and outcome of an inquest or who may be required to appear as a witness at an inquest of the court's intention to hold an inquest prior to inquest hearing dates being set.

LEGAL REPRESENTATION AT AN INQUEST

As noted above, s 44 provides for interested persons to be represented by a legal practitioner at an inquest. Table 10 in Appendix B shows the incidence of legal representation at Western Australian inquests for the period 2000 to 2009.²⁸ An examination of inquest records shows that most counsel appear for

parties described in reg 17(e)–(g). The most represented persons at inquests appear to be nurses, doctors, hospitals and police officers called as witnesses. In some cases, counsel will be provided by or paid for by the relevant workers' union or by the person's professional insurer.

Unlike other interested persons, there is a relatively low incidence of lawyers appearing for the family of a deceased at inquest in Western Australia.²⁹ Although it is not their role to act as the family's representative, counsel assisting the coroner will often try to assist the family of the deceased by exploring relevant issues raised by the family in the inquest forum. The Commission received a number of comments on its public survey commending the attention of counsel assisting to families during the inquest process. At the same time, respondents to the public survey also commented on the need for legal aid funding for families at inquests, particularly in light of the frequent adversarial approach to proceedings (discussed below). Evidence given before the Victorian Parliamentary Law Reform Committee highlighted the comparative disadvantage of families who were not independently legally represented where other interested persons (such as government agencies) did have legal representation.³⁰ The Commission was told that it was very difficult to obtain any sort of legal aid funding for the representation of families at inquest, even where such representation might be in the public interest. While there appears to be no policy for representation of families at inquests involving Aboriginal deceased, the Aboriginal Legal Service advised that they were usually informed by the Coroners Court when there was to be an inquest involving an Aboriginal deceased³¹ and that arrangements were made, wherever possible, to arrange representation for the family. A number of private lawyers also act on a pro bono basis (or otherwise seek Commonwealth funding)³² for the assistance of families of Aboriginal deceased. However,

26. Proposal 67.

27. Proposal 68.

28. 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 record of investigation into death. 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 the footnotes to the table.

29. See Appendix B, Table 10.

30. See evidence of Mr Kauffman before the VPLRC reproduced in Gibson F, 'Legal Aid for Coroners' Inquests' (2008) 15 *Journal of Law and Medicine* 587, 589.

31. Pursuant to recommendations 20 and 21 of the Royal Commission into Aboriginal Deaths in Custody, *National Report* (1991) vol 5.

32. One lawyer noted that he had been able to gain funding for some high-profile inquests involving Aboriginal deceased by petitioning the Commonwealth Minister for Families.

recommendation 23 of the Royal Commission into Aboriginal Deaths in Custody, which states that the family of the deceased be entitled to government-funded legal representation for deaths in custody inquests does not appear to have been legislatively implemented, either in Western Australia or elsewhere.³³

In an article published in 2008, Francis Gibson examined the circumstances in which legal aid is available for representation at an inquest in each Australian jurisdiction.³⁴ In Western Australia legal aid is only given for inquests in circumstances where there is a 'realistic risk that serious criminal charges may arise against the applicant; where the outcome of the inquest can reasonably be seen to be likely to have a significant impact on civil proceedings involving the applicant; and as a result of such representation, there is a real likelihood of some substantial benefit accruing to the applicant'.³⁵ Under these criteria family members would rarely, if ever, receive legal aid for representation. In contrast, in all other Australian jurisdictions, legal aid may be granted for inquests where it is considered to be in the public interest.³⁶

PROPOSAL 70

Funding of legal representation at inquest

That the Western Australian government fund Legal Aid WA, the Aboriginal Legal Service of Western Australia and community legal centres to provide legal representation and assistance to families for the purposes of an inquest where such representation is in the public interest.

Lawyers in the inquisitorial context

In Chapter Two, the Commission described the nature of inquest proceedings as being inquisitorial rather than adversarial like other courts in Western Australia.³⁷ As discussed earlier in this chapter, the purpose of the

inquest is not to apportion blame, but to better understand the circumstances surrounding the death in order to make the various findings required under s 25(1) of the Coroners Act and to arrive at possible recommendations to prevent future deaths in similar circumstances.³⁸ During the Commission's consultation phase there were a great number of comments from witnesses that the behaviour of lawyers, counsel assisting and coroners at inquests was extremely 'adversarial'. The following are some responses to the Commission's public survey made by respondents who had appeared as witnesses in inquests.

The purpose of a Coronial Inquest is to find out what happened to the deceased and what led up to the death. Also, whether anything could have been done differently, to prevent the death, and whether anything can be learned from that person's death in terms of changing procedures. The very adversarial nature of the Counsel assisting the Coroner mitigates against the free and fulsome disclosure by a witness.

Unfortunately, I had the displeasure of being involved as a witness in a Coronial Inquest where the cost to me emotionally has been immeasurable.

The court needs to provide a less adversarial approach if it is to get the best out of witnesses – who are often very distressed and need guidance, not to be treated like criminals. I personally was very traumatized by my treatment in the witness box and that the Coroner did not see fit to assist me by putting an end to the inane and constant battering by lawyers (and at times the Coroner).

I was a professional person providing nursing care to a death in custody. I found that the process which I had been told was inquisitorial was quite adversarial and provided a great deal of stress some years after the event.

There was no representation or support for you as a witness. You were basically at the mercy of the "Inquisitor". I felt powerless and defenceless.

Witnesses were treated differently depending on their status ie, doctor v nurse. It appeared the coroner had made up his mind before he even started the questions ... The process resembled a trial.

One staff member was so badly affected by the way that questions were asked of other witnesses that she was admitted to hospital suffering self harm before she was able to give her evidence. She has been unable to

33. Gibson F, 'Legal Aid for Coroners' Inquests' (2008) 15 *Journal of Law and Medicine* 587, 600.

34. *Ibid* 595–7.

35. Legal Aid WA, *Legal Aid Manual – State Eligibility Guidelines* (July 2006) guideline 18. See also *ibid* 597.

36. *Ibid* 598.

37. See Chapter Two, 'An Inquisitorial Jurisdiction'.

38. See 'Purpose and Scope of an Inquest', above.

return to her previous role despite being an exceptional nurse with very high standards and a very caring nurse who went beyond her necessary duties.

Witnesses were badgered and made to feel like criminals and their professionalism was called into account even though they had done nothing wrong. It felt as if various government departments were on trial and that the coroner had made up his mind beforehand that he was going on a witch hunt.

It appears that an adversarial approach to inquest proceedings can be counter-productive forcing witnesses to 'clam up' and perhaps not feel able to say as much as they would like to say about the circumstances of the death.³⁹ This not only impacts upon the quality of the information given to the coroner at inquest, but also upon the appropriateness of recommendations for the prevention of deaths in similar circumstances that may come out of the inquest. From the comments extracted above and consultations with representatives of various government departments, police and hospitals, it appears that inquests can be an exceptionally traumatic experience for witnesses. Responses to the Commission's public survey also show that family members are sometimes traumatised or emotionally stressed by inquest proceedings. It is possible that an adversarial approach to proceedings may also encourage the expectations of family members that the purpose of an inquest is to find someone to 'blame' for the death. While this may be an outcome of an inquest, emphasis should be placed on the role of the inquest in collecting information that may assist in the prevention of future deaths. This cannot be achieved effectively if witnesses feel they are being 'put on trial'.

As noted in Chapter Two the coroner, having ultimate control of the proceedings, is in a position to curb the adversarial inclinations of counsel and should exercise the power to do so when necessary. The guidelines power under s 58 of the Coroners Act requires the State Coroner to issue guidelines 'with respect to the principles, practices and procedures of the state coronial system'.⁴⁰ In addition, the State Coroner *may* issue guidelines in respect of a number of matters including the administration

39. See also 'Statements Made by Witnesses', below.

40. *Coroners Act 1996* (WA) s 58(1).

of the coronial system; the forms to be used; and the functions of coroners, coroner's registrars and coroner's investigators.⁴¹ In the Commission's opinion, these provisions should cover the conduct of inquest hearings under the Coroners Act; however, the Commission is not aware of any guidelines referring to the conduct of inquests for counsel and the guidelines for coroners do not cover any 'in court' aspects of inquest proceedings.⁴²

In the circumstances, the Commission believes it would be of great benefit for the State Coroner to issue guidelines relating to the conduct of inquests and pre-inquest hearings making clear the purpose of an inquest as discussed earlier in this chapter.⁴³ For the sake of clarity, the Commission suggests that s 58 be amended to include specific reference to the State Coroner's power in this regard.

PROPOSAL 71

State Coroner's guidelines: conduct of hearings

1. That the authority in the Coroners Act of the State Coroner to issue guidelines (currently s 58) include that the State Coroner may issue guidelines relating to the conduct of inquests and pre-inquest hearings.
2. That the State Coroner's guidelines contain a statement to the effect that the purpose of an inquest is to investigate the circumstances and cause of death and not the forum in which the allocation of blame is considered or determined, that counsel appearing at an inquest should bear the purpose of an inquest in mind in the questioning of any witness and that a failure to do so may result in questions being disallowed.

In addition, it was noted by counsel that there was no specific training for lawyers in the coronial jurisdiction either at law school or in professional development courses. As a

41. *Coroners Act 1996* (WA) s 58(2).

42. The Commission is aware that the State Coroner has issued 'practice directions', but they all appear to be addressed to Coroners Court staff and relate to administrative matters. In addition, they are not publicly available.

43. See 'Purpose and Scope of an Inquest', above.

result, it was suggested that many lawyers did not appreciate the differences between the inquisitorial and traditional adversarial system; an issue also reinforced by the Deputy State Coroner. A similar point was made in evidence before the Victorian Parliamentary Law Reform Committee in its review of the coronial legislation in that state.⁴⁴ The Commission therefore makes the following proposal.

PROPOSAL 72

Enhance legal professional education

That the Law Society of Western Australia and the Western Australian Bar Association, in conjunction with the Office of the State Coroner, consider offering ongoing education (as part of the compulsory Continuing Professional Development program) to lawyers about the inquisitorial functions, procedures and culture of the Coroners Court.

44. VPLRC, *Coroners Act 1985 – Final Report* (2006) 592.

Inquest practice and procedure

POWERS OF CORONERS AT INQUESTS

Section 46 of the *Coroners Act 1996* (WA) ('the Coroners Act') sets out the specific powers of coroners at an inquest:

- (1) If a coroner reasonably believes it is necessary for the purpose of an inquest, the coroner may—
 - (a) summon a person to attend as a witness or to produce any document or other materials;
 - (b) inspect, copy and keep for a reasonable period any thing produced at the inquest;
 - (c) order a witness to answer questions;
 - (d) order a witness to take an oath or affirmation to answer questions; and
 - (e) give any other directions and do anything else the coroner believes necessary.
- (2) A coroner may be assisted by counsel, or by any other person that the coroner believes will be of assistance.
- ...
- (4) If a person to whom a summons is issued does not appear, the coroner may issue a warrant to apprehend the person and bring him or her before a coroner.
- (5) If under a warrant issued under subsection (4) a person is brought before a coroner, the coroner may order that the person be kept in custody until it is practicable to take or receive evidence from the person, but in any event for not longer than 7 days.¹

Section 46A provides that disobeying a summons, order or direction of a coroner made under s 46(1) is an offence punishable by imprisonment for up to five years and a fine of \$100,000. Section 46A was inserted in 2001 following the refusal by members of a 'motorcycle gang' to answer the questions of the coroner during an inquest.² It repealed the previous penalty provision providing for a

1. Subsection (3), which provided a penalty for disobeying a coroner was repealed in 2001 and replaced by s 46A.
2. Western Australia, *Parliamentary Debates*, Legislative Council, 5 December 2001, 6433b (Mr Nick Griffiths).

fine of \$2,000, which was clearly inadequate to compel a witness to answer questions. The Commission notes that the current penalty is substantially higher than those in other jurisdictions, with the highest penalty for a similar offence being a maximum term of 12 months' imprisonment or a maximum fine of \$14,334.³ The Commission has heard no comment or criticism of the provisions of ss 46 or 46A, but is happy to receive submissions as to their adequacy and appropriateness.

EXPERT ADVICE TO CORONERS AT INQUEST

In some overseas jurisdictions coroners have medical backgrounds and conduct inquests (often with juries) to establish findings regarding cause, manner and circumstances of death and, if appropriate, to make recommendations to prevent future deaths in similar circumstances.⁴ However, in Australia the tradition has been to appoint legally trained persons (usually magistrates) as coroners to conduct inquests and this is the system we currently have in Western Australia.

During the Commission's consultations, the issue was raised whether judicial officers had the necessary qualifications to make findings about cause and circumstances of death in every coronial case, particularly those involving complex scientific or technical evidence.⁵ Some respondents suggested that because there

3. *Coroners Act 2008* (Vic) s 103(7). In the case of corporations the penalty is a fine of 600 penalty units (\$71,670).
4. Eg, Ontario in Canada: see Freckelton I & Ranson D, *Death Investigation and the Coroner's Inquest* (Melbourne: Oxford University Press, 2006) 77. In some states of the United States of America, such decisions are left to medical examiners (the equivalent of Australia's forensic pathologists), who do not hold inquests but whose investigation records may be used in civil or criminal proceedings: 70–3.
5. A former Justice of the Court of Appeal of Queensland has raised the same question, stating that '[t]here is an increasing number of questions coming before courts, especially scientific ones, which are, I believe, quite beyond the capacity of most judges to understand, let alone decide, at least without considerable assistance: Davies GL, 'Court Appointed Experts'(2005) 5 *Queensland University of Technology Law Journal* 89, 92.

are no parties to an inquest to cross-examine witnesses and call evidence in rebuttal, evidence given at inquests could be insufficiently tested in circumstances where a coroner did not have the necessary background to act as an effective inquisitor. It was noted that, even where a coroner has granted standing to interested persons, such persons may not have a specific interest in testing all evidence adduced at an inquest and legal representatives may not be sufficiently informed to ask pertinent and appropriate questions, especially in the inquisitorial forum where there are no rules of evidence. Others identified a 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 enable specialist advisers to sit with the coroner in complex inquests to assist the coroner in asking pertinent questions of witnesses (including expert witnesses), and formulating appropriate and practical recommendations. The notion of such advisers is not new: superior courts in most jurisdictions have the capacity to appoint a specially qualified 'assessor' who may sit with a judge as a neutral court-appointed expert to assist during the hearing of a matter.⁶ While assessors appear to be used relatively rarely, the increasing technical complexity of matters coming before courts has been said to be 'likely to reinforce the pressure on the legal system' to use more reliable means of evaluating expert evidence 'other than the conventional adversarial means' where litigants pit one expert against another.⁷ In an inquisitorial system such as the Coroners Court, this adversarial means of testing expert evidence cannot be relied upon, which makes the use of specialist advisers a particularly attractive option in complex coronial inquests.

6. See eg, *Supreme Court Act 1935* (WA) s 56.

7. Freckelton I, 'Assessors' in Freckelton I & Selby H, *Expert Evidence: Law, practice, procedure and advocacy* (Sydney: Thompson Reuters, 2009) 455, 455-6. See also Davies GL, 'Court Appointed Experts'(2005) 5 *Queensland University of Technology Law Journal* 89.

Perhaps in recognition of this, New Zealand has made specific provision for the use of specialist advisers in the coronial jurisdiction.⁸ Section 83 of the *Coroners Act 2006* (NZ) provides:

Specialist advisers to sit with and help coroners

- (1) If satisfied that it is desirable to do so, the chief coroner may, on the recommendation of a coroner, appoint a cultural, legal, medical, or other specialist adviser to sit with and help the coroner at an inquest by giving advice.
- (2) The coroner's recommendation that a specialist adviser be appointed must be made after having regard to any relevant practice notes issued under section 132 by the chief coroner.
- (3) The specialist adviser must give the advice—
 - (a) on any questions referred to the specialist adviser; and
 - (b) in any manner the coroner may direct.
- (4) The appointment of a specialist adviser ends when the coroner conducting the inquiry concerned completes and signs a certificate of findings in relation to the death concerned.
- (5) Advice given by a specialist adviser may be given any weight the coroner thinks fit.

There was wide support among those consulted for the coroner to be able to call upon specialist advisors to sit with him or her in factually or technically complex inquests. A senior forensic pathologist who strongly supported such assistance to coroners suggested that, in medical cases, a general medical practitioner would not be sufficient. Instead, she argued, it should be a specialist physician nominated by the relevant professional college who is familiar with the medical procedure, the potential complications and the equipment used in the case at hand to ensure that pertinent questions are asked of witnesses and expert witnesses. It was suggested that such a facility would ensure evidence given by expert witnesses was properly tested and understood by the court. A number of mental health experts from different

8. Unfortunately, there is no discussion of specialist assistance for coroners at inquest either in Hansard or in the New Zealand Law Commission report which preceded the Coroners Bill 2006 (NZ), so the motivations of Parliament may only be subject to speculation.

organisations were also strongly attracted to the idea of specialist advisers sitting with the coroner to provide advice during an inquest. One noted from his experience observing inquests that evidence very confidently delivered by an expert witness was clearly given more weight than evidence from another expert witness which was given with less of a 'theatrical display'. It was argued that a specialist trained in the area would be able to assess such evidence and advise the coroner on the weight that should be given to each witness. A senior mines inspector within the Department of Mines and Petroleum stated that it was essential that coroners had access to professional technical advice during an inquest into a mining fatality because of a tendency of witnesses to engage in 'technical obfuscation'. He cited instances where lawyers and coroners clearly could not understand the evidence being given at inquest and where recommendations were made that were 'positively unhelpful and actually hazardous'.

Like those consulted, the Commission sees potential in a panel approach (similar to the State Administrative Tribunal) to permit for more-informed analysis of evidence presented at an inquest and expert input during the questioning and decision-making process. Such an approach would undoubtedly lead to a better understanding of the circumstances of the death and better-informed and targeted recommendations to prevent future deaths in comparable circumstances. Arguably, the power to appoint specialist advisers already exists in s 46(2) of the Coroners Act which provides that a coroner may be assisted at an inquest 'by counsel or by any other person that the coroner believes will be of assistance'.⁹ However, the role such advisers may have, including their decision-making function (if any) and the availability of the advice to interested persons (on procedural fairness grounds) would require legislative clarification. The Commission therefore poses the following questions.

9. Similar provisions exist in other Australian jurisdictions: see *Coroners Act 2003* (Vic) s 60; *Coroners Act 1995* (Tas) s 53; *Coroners Act* (NT) s 41.

QUESTION E

Expert advice to coroners at inquest

Should there be facility for a person with appropriate expertise to sit with the coroner at inquest to assist them in understanding and testing complex, technical evidence? If so, should any advice the specialist adviser gives to the coroner be available to the interested persons appearing at the inquest? Alternatively, should the specialist adviser have a decision-making role (similar to the role of a panel member in the State Administrative Tribunal)?

Concurrent expert evidence

In the Commission's opinion the informed questioning of witnesses by a specialist adviser would reinforce the inquisitorial nature of the Coroners Court and may deflect the adversarial inclinations of counsel who 'tend to cause such questions to be presented to the court as a clear dichotomy between opposing views'.¹⁰ Obviously not all inquests will require the assistance of experts sitting with the coroner: less-complex inquests may be dealt with by the coroner calling a sufficient range of independent expert witnesses, perhaps taking advice from professional associations¹¹ in relation to the choice of such experts.

There is already scope for discursive testing of expert evidence using the facility of concurrent evidence, which is widely used in Australian tribunals (including the State Administrative Tribunal in Western Australia) and is increasingly being used in Australian courts.¹² Concurrent evidence involves taking sworn evidence from a number of experts at the same time, rather than examining, cross-examining and then re-

10. Davies GL, 'Court Appointed Experts' (2005) 5 *Queensland University of Technology Law Journal* 89, 89.

11. Such as medical colleges (eg, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists) and professional organisations that accredit individuals in the relevant profession.

12. Most particularly in the Federal Court, New South Wales Land and Environment Court and some Supreme Courts including New South Wales and Western Australia. See, Downes J, 'Concurrent Expert Evidence in the Administrative Appeals Tribunal: The New South Wales Experience', paper presented at the Australasian Conference of Planning and Environment Courts and Tribunals, Hobart (27 February 2004); Parry DR, 'Concurrent Expert Evidence', paper prepared for the Council of Australasian Tribunals (31 May 2010).

examining each expert witness individually.¹³ Experts give their evidence in answers to questions from the adjudicator, from the parties (or their representatives) and from the other experts on the panel. Concurrent evidence therefore 'provides a forum in which, in addition to providing their own evidence, expert witnesses can listen to, question and critically evaluate other experts' evidence'.¹⁴ An evaluation of the use of concurrent evidence in the Administrative Appeals Tribunal found that there were 'improvements in the objectivity and quality of expert evidence', which enhanced the decision-making capacity of tribunal members.¹⁵

The use of concurrent expert evidence would appear to be extremely well suited to the inquisitorial process of the Coroners Court and to the primary functions of an inquest, which are to find the truth about the circumstances and cause of the deceased's death and to consider whether anything might be done differently to prevent future deaths in similar circumstances. Because the concurrent evidence process is controlled by the decision-maker (in this case, the coroner), it reminds expert witnesses that their primary obligation is to the court in discharging these functions rather than to any specific person or 'party'.¹⁶ This approach might also assist the Coroners Court to encourage a less-adversarial approach to inquest proceedings.¹⁷ The Commission therefore proposes that coroners consider the use of concurrent expert evidence during inquests where appropriate and practicable.¹⁸ The Commission also proposes that interested persons should have the opportunity to make submissions to the coroner regarding appropriate witnesses to be called to give expert evidence at an inquest. This would be a matter that could be canvassed during a pre-inquest hearing and

one which is contemplated by Proposal 68. The State Administrative Tribunal, which routinely requires experts to give evidence concurrently, has created a guide to assist experts giving evidence in the tribunal.¹⁹ Given that the use of concurrent evidence will be a new process for the Coroners Court, the Commission proposes that the State Coroner issue guidelines for this purpose. In designing these guidelines, the State Coroner may wish to take advice from the State Administrative Tribunal of Western Australia.

PROPOSAL 73

Use of concurrent expert evidence at inquest

1. That coroners consider the use of concurrent expert evidence during inquests, where appropriate and practicable.
2. That the State Coroner issue guidelines for the use of concurrent expert evidence in the Coroners Court.
3. That coroners may hold pre-inquest hearings for the purposes of taking submissions from interested persons as to whom should be called to give evidence as an expert.

STATEMENTS MADE BY WITNESSES

As noted above, the coroner has the power to compel witnesses to answer questions at an inquest under s 46(1)(c) of the Coroners Act. Section 47 of the Coroners Act provides protection to witnesses who may be called upon to answer questions in a way that might incriminate them.

- (1) If a person called as a witness at an inquest declines to answer any question on the ground that his or her answer will criminate or tend to criminate him or her, the coroner may, if it appears to the coroner expedient for the ends of justice that the person be compelled to answer the question, tell the person that if the person answers the question and other questions that may be put to him

13. Administrative Appeals Tribunal (AAT), *An Evaluation of the Use of Concurrent Evidence in the Administrative Appeals Tribunal* (2005) 63.

14. *Ibid.*

15. *Ibid.* 59. In the context of the State Administrative Tribunal (WA) David Parry has observed that 'the process has the character of a professional discussion, rather than an adversarial context ... [and] enables all participants to focus on the principal issues in question: Parry DR, 'Concurrent Expert Evidence', paper prepared for the Council of Australasian Tribunals (31 May 2010) 16.

16. Parry, *ibid.* 15.

17. See 'Lawyers in the Inquisitorial Context', above.

18. In respect of the latter, the Coroners Court may need access to a courtroom equipped to facilitate the giving of evidence by more than one person at the same time.

19. State Administrative Tribunal, 'A Guide for Experts Giving Evidence in the State Administrative Tribunal', <http://www.sat.justice.wa.gov.au/_files/Expert_Evidence_Brochure.pdf>.

or her, the coroner will grant the person a certificate under this section.

- (2) After a person has been offered a certificate, the person is no longer entitled to refuse to answer questions on the ground that his or her answers will criminate or tend to criminate him or her, and if the person gives evidence to the satisfaction of the coroner, the coroner must give the person a certificate to the effect that the person was called as a witness in the inquest and that the person's evidence was required for the ends of justice and was given to the coroner's satisfaction.
- (3) Where a person is given a certificate under this section in respect of any evidence given at an inquest, a statement by the person as part of that evidence in answer to a question is not admissible in evidence in criminal proceedings against the person other than on a prosecution for perjury committed in the proceedings.

As can be seen from the above provisions, a certificate issued by the coroner under s 47 only extends to criminal proceedings. In almost all other Australian jurisdictions a person is protected from use of statements made by witnesses in a Coroners Court in criminal and civil proceedings.²⁰ The fact that Western Australia does not feature this protection may explain why lawyers must revert to adversarial tactics to gain evidence and why some witnesses exhibit a reluctance to give full and frank evidence at an inquest.²¹ The Northern Territory and Queensland also extend the protection to disciplinary proceedings.²² The Northern Territory provision is in the same terms as the Western Australian provision set out above; however, subsection (3) provides:

Where a person is given a certificate under this section in respect of evidence given at an inquest, a statement by the person as part of that evidence in answer to a question is not admissible in evidence in criminal or civil proceedings, or in proceedings before a tribunal or person exercising powers and functions in a judicial manner, against the person other than on a prosecution for perjury.

20. South Australia appears to be the only other jurisdiction that confines the protection to criminal proceedings; although in that jurisdiction 'a person is not required to answer a question, or to produce a record or document, if the answer to the question, or the contents of the record or document, would tend to incriminate the person of an offence': *Coroners Act 2003* (SA) s 23.

21. As evidenced by the comments extracted in the previous section: see 'Lawyers in the Inquisitorial Context', above.

22. *Coroners Act 2003* (Qld) s 39; *Coroners Act* (NT) s 38. Queensland provides protection for 'any proceedings'.

The Commission heard from a number of lawyers that they would like to see the protection for witnesses extend to disciplinary proceedings, not just for the sake of clients but for the sake of families who are seeking the unadulterated truth about the circumstances of their relative's death. The Commission agrees that it is in the interests of all 'parties' to an inquest that there be full and frank disclosure of the facts and circumstances surrounding the death without fear that subsequent proceedings will have recourse to statements made in evidence. The Commission therefore proposes that a similar amendment be made to s 47(3) of the Coroners Act.

PROPOSAL 74

Extend protection against self-incrimination

That a certificate given under the Coroners Act (currently s 47) extend to provide protection for a witness against the use of evidence given at an inquest in subsequent criminal or civil proceedings, or in proceedings before a tribunal or person exercising powers and functions in a judicial manner against the person other than on a prosecution for perjury.

USE OF AFFIDAVITS

The officer in charge of the Coronial Investigation Unit (CIU) has drawn to the Commission's attention the lack of information in the Coroners Act and Coroners Regulations regarding use and format of affidavits in the coronial jurisdiction. Section 15 of the Coroners Act provides that 'an affidavit relating to an investigation by a coroner may be sworn before a coroner's registrar or investigator'; however, there is no other mention in the Act or Regulations of how an affidavit may be used in inquest proceedings. It appears that affidavits are rarely employed in the coronial jurisdiction in Western Australia, with the practice being to take statements from witnesses and require them to appear before the court for an inquest. Other jurisdictions rely on affidavit evidence more regularly and provide for its use under their respective Acts or Regulations. For example, the *Coroners Rules 2006* (Tas) provide:

19. Forms of evidence that may be accepted in inquest

A coroner may accept evidence given or produced at or for the purposes of an inquest in any of the following forms:

- (a) oral evidence given under oath at the inquest;
- (b) evidence tendered by deposition or affidavit;
- (c) documentary or other evidence tendered as an exhibit.

20. Evidence by deposition or affidavit

- (1) A witness may give evidence in an inquest by tendering a deposition.
- (2) If a deposition is tendered as evidence in an inquest, the coroner may—
 - (a) direct the witness, the coroner's associate or any other person to read the deposition; or
 - (b) read the deposition; or
 - (c) accept the deposition as read.
- (3) If an affidavit is tendered as evidence in an inquest, the coroner may—
 - (a) if the deponent is summonsed as a witness, direct the deponent to read the affidavit; or
 - (b) if the deponent is not summonsed as a witness, direct the coroner's associate or any other person to read the affidavit; or
 - (c) read the affidavit; or
 - (d) accept the affidavit as read.

The officer in charge of the CIU rightly pointed out that the use of affidavits where appropriate in inquests can result in increased efficiencies for both police and the Coroners Court. For example, there are many witnesses to relatively inconsequential matters relating to a death who are required to give evidence before the court even though that evidence is uncontroversial. In these cases, police are required to track down the witness (sometimes many years after the event). The Commission understands that there is particular difficulty with locating nurses, which is a notorious profession for movement both interstate and overseas.²³ The Commission agrees that the use of sworn affidavits in

appropriate circumstances²⁴ would expedite the inquest process and be an efficient use of coronial and police resources, and proposes that regulations be drafted to govern their use at inquest.

PROPOSAL 75

Use of affidavits at an inquest

1. That the section in the Coroners Act dealing with affidavits (currently s 15) expressly provide for the acceptance and use of affidavits at inquest.
2. That the Coroners Regulations be amended to provide a form for affidavits relating to a coronial investigation and sworn before a coroner's registrar or coroner's investigator pursuant to the Coroners Act.

INTERRUPTION OF AN INQUEST

Section 51 of the Coroners Act provides simply that 'a person must not interrupt an inquest'. A fine of \$5,000 is the penalty for the offence. In all other Australian jurisdictions such behaviour is dealt with under contempt provisions. A typical contempt provision focussing solely on interruption of inquest proceedings is found in the Northern Territory and Tasmanian Coroners Acts, which read:

A person shall not:

- (a) insult a coroner in relation to the exercise of his or her powers or functions as a coroner;
- (b) interrupt an inquest; or
- (c) create a disturbance or take part in creating or continuing a disturbance in or near a place where an inquest is being held.²⁵

The maximum fine for breach of these provisions is \$5,320 in the Northern Territory and \$6,500 in Tasmania. Both jurisdictions also have an alternative of a term of imprisonment for up to six months. Having regard to the penalties in these and other jurisdictions, the

23. A respondent to the Commission's public survey commented that her nursing colleague was 'expected to return to the state from NSW with a very young baby at reasonably short notice and under some hardship to appear in front of the court for a very short period of time. There appeared to be no device to garnish her evidence from NSW'.

24. The Commission notes that its Proposal 68 for pre-inquest hearings would permit all persons involved in the inquest to discuss in advance whether an affidavit may be sufficient for the purposes of the inquest or whether a witness is required to attend in person.

25. *Coroners Act* (NT) s 46; *Coroners Act 1995* (Tas) s 66.

Commission finds that the current level of fine is adequate; however, it seems appropriate that the coroner has the power to imprison a contemnor in appropriate circumstances to a term of not more than six months.²⁶ It should be remembered that general disobedience of a coroner's directions, orders or summonses is subject to the significantly higher penalties under s 46A (discussed above).

PROPOSAL 76

Interruption of an inquest

That the penalty for breach of the offence of interrupting an inquest include a term of not more than 6 months' imprisonment or a fine of \$5,000.

EXCLUSION FROM AN INQUEST

Section 45 of the Coroners Act provides that a coroner may order the exclusion of any or all persons from an inquest if they reasonably believe that it is in the interests of any person, in the public interest or in the interests of justice. Such orders are required to be recorded on Form 12 to the Coroners Regulations²⁷ and be displayed in a conspicuous place in the building where the inquest is being held.²⁸ The coroner can order the removal of a person who disobeys an exclusion order, and can order his or her imprisonment for not more than 24 hours if the coroner reasonably believes that the person will continue to disobey the order.

This is a wide discretion enabling the coroner to manage court proceedings at an inquest and similarly wide powers exist in other Australian jurisdictions. The Commission has not received any submissions suggesting change to this power; however, given the Commission's Proposal 68 to legislate for pre-inquest hearings, it seems appropriate for this power to extend to such hearings as it currently does in Queensland.²⁹

26. The Supreme Court's protective power to punish summarily for contempt arising from an interference with the administration of justice also extends to the Coroners Court: *Attorney-General (NSW) v Mirror Newspapers Ltd (Luna Park Case)* [1980] 1 NSWLR 374.

27. *Coroners Regulations 1997* (WA) reg 18(1).

28. *Coroners Act 1996* (WA) s 45(2).

29. *Coroners Act 2003* (Qld) s 43(1).

PROPOSAL 77

Power to exclude from inquest

That the coroner's power to exclude a person or persons from an inquest also applies to pre-inquest hearings.

RESTRICTING PUBLICATION OF INQUEST EVIDENCE

The Coroners Acts of all Australian jurisdictions give coroners the power to restrict publication of some or all of the evidence given at inquest. Western Australia's provision is s 49 which provides:

- (1) A coroner must order that no report of an inquest or of any part of the proceedings or of any evidence given at an inquest be published if the coroner reasonably believes that it would—
 - (a) be likely to prejudice the fair trial of a person; or
 - (b) be contrary to the public interest.
- (2) A person must not contravene an order made under subsection (1).

Penalty: \$5 000.

Similar provisions exist in Victoria, the Northern Territory and Tasmania; however, the latter two also permit the coroner to restrict publication of reports that 'involve the disclosure of details of sensitive personal matters including, where the senior next of kin of the deceased have so requested, the name of the deceased'.³⁰ These provisions would allow coroners to respond to concerns of senior next of kin in the naming Aboriginal deceased. In the report of the Royal Commission into Aboriginal Deaths in Custody, Commissioner Johnstone stated that:

[R]espect for the traditional, cultural values of Aboriginal people should be shown regarding the publication of the name of a deceased Aboriginal person, irrespective of the cause of death. Advice sought from the family of the deceased or their legal representative should provide guidance for the exercise of a coroner's discretion in considering this matter.³¹

30. *Coroners Act* (NT) s 43(1)(c); *Coroners Act 1995* (Tas) s 57(1)(c).

31. Royal Commission into Aboriginal Deaths in Custody, *National Report* (1991) vol 1, 149

The Commission notes that most media outlets are now sensitive to Aboriginal taboos forbidding the naming of a deceased, referring to deceased instead by only their surname or tribal name. Nonetheless, it is the Commission's opinion that there should be specific facility for family to request that an order be made in circumstances similar to the Northern Territory and Tasmanian provisions. Such facility should extend to pre-inquest hearings as proposed earlier in this chapter.³²

In respect of restrictions on disclosure of sensitive information also covered by the Northern Territory and Tasmanian provisions, the Commission notes a report of the UK Ministry of Justice where a number of cases of unintended consequences following reporting by press of sensitive issues were discussed.³³ These included a case where a 'young man had died during a sexual act where no other person was implicated and his mother had told others that he died in a road crash. Following the inquest, the actual details of his death were published in the local press; his mother subsequently attempted to take her own life.'³⁴ Another case involved

[a] mother who had hanged herself after suffering for twenty years with manic depression. The local paper reported the inquest in detail. This caused the husband great distress as he had managed to keep the details of his wife's death from his young son up until then, and was planning to tell him at the appropriate time. However, the detailed reporting meant that he was forced to discuss the details of the mother's death with his child earlier than he intended.³⁵

An amendment in the nature of that in the Northern Territory and Tasmanian provisions would permit family to make submissions to the coroner to avoid the unwitting disclosure of sensitive information by the media that could impact significantly on family members.

The Commission has also compared the penalties for breach of such an order across Australian jurisdictions. Penalties range from \$1,100 fine or six months' imprisonment in New South Wales to \$11,305 fine or two years'

imprisonment in the Northern Territory.³⁶ Of the jurisdictions that have no alternative term of imprisonment, fines range from a maximum of \$6,500 in Tasmania to \$15,000 in Queensland.³⁷ The Australian Capital Territory and New South Wales feature fines for corporations at a level of five times the fine of individuals.³⁸ As can be seen, Western Australia has the lowest fine (in the absence of imprisonment) at only \$5,000 and as such there is clearly a need to increase the penalty. Having considered the penalties for breach of a publication order in other jurisdictions, the Commission believes that a fine of \$10,000 is appropriate. In light of the fact that likely breaches would be made by corporate media outlets, the Commission proposes an increased penalty for corporations being at five times the rate of the penalty for individuals.

PROPOSAL 78

Restriction of publication

That the coroner's power to restrict publication of some or all of the evidence (currently s 49) be amended as follows:

- (1) A coroner must order that no report of a pre-inquest hearing or an inquest or of any part of the proceedings or of any evidence given at an inquest be published if the coroner reasonably believes that it would —
 - (a) be likely to prejudice the fair trial of a person; or
 - (b) be contrary to the public interest.
- (2) A coroner may order the restriction of publication of specified matters revealed at an inquest or a pre-inquest hearing that involve the disclosure of details of sensitive personal matters including, where the senior next of kin of the deceased have so requested, the name of the deceased.

That the penalty for contravening an order made under the above section be increased to \$10,000 for individuals and \$50,000 for corporations.

32. See Proposal 68, above.

33. Ministry of Justice (UK), *Sensitive Reporting in Coroners Courts* (March 2008).

34. *Ibid* 7.

35. *Ibid*.

36. *Coroners Act 2009* (NSW) s 74; *Coroners Act* (NT) s 49.

37. *Coroners Act 1995* (Tas) s 57; *Coroners Act 2003* (Qld) s 41.

38. *Coroners Act 2009* (NSW) s 74; *Coroners Act 1997* (ACT) s 40.

PUBLICATION OF INQUEST FINDINGS, COMMENTS AND RECOMMENDATIONS

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 findings³⁹ are publicly available on the coroners courts' websites, 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 not featured inquest findings for many years. Until recently the page displayed a message of 'under construction'; however, since the release of the Commission's Background Paper commenting on this matter⁴⁰ the page has been changed to advise visitors that inquest findings are 'available on the date of delivery of the finding or later by request in writing to the Office of the State Coroner'.⁴¹

The Commission was advised that all inquest findings were removed after an inquest the subject of a suppression order was mistakenly uploaded to the website.⁴² The Commission acknowledges that there will be a need to anonymise, summarise or otherwise withhold a small number of coronial findings to protect privacy (eg, of families and witnesses) or recognise the continuing currency of suppression orders, but there is no justification for removing all inquest findings from the website. The *Coroners Regulations 1997* (WA) recognise the public interest in having open access to inquest findings by providing in reg 19:

39. 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.
40. The lack of accessibility of coronial findings and guidelines was also raised by this Commission in the context of its Aboriginal customary laws reference. 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': Alastair Hope, State Coroner of Western Australia, submission to Aboriginal customary laws Discussion Paper (7 March 2006) 5. See also discussion in LRCWA, *Aboriginal Customary Laws: The interaction of Western Australian law with Aboriginal law and culture*, Project No 94, Final Report (September 2006) 256-7.
41. Coroners Court (WA), 'Coroners Inquest Findings' <http://www.coronerscourt.wa.gov.au/I/inquest_findings.aspx?uid=9349-4756-3915-2531> (accessed 13 May 2011).
42. State Coroner, consultation (26 November 2009).

After the completion of an inquest into a death the coroner's record of the investigation of the death is to be open to public access unless the coroner orders otherwise.

The Commission notes that 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.⁴³

The Commission's consultations have demonstrated a need to encourage greater understanding of the coronial system, both among members of the public and among those professions (eg, lawyers and doctors) that are required to interact with the system. The availability of findings online would enable analysis of coronial reasoning, promote a better understanding of coronial outcomes and, as discussed in Chapter Six, may assist in encouraging auditing and implementation of recommendations.⁴⁴ In the Commission's opinion, Western Australia should follow Victoria's example of legislating for the online publication of findings, comments and recommendations following an inquest and makes the following proposal.⁴⁵

PROPOSAL 79

Publication of inquest findings, comments and recommendations

That, unless otherwise ordered by a coroner, the findings, comments and recommendations made following an inquest must be published on the Coroners Court website as soon as practicable.

43. <http://www.safetyandquality.health.wa.gov.au/mortality/inquest_finding.cfm> (accessed 14 August 2010).
44. See Chapter Six, 'Mandatory Response to Recommendations'.
45. See *Coroners Act 2008* (Vic) s 73(1).

Chapter Six

Role of the Coroner in Preventing Death and Injury

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Coroner's prevention role

Western Australia was one of the first Australian jurisdictions to legislatively embrace a role for its coroners that is wider than simply finding the cause and immediate circumstances of a death. As discussed in Chapter Five, s 25 of the *Coroners Act 1996* (WA) ('the Coroners Act') hints at a broader coronial objective with the power to make comments 'on any matter connected with the death including public safety or the administration of justice'.¹ It also includes 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'.²

Coroners in Western Australia often use the recommendation function to make recommendations aimed at preventing deaths in similar circumstances in the future.³ 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 included in legislation in Queensland, Victoria, South Australia and New Zealand.⁴ 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 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.

The Commission has embraced the prevention role of the coroner in many of the proposals featured throughout this Discussion Paper.⁵ Chief among these is Proposal 1 for the insertion of an objects clause into the Coroners Act to provide, among other things, that a primary object of the Act is

to contribute to a reduction in the incidence of preventable deaths and injury by the findings and recommendations made by coroners and by the timely provision by coroners of relevant data to appropriate authorities and research bodies.⁶

The following sections look at ways in which this object may practically be achieved.

USING CORONIAL DATA TO SUPPORT THE PREVENTION ROLE

Collection of coronial 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. The Coroners Court of Western Australia has struggled in the past with the lack of a comprehensive file management system; however, as discussed below, this has now been rectified permitting the Coroners Court to contribute effectively to the National Coroners Information System (NCIS). NCIS is a national online database which ostensibly records every case that has come before an Australian coroner in the past decade.⁷ It contains case detail including (but not limited to) the date, location and cause of death; the deceased's personal details including Indigenous, employment and residential status; whether the death was work-related; whether

1. 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, *National Report* (1991) vol 5.

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

3. See 'Recommendations', below.

4. 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.

5. See, eg, Proposals 1, 12, 40, 41, 44, 72, 79 above and Proposals 80–84 below.

6. See Chapter One, 'Objects of the Coroners Act', Proposal 1.

7. 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. 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.

an object or a substance was involved in the death; and whether a vehicle was involved in the death and if so what type.⁸ It also includes, in most circumstances, full-text reports including police reports, toxicology reports, post mortem examination findings and coronial findings.⁹ 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.

NCIS is not publicly accessible but is available for use by coroners and approved researchers on a subscription basis.¹⁰ 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'.¹¹ However, NCIS data has also been used very effectively by researchers and government agencies elsewhere in Australia to support evidence-based death prevention strategies and to provide reliable data about the incidence of certain types of deaths.¹²

Approved users of coronial data

Access to and use of coronial data from NCIS must be approved by the Victorian Department of Justice Human Research Ethics Committee. If access to Western Australian NCIS data is sought, the applicant must also apply to the Coronial Ethics Committee of the Office of the State Coroner in Western Australia.¹³ Western Australia is the only Australian jurisdiction to have a Coronial Ethics Committee recognised by

statute.¹⁴ The committee has eight members: a paediatric pathologist (Chair), a forensic pathologist, a medical research academic, the Deputy State Coroner, counsel assisting the coroner (Secretary), two lay members and an Aboriginal member.¹⁵ Applicants wishing to access coronial data must complete a 12-page application form outlining the nature of the project, the information sought, the names and qualifications of the researchers, the research methodology, and measures to protect the confidentiality of the material.¹⁶ The latest available Annual Report of the Office of the State Coroner states that in reviewing applications for access to coronial data the

committee attempts to strike a balance between family concerns (including privacy, confidentiality and consent issues), and the possible benefits of research to the community at large. The Committee then makes recommendations to the State Coroner to assist him to decide whether to approve a project or to allow access to coronial records.¹⁷

According to information received from the Office of the State Coroner the committee considered four applications for access to Western Australian coronial data in 2010 and 12 applications in 2009.¹⁸ Applications appear to have steadily declined since the committee began in 1998 when it considered 28 applications.¹⁹ As well as considering applications for offsite access to Western Australian NCIS data,²⁰ the committee also considers applications for onsite access to closed files and for provision of statistical

8. See NCIS, <http://www.ncis.org.au/web_pages/what_data_is_available.htm> (accessed 19 May 2011).

9. In Western Australia police reports and post mortem examination findings are summaries only.

10. Annual subscription fees vary between \$1,000 (eg, for non-profit organisations and community groups) and \$17,000 (eg, for government agencies) based on an assessment of organisation size, regularity of use and capacity to pay: Jessica Pearse, Manager NCIS, email (23 May 2011).

11. See < <http://www.ncis.org.au/index.htm>>.

12. NCIS, 'The National Coroners Information System: Ten years of contributing to public health and safety' (2010) <http://www.ncis.org.au/web_pages/NCIS%20Anniversary%20brochure%20v3.pdf> (accessed 19 May 2011).

13. The Coronial Ethics Committee was originally set up to deal with applications by members of the medical profession to utilise tissue taken during post mortem examination for research purposes. However, as discussed in Chapter Seven, this is no longer an active function of the committee: Chapter Seven, 'Removal and Retention of Tissue'.

14. While the Committee is not established by the *Coroners Act 1996* (WA) its potential is recognised in s 58(2)(d) which states that the State Coroner may issue guidelines relating to 'the establishment and functions of an advisory ethics committee'.

15. In the past the committee has included a 'minister of religion or a person who performs a similar role in a community such as an Aboriginal elder'. In the past this has been the Director of Communicare, a Christian charity organisation. This position is currently vacant.

16. If approved, progress and completion reports are also required as well as copies of any publications or papers in which the data has been used or referenced.

17. Office of the State Coroner, *Annual Report 2007–2008* (2008). This is the latest available annual report that the Commission has been given access to; the Coroners Court website only features reports up to 2007.

18. Manager Coroner's Office (WA), email & attachments (23 May 2011). Not all applications are for local access; an undetermined number of these applications are for nationwide access of online data through NCIS.

19. Office of the State Coroner, *Annual Report 1998–1999* (1999). This may be the result of the development of the 12-page application form, which requires very detailed and considered information about the proposed use of coronial data as well as assurances that there are sufficiently qualified individuals leading the project.

20. That is, through the online NCIS database.

information collated by staff of the Office of the State Coroner. Each request for onsite access to files or statistical information therefore represents a resource burden on the Office of the State Coroner.

Dissemination and use of coronial data

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 groups²¹ have been given supervised local access to closed case²² 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 NCIS. 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.²³

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 full-text reports, which provide the information necessary for early identification of particular trends in deaths.²⁴ The Office of the State Coroner, on the other hand, has immediate access to information about the circumstances and location of death and priority access to interim post mortem findings as to cause of death.²⁵ 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.²⁶ 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,²⁷ it now has adequate technological resources to enable reliable data collection. 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.²⁸ Indeed, the Commission was informed that staff find it difficult to keep up with internal requests for research and analysis of information to support the coronial function or to respond to parliamentary questions requiring specific data.²⁹ As a result of the systems information officer being engaged in such (essential) research, the upload of data to NCIS on completed files has suffered, meaning that those files remain 'open' for research purposes and therefore inaccessible to many NCIS users.³⁰

The Commission's consultations revealed a strong case for extending the current role

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.

21. Such as the Ministerial Council for Suicide Prevention, SIDS and Kids and the Royal Lifesaving Association.
22. That is, cases that have been finalised by a coroner.
23. 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 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, NCIS Access Liaison Officer, consultation (17 August 2010).
24. Ibid.
25. For example, the P98 mortuary admission form provides a basic narrative as to circumstances of death, while toxicology

26. The Commission is aware that the Office of the State Coroner is currently negotiating the use of the Queensland case management database which interfaces with NCIS but provides a superior search function enabling greater accessibility to information with language-based parameters: Manager Coroner's Office (WA), consultation (20 May 2011).
27. See, eg, comments of State Coroner Hope in Office of the State Coroner (WA), *Annual Report 2006–2007* (2008) 9.
28. 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 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.*
29. Manager Coroner's Office (WA), consultation (20 May 2011).
30. *Ibid.*

of systems information within the Office of the State Coroner to include detailed data analysis, research and timely dissemination of coronial information to approved research and prevention bodies and government agencies. This role would not only include providing information in response to requests from such agencies and bodies, but would also extend to ongoing analysis of data for early identification of possible trends in deaths³¹ and to inform education and liaison activities undertaken by coronial counsellors and the proposed specialist healthcare death investigation team.³² This 'prevention team' would constitute an important contribution to death prevention in Western Australia by enabling these entities and individuals to be aware of incipient trends or other important information to assist them to focus their resources to support strategies that may prevent further deaths.

As well as conducting research and data analysis to support the death prevention functions of coroners and other bodies, the establishment of a prevention team within the Office of the State Coroner will enable it to respond more rapidly to parliamentary questions and to support the Commission's proposed function of the office in publishing, monitoring and evaluating responses to and implementation of coronial recommendations (Proposal 84). As discussed below, it is important that responses are evaluated to provide coroners with useful feedback on the effectiveness and formulation of their recommendations as well as to provide essential information about the implementation of coronial recommendations. Such feedback may also be gained through stakeholder consultation during the formulation stage of recommendations. This has been a successful strategy of the Coroners Prevention Unit in Victoria, which provides coroners with detailed research and analysis to support the coronial recommendation function.³³ The unit

31. Such information will not only assist prevention bodies to implement early intervention strategies but will also assist coroners to identify matters that may be jointly inquired, thereby avoiding possible inconsistent recommendations among coroners on the same subject matter and providing greater impetus for implementation of any resulting coronial recommendations.

32. See Chapter Four, 'Improving Relationships between Coroners and Healthcare Professionals' and Proposal 41.

33. The Coroners Prevention Unit (Vic) has 18 staff members including epidemiologists, analysts and researchers who may contribute at any stage of the coronial process including: when a death is initially reported (to analyse possible trends

has found that it receives valuable input into the formulation and effectiveness of proposed recommendations by engaging stakeholders at an early stage,³⁴ which has an added benefit of ensuring that those who ultimately have control over whether the recommendation is implemented become invested in the process of reform. The Commission suggests that a similar approach be considered in Western Australia.³⁵

PROPOSAL 80

Support for the coroner's prevention role

That a prevention team be established within the Office of the State Coroner employing sufficient research and systems information staff to:

- (a) update and maintain the Coroners Court website;
- (b) monitor and evaluate responses to and implementation of coronial recommendations;
- (c) undertake analysis of coronial data to identify incipient trends in deaths and opportunities for prevention activities;
- (d) conduct research to support the coroners' decision-making and recommendatory functions;
- (e) conduct consultations with stakeholders to inform the proposed formulation of coronial recommendations; and
- (f) liaise with and provide relevant coronial information to death prevention bodies, researchers and special interest advocacy groups approved by the Coronial Ethics Committee.

in deaths and potential for cluster investigations); when recommendations are being developed (by providing research and data analysis to assist coroners); when recommendations are being finalised (by conducting stakeholder consultations to inform the formulation of recommendations); and after recommendations have been made (by monitoring and collecting information on the response to and implementation of coronial recommendations): see < http://www.coronerscourt.vic.gov.au/wps/wcm/connect/justlib/coroners+court/home/investigations/who_s+involved/coroners+prevention+unit/coroners2+-+coroners+prevention+unit >.

34. Samantha Hauge, Manager Coroners Prevention Unit, Coroners Court of Victoria, consultation (26 May 2011).

35. Where recommendations impact the healthcare sector, the prevention team would work in conjunction with the specialist healthcare-related death investigation team to conduct stakeholder consultations and provide advice to coroners on the appropriateness and formulation of proposed recommendations.

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. In Western Australia, coronial recommendations are made in approximately 40% of inquests.¹ Recommendations are the modern equivalent of 'riders'.² A rider was a statement appended to the verdict of a coroner's jury 'as a means of reflecting extralegal, communal judgement regarding the conduct of individuals or corporate entities'.³ Section 43 of the *Coroners Act 1920* (WA) governed the issuing of riders by coroners until the current Coroners Act came into force in 1997. That section explicitly provided that coroners were not permitted to 'express any opinion on any matter outside the scope of the inquest except in a rider which, in the opinion of the coroner is designed to and may, if given effect to, prevent the recurrence of similar occurrences'.⁴ A rider has never been considered part of the decision or finding of a coroner⁵ and to this day recommendations remain distinct from coroner's findings and, like comments, are not subject to judicial review.⁶

RECOMMENDATIONS POWER

Sections 27(3) and (4) of the *Coroners Act 1996* (WA) ('the Coroners Act') govern the making of coronial recommendations and provide:

- (3) The State Coroner may make recommendations to the Attorney General on any matter connected with a death which a coroner investigated, including public health or safety, the death of a person held in care or the administration of justice.
- (4) Where a recommendation made under subsection (3) regarding a death of a person held in care is relevant to the operation of an agency, the State Coroner must inform that agency in writing of the recommendation.

It is not entirely clear from s 27(3) whether the making of recommendations in a coronial case is confined to the State Coroner. Certainly the State Coroner may make recommendations on a matter investigated by another coroner, but there is no explicit provision permitting a coroner other than the State Coroner to make recommendations. This is unusual: all other Australian jurisdictions permit any coroner investigating a death at inquest⁷ to make recommendations.⁸ In practice all coroners in Western Australia make recommendations, where appropriate, and the Commission proposes that the legislative provision for coronial recommendations reflect this reality.

The Commission also proposes that coroners be legislatively enabled to make recommendations directly to the Minister, public statutory authority, public or private entity or individual⁹ the subject of the recommendation. This not only reflects the current practice in Western Australia, but also the statutory situation in most other Australian jurisdictions.¹⁰ The Commission believes it is more appropriate that recommendations be directed to and received by the entity the

1. See Appendix B, Table 13. Table 14 shows that a total of 565 coronial recommendations were made over the period 2000–2009. Where recommendations are made in an inquest it is usual that between one and four recommendations will be made. However, some very long 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.
2. McCann D, 'The Range of Findings Open to a Coroner' in Selby H (ed), *The Aftermath of Death* (Sydney: Federal Press, 1992) 20.
3. Cornish WR, *The Jury* (London: Penguin, 1968) 5 as cited in Freckelton I & Ranson D, *Death Investigation and the Coroner's Inquest* (Melbourne: Oxford University Press, 2006) 20.
4. *Coroners Act 1920* (WA) s 43(8)(a).
5. This was made clear in *Coroners Act 1920* (WA) s 43(8)(b).
6. See Chapter Five, 'Limitation on Comments'.

7. And in some instances outside of an inquest.
8. *Coroners Act 2003* (Qld) s 46(1); *Coroners Act 2003* (SA) s 25(2); *Coroners Act 2009* (NSW) s 82(1); *Coroners Act* (NT) s 26(2); *Coroners Act 2008* (Vic) s 72(2); *Coroners Act 1997* (ACT) s 57(3); *Coroners Act 1995* (Tas) s 28(2).
9. The Commission acknowledges that it is rare that an individual will be the subject of a recommendation; however, the facility to make recommendations to individuals exists in a number of Australian jurisdictions.
10. *Coroners Act 2003* (Qld) s 43; *Coroners Act 2003* (SA); *Coroners Act 2009* (NSW) s 82; *Coroners Act 2008* (Vic) s 72; *Coroners Act 1995* (Tas) s 28(2).

subject of the recommendation rather than just to the Attorney General because, under the Commission's proposals (discussed below), it is the entity that will be responsible for providing a response directly to the coroner.¹¹

Unlike some jurisdictions,¹² in Western Australia coronial recommendations are not restricted in type and may be 'on any matter connected with a death which a coroner has investigated, including public health or safety, the death of a person held in care or the administration of justice'.¹³ As discussed in Chapter Five in the context of coronial comments,¹⁴ it is the Commission's opinion that the power to make comments and recommendations should be confined to matters relating to public health or safety, the administration of justice, or the prevention of future deaths in similar circumstances. In the Commission's view this formulation, derived from s 46 of the *Coroners Act 2003* (Qld), covers all matters on which a coroner may reasonably make a recommendation and properly recognises the prevention role of the coroner in making such recommendations.

The current formulation of s 27(3) also permits the State Coroner to make recommendations arising out of non-inquested deaths. This is unusual in Australia with only two other jurisdictions (Tasmania and Victoria) permitting a coroner to make recommendations in respect of cases that have not been the subject of an inquest. The Commission's inquiries of the National Coroners Information System (NCIS) database found that recommendations made outside of inquests are very rare in Western Australia, with only seven such incidences discovered,¹⁵ all of which were investigations undertaken by regional magistrates.¹⁶ In the

11. See 'Response to Recommendations', below.

12. 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 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.

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

14. See Chapter Five, 'Comments'.

15. Between July 2000 (the date that Western Australia began uploading data to NCIS) and December 2009.

16. The Commission understands that recommendations made by the State Coroner and Deputy State Coroner are always made within the context of an inquest.

Commission's opinion it is not appropriate that coroners be permitted to make recommendations outside the context of an inquest. An inquest provides the environment for the proper testing of evidence which enables coroners to formulate practical recommendations. It also enables those entities that are likely to be the subject of recommendations the opportunity to provide input that may inform the formulation of possible recommendations. Importantly, involvement of entities that may be the subject of coronial recommendations will likely increase the chances of implementation of coronial recommendations by those entities.¹⁷

PROPOSAL 81

Coroners' power to make recommendations

1. That a coroner may make a recommendation on any matter connected with a death investigated at an inquest that relates to—
 - (a) public health or safety; or
 - (b) the administration of justice; or
 - (c) the prevention of future deaths in similar circumstances.
2. That recommendations may be addressed to any Minister, public statutory authority, public or private entity or individual.

Guidance to coroners considering whether to make comments or recommendations

As discussed in Chapter Five, during the consultation phase the Commission heard a number of complaints that inquests were becoming too broad in scope and that recommendations were sometimes insufficiently connected with the death or deaths under investigation.¹⁸ The example that was overwhelmingly cited by respondents

17. The Ombudsman's review of coronial recommendations in Queensland found that 'a significant reason for public sector agencies not implementing coronial recommendations is that the relevant agency considers that the recommendation is not soundly based or is not practicable': Queensland Ombudsman, *The Coronial Recommendations Project: An investigation into the administrative practice of Queensland public sector agencies in assisting coronial inquiries and responding to coronial recommendations* (December 2006) xiii.

18. See Chapter Five, 'Purpose and Scope of an Inquest'.

was the 'Kimberley Inquest'.¹⁹ As mentioned above, the Kimberley Inquest was a joint inquest into the deaths of 22 Aboriginal people in the Kimberley region in which drug and alcohol abuse or self-harm was a factor. Many recommendations arising from that inquest were extremely broad and were only tenuously connected to the deaths. As discussed, these recommendations included that school football programs be expanded, that a swimming pool be constructed in Fitzroy Crossing and that a system of compulsory income management be introduced for Western Australia.²⁰ Although these recommendations may be useful and certainly worth consideration, it is extremely difficult to understand how they can reasonably be said to be connected to the deaths being investigated at that inquest. It is pertinent also to observe that coroners are unlikely to be in a position to receive and evaluate, in the context of an inquest, all relevant evidence necessary to make informed recommendations that impact so widely on social policy.

While there is no doubt that the Kimberley Inquest assisted in bringing attention to disadvantage experienced by many Aboriginal communities in the region, in the Commission's opinion an inquest is not the appropriate forum to investigate non-specific social problems, particularly if such investigation is undertaken for the purpose of making recommendations. In the Commission's view, the recommendatory function, like the comment function, is ancillary to the coroner's role in making the findings that are necessary under s 25(1) of the Coroners Act. The above proposal (in addition to Proposal 44) provides guidance to coroners by specifying the matters upon which a coroner may make comments or recommendations. Such matters must pass the threshold test of being sufficiently connected with the death

19. Inquest No 37/07.

20. 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>.

investigated at the inquest and must relate specifically to public health or safety, the administration of justice or the prevention of future deaths in circumstances similar to the death under investigation. Where a coroner is considering making recommendations he or she may call upon the proposed prevention team within the Office of the State Coroner (Proposal 80) to assist by providing research and data analysis to inform the recommendations. Where such recommendations impact the healthcare sector, the proposed specialist healthcare-related death investigation team (Proposal 41) will be tasked advice to the coroner on the appropriateness and formulation of proposed recommendations.²¹ Further, by establishing collaborative relationships with independent 'watchdog' agencies such as the Office of the Inspector of Custodial Service (Proposal 40), coroners will have better access to information to inform coronial recommendations that impact systemically.²² The following proposal gives further guidance to coroners in determining whether the power to make recommendations and comments should be exercised.

PROPOSAL 82

Considerations relevant to the making of comments or recommendations

That, in determining whether to make comments and recommendations in connection with a death investigated at an inquest, a coroner must consider:

- (a) the potential for comments or recommendations to play a constructive role in the prevention of future deaths in circumstances similar to the death of the deceased;
- (b) the extent to which the evidence presented at the inquest enables the making of comments or recommendations that have application to the particular circumstances of the death of the deceased; and
- (c) the advice, if any, of the specialist adviser or advisers appointed to assist the coroner at the inquest.

21. See Chapter Four, 'Improving Relationships between Coroners and Healthcare Professionals'.

22. See Chapter Four, 'Collaboration with the Office of the Inspector of Custodial Services'.

RESPONSE TO CORONIAL RECOMMENDATIONS

As part of its research for this reference the Commission undertook a review of coronial recommendations for Western Australian inquests performed in 2007.²³ The review studied the incidence of coronial recommendations, the responsiveness of agencies to recommendations and the rate of substantive implementation of recommendations. In that year, 22 of the 39 inquests featured recommendations with a total 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;

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

- 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 or support and a high level of responsiveness with ongoing progress updates provided by the Office of Safety and Quality in Healthcare and the Office of the Chief Psychiatrist every six months.²⁴ The Department of Corrective Services and Western Australia Police also provided a high level of responsiveness to recommendations, but with varying levels of implementation and support and no ongoing progress reports. 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 action tended to receive platitudinous responses with little likelihood of implementation. It was clear from a number of responses that some recommendations could not feasibly be implemented, although the intent behind the recommendation may have been supported.²⁵ This highlights the need for expert assistance and consultation with relevant parties on the formulation of recommendations.

A national study of coronial recommendations undertaken in 2005–2006 showed that a number of factors affected the implementation of coronial recommendations: These included:

- the feasibility of a coronial recommendation;
- whether or not the implementation of a recommendation accords with government policies and priorities;
- the manner in which a recommendation is formulated or expressed by a coroner;

24. Pursuant to internal Department of Health policy: Information Circular IC0008/07.

25. For example, the Commission was told of a recommendation that the Med-Alert system (which provides information on a patient's allergies, anaesthetic incidents, etc) available in public hospitals be extended to all private hospitals. While the intent of the recommendation was appreciated by the Department of Health, the content of the recommendation could not be fulfilled because the transfer of patient information between public and private providers breached patient confidentiality and because the physical infrastructure would not support such information exchange.

- whether or not a pro-active system for review of recommendations exists within the organisation to whom the recommendation(s) is directed;
- whether or not a mandatory system of reporting organisational responses to recommendations is in place;
- whether or not prior coronial recommendations arising out of similar deaths are drawn to the attention of relevant authorities by coroners or others;
- whether or not an inquest and its recommendations attract media attention; and
- whether or not some form of public advocacy accompanies the recommendation.²⁶

Each of these factors appears to have impacted on the implementation of the recommendations reviewed in the Commission's study. While the above proposals seek to assist coroners to make more-informed recommendations, the following proposals seek to enhance consideration of implementation of those recommendations and of strategies that may prevent future deaths in similar circumstances.

Informing relevant entities of recommendations

A particular finding of the national study of coronial recommendations was 'the recurring instances where coronial recommendations had not been communicated or had been miscommunicated, or were lost in the bureaucratic process'.²⁷ Section 27(4) requires that where a recommendation made under s 27(3) is relevant to the death of a person held in care (eg, the death of a prisoner or an involuntary mental health patient),²⁸ the State Coroner must inform the relevant agency in writing of the recommendation. This reflects recommendation 14 of the Royal Commission into Aboriginal Deaths in Custody.²⁹ There is otherwise no legislative requirement to inform entities the subject of a recommendation that a recommendation has been made. However, in practice most coronial recommendations are communicated by the Coroners Court to the

relevant agency, entity or Minister within one month of the delivery of the inquest findings.

In other Australian jurisdictions the requirement to inform entities the subject of a recommendation is entrenched by legislation. For example, s 82(4) of the *Coroners Act 2009* (NSW) provides:

- (4) The coroner is to ensure that a copy of a record that includes recommendations made under this section is provided, as soon as is reasonably practicable, to:
 - (a) the State Coroner (unless the coroner is the State Coroner), and
 - (b) any person or body to which a recommendation included in the record is directed, and
 - (c) the Minister, and
 - (d) any other Minister (if any) that administers legislation, or who is responsible for the person or body, to which a recommendation in the record relates.

While s 46(2) of the *Coroners Act 2003* (Qld) requires that a written copy of any comments and recommendations must be given to:

- (a) a family member of the deceased person who has indicated that he or she will accept the document for the deceased person's family; and
- (b) any person who, as a person with a sufficient interest in the inquest, appeared at the inquest; and
- (c) if the coroner is not the State Coroner—the State Coroner; and
- (d) if a government entity deals with the matters to which the comment relates—
 - (i) the Attorney-General; and
 - (ii) the Minister administering the entity; and
 - (iii) the chief executive officer of the entity; and
- (e) if the comments relate to the death of a child—the children's commissioner.

Notification of an entity the subject of a recommendation is obviously essential if recommendations are to fulfil a prevention function. The Coroners Court should be commended for adopting this practice in the absence of any legislative direction. However, in light of the Commission's proposals below regarding mandatory written responses to coronial recommendations, the notification of entities the subject of recommendations

26. Watterson R, Brown P & McKenzie J, 'Coronial Recommendations and the Prevention of Indigenous Death' (2008) 12(2) *Australian Indigenous Law Review* 4, 5.

27. *Ibid.*

28. For a discussion of person held in care, see Chapter Five, 'Mandated Inquests'.

29. Royal Commission into Aboriginal Deaths in Custody, *National Report* (1991) vol 5.

becomes more crucial. The Commission, therefore, makes the following proposal specifying who must be notified of a coronial recommendation and providing for the flexibility to prescribe by regulation further entities or people to be notified in particular cases. Such persons might include the Commissioner for Children and Young People (in relation to child deaths) or the Inspector of Custodial Services (in relation to deaths in custody). The Commission notes that a legislative requirement to notify those who are the subject of a coronial recommendation will, of necessity, encourage coroners to carefully consider to whom the recommendation is directed so as to avoid the problem identified in the Commission's study where recommendations were ignored because no agency, entity or person was specified as the responsible party.

PROPOSAL 83

Notification of coroners' recommendations

1. That any coroner who makes a recommendation following an inquest must ensure that a copy of a record of investigation that includes the recommendations is provided, as soon as is reasonably practicable, to:
 - (a) the State Coroner (unless the coroner is the State Coroner);
 - (b) any entity to which a recommendation included in the record is directed;
 - (c) the Attorney General;
 - (d) any other Minister (if any) that administers legislation, or who is responsible for the entity, to which a recommendation relates; and
 - (e) any other person or entity prescribed by regulation.
2. That a letter be included with the copy of a record of investigation drawing attention to the existence of the recommendations and to the obligation of the party or parties to whom they are directed to acknowledge receipt of the recommendations and provide a response to them within the time frame specified in Proposal 84.

Mandatory response to recommendations

The standard letter sent by the Administrator of the Office of the State Coroner informing entities of a coronial recommendation addressed to the recipient also seeks advice on the implementation (or otherwise) of the recommendations for the purposes of the State Coroner's annual report to the Attorney General.³⁰ However, currently in Western Australia there is no obligation on such entities to respond to coronial recommendations.³¹

Elsewhere in Australia, the requirement of certain parties to respond to coronial recommendations or reports is encapsulated in legislation or whole-of-government policy. For example, the Coroners Acts of South Australia and the Australian Capital Territory require that the relevant custodial agency or minister respond to coronial recommendations within six months and three months respectively for any deaths in custody³² and, in the case of South Australia, the response must be tabled in Parliament by the relevant minister.³³ The *Coroners Act* (NT) requires that any government agency to which a coronial recommendation is directed (irrespective of the type of death) must respond within three months after receiving the recommendation and such response must be tabled in Parliament by the Attorney General without delay.³⁴ In Victoria, a response must be provided by the public statutory authority or entity to the coroner within three months of receiving the recommendations and that response (together with the findings and recommendations) must be made publicly available on the internet.³⁵ Responses to coronial recommendations in New South Wales are governed by a whole-of-government policy issued by the Department of Premier and Cabinet, which requires agencies or ministers

30. Required under the *Coroners Act 1996* (WA) s 27(1).

31. Other than the Department of Health which, by virtue of internal policy contained in Information Circular IC0008/07, must provide a response to the coroner outlining any action to be taken in respect of a coroner's recommendation. Such response is provided by the Office of Safety and Quality in Healthcare and six-monthly progress reports are also provided.

32. *Coroners Act 2003* (SA) s 25(5); *Coroners Act 1997* (ACT) s 76. In the Australian Capital Territory the relevant custodial agency must also make a response to the coroner's findings in any death in custody, regardless of whether the coroner has made any recommendations.

33. *Coroners Act 2003* (SA) s 25(5).

34. *Coroners Act* (NT) s 46B.

35. *Coroners Act 2008* (Vic) s 73.

to write to the Attorney General within six months of the recommendation outlining what steps have been taken to implement the recommendation or reasons why it cannot be implemented.³⁶ In Queensland, a similar whole-of-government policy has been in place since 2008 and each year an annual report outlining the government's response to every coronial recommendation is tabled in Parliament and published on the internet.³⁷ This followed a report by the Queensland Ombudsman into, among other things, the responsiveness of public sector agencies to coronial recommendations.³⁸

As can be seen from this summary, all Australian jurisdictions, except Western Australia and Tasmania, now have substantive mechanisms in place to require responses to coronial recommendations by public sector agencies or entities. For the majority of jurisdictions, this requirement extends beyond recommendations relating to deaths in custody³⁹ to apply generally to all coronial recommendations. The Commission is aware that the issue of responsiveness to coronial recommendations generally has been the subject of consideration by the Standing Committee of Attorneys General (SCAG) since 2009. Although no further public information is available as to the outcomes of SCAG, this indicates a level of concern among Australian governments about the rate of response and implementation of such recommendations. In April 2010, following the Ward Inquest in Western Australia, the Legislative Council's Standing Committee on Environment and Public Affairs announced an inquiry into the transportation of detained persons with one of its terms of reference being:

Whether the *Coroners Act 1996* (WA) should be amended to require the Government to respond to coronial recommendations within a set timeframe.⁴⁰

36. Department of Premier and Cabinet (NSW), Policy M2009-12 (June 2009).
37. See, eg, Queensland Government, *The Queensland Government's Response to Coronial Recommendations 2009* (2010).
38. Queensland Ombudsman, *The Coronial Recommendations Project: An investigation into the administrative practice of Queensland public sector agencies in assisting coronial inquiries and responding to coronial recommendations* (December 2006).
39. The Royal Commission into Aboriginal Deaths in Custody (RCIADIC) recommended that coronial recommendations be the subject of response by the relevant agency within three months of 'publication of the findings': RCIADIC, *National Report* (1991) vol 5, recommendation 15.
40. Western Australia Legislative Council, Standing Committee on Environment and Public Affairs, *Inquiry into the Transportation of Detained Persons* (2010), Terms of Reference, no 4.

The Committee received 13 submissions on this issue with no submissions objecting to the idea of mandating responses to coronial recommendations.⁴¹ This accords with evidence provided to the Victorian Parliamentary Law Reform Committee (VPLRC) during its 2006 review of the Coroners Act in that state.⁴² It also accords with the Commission's own consultations in Western Australia where the idea of legislatively mandating responses to coronial recommendations was overwhelmingly supported. Of course, mandating responses to coronial recommendations does not mean that those recommendations will automatically be implemented.⁴³ In some cases recommendations may be ill-conceived or not amenable to practical implementation. In this regard, the Commission notes the reservations of some individuals who raised questions about the quality of coronial recommendations in Western Australia and the ability of government or others to implement them effectively.⁴⁴ This is an important point and one which should be addressed to some extent by the Commission's proposals to provide legislative guidance to coroners on the exercise of the recommendatory power⁴⁵ and to assist coroners by providing for a prevention team to conduct research and stakeholder consultations to inform the formulation of recommendations.⁴⁶ An important benefit of a mandatory response system is that coroners receive public feedback on the appropriateness of their recommendations and, in particular, whether or not they are capable of being implemented. This type of feedback should encourage coroners to strive for constructive, workable and informed recommendations and to actively seek advice, where appropriate, on the formulation of recommendations.

Another, related, benefit of a mandatory response system is that it allows the

41. The Department of the Attorney General submitted to the Committee that it would await the outcome of the Commission's review of coronial practice before committing to either a policy or a legislative response: Department of the Attorney General, 'Submission to the Legislative Council's Inquiry into the Transportation of Detained Persons' (26 May 2010) 5.
42. VPLRC, *Coroners Act 1985*, Final Report (2006) 400-2.
43. Although it does make entities accountable for considering the recommendation and possible implementation.
44. See, eg, the comments of Grant Donaldson SC in the Western Australian Bar Association's submission to the Legislative Councils Inquiry into the Transportation of Detained Persons (19 May 2010) 2. Similar comments were made by a number of people consulted by the Commission.
45. See Proposal 82, above.
46. See Proposal 80, above.

implementation of coronial recommendations to be easily monitored, which should provide a measure of the effectiveness of coronial recommendations as well as increasing the accountability of entities to whom a recommendation is directed.⁴⁷ Such monitoring should not be left to the coroner's office alone: responses to recommendations must be readily accessible to all who may draw from them in respect of the prevention of future deaths.⁴⁸ In addition, they must be available to families of deceased and the community at large; both of which have an understandable interest in the outcome of coronial recommendations that may reduce the future incidence of death and injury in similar circumstances.⁴⁹ The Victorian model which requires the coroner to publish findings, recommendations and the responses to recommendations on the internet received strong support from those consulted by the Commission. This was seen as an important means of promoting public confidence in the coronial system and strengthening the prevention role of the coroner.

As to the time frame in which an entity must respond regarding a coronial recommendation, the Commission observes that most Australian jurisdictions require such response within three months of receiving the recommendation. The Commission also notes that this is the time stipulated by recommendation 15 of the Royal Commission into Aboriginal Deaths in Custody as reflected in the Western Australian State Coroner's guidelines for the provision of a report in response to coronial findings for deaths in custody.⁵⁰ A submission to the Legislative Council's Inquiry into the Transport of Detained Persons noted that in South Australia, where a six-month mandatory response system exists, parties represented at coronial inquests generally come prepared to make submissions

47. The Health Consumers' Council submitted that such a system in Western Australia would 'create more pressure on a healthcare provider to make changes and communicate problems with the system amongst staff': Health Consumers' Council, submission (17 December 2009) 4.

48. Watterson R, Brown P & McKenzie J, 'Coronial Recommendations and the Prevention of Indigenous Death' (2008) 12(2) *Australian Indigenous Law Review* 4, 7.

49. The Aboriginal Legal Service submitted that the publication of findings and recommendations was crucial to enable community groups to engage in ongoing advocacy for the consideration and implementation of coronial recommendations: Aboriginal Legal Service of Western Australia (Inc), submission (December 2010) 5.

50. State Coroner of Western Australia, 'Guidelines for Persons Held in Care, Prisoners Held in the Custody of the Ministry of Justice' (undated) guideline 15.

on the subject of potential recommendations and are often 'anxious themselves to inform the coroner of reforms they have instigated themselves before the hearing'.⁵¹ It was argued that in these circumstances the time required for responses by public authorities 'is appreciably less than what it might have been in former times' and the six-month time period could usefully be decreased.⁵² The majority of submissions to the inquiry that commented on this matter appeared to favour a time frame of three months or less in which to respond to coronial recommendations. The Commission notes that compliance with this reporting requirement (as distinct from implementation) is not difficult and suggests that, in the light of the above discussion, three months is an appropriate time frame.

PROPOSAL 84

Mandatory response to coronial recommendations

1. That a public statutory authority or public entity the subject of a coronial recommendation must, within 21 days of receiving the recommendation, acknowledge receipt of the recommendation in writing to the State Coroner.
2. That a public statutory authority or public entity the subject of a coronial recommendation must within three months of receiving the recommendation, provide a written response to the State Coroner specifying a statement of action (if any) that has, is or will be taken in relation to the recommendations made by the coroner.
3. That, as soon as reasonably practicable upon receipt of the written response from a public statutory authority or public entity, the State Coroner must publish the response on the internet and provide a copy of the response to any person who has advised the Principal Registrar that they have an interest in the subject of the recommendations.

51. Aboriginal Legal Rights Movement Inc, 'Submission to the Inquiry into the Transport of Detained Persons' (14 May 2010) 3.

52. *Ibid.*

Should private entities and individuals be subject to mandatory response reporting?

Although most coronial recommendations are directed to government agencies, recommendations are also routinely addressed to private entities. Private entities the subject of recommendations may be large corporations (such as energy companies, private hospitals, trucking companies or airlines) or small companies (such as nursing homes, general practitioner clinics, tourism operators or contractors). There was some division among those consulted as to whether mandated responses should apply to private entities as well as public entities. In light of the circumstances of the death of an Aboriginal elder (Mr Ward) in the back of a privately operated prisoner transport service in January 2008, many groups have argued for mandatory responses to coronial recommendations to apply across the board.⁵³ This was also the position taken by the VPLRC in its 2006 review of the Victorian Coroners Act, which considered that responses should be mandated from incorporated companies and other private entities.⁵⁴ However, one lawyer suggested that if the mandatory requirement was extended to private entities and individuals there would need to be some statutory protection to prevent responses from being admissible in civil proceedings. It was argued that without this protection responses would probably become vague and meaningless and subject to the directions of the entity's insurer.

The Victorian legislation, which refers to 'a public statutory authority or entity',⁵⁵ is the only legislation to mandate the provision of a response to coronial recommendations by private entities. Under s 38 of the *Interpretation of Legislation Act 1984* (Vic) 'entity includes a person and an unincorporated body' so both

the recommendation and response provisions of the *Coroners Act 2008* (Vic) also apply to individuals.⁵⁶ The Commission has no firm view about whether private entities and individuals should be subject to the same mandatory reporting requirements as ministers, statutory bodies and public entities. However, it notes that there is a strong case that private entities that perform public functions (such as the privately operated prisoner transport service in the Ward case) should be subject to mandatory response requirements under the Coroners Act.⁵⁷ The Commission seeks submissions on the following questions.

QUESTION F

Mandatory responses to coronial recommendations – private entities and individuals

Should private entities and individuals be subject to the same mandatory reporting requirements in response to coronial recommendations as public entities? If not, should an exception be made for private entities that perform public functions pursuant to a contract with a public entity, government department or minister?

What should be the consequence of a failure to respond?

The Commission notes that nowhere in Australia is there an offence for failure to respond to coronial recommendations within the required time. In the Victorian system where responses are public, the 'name and shame' approach is used to encourage entities the subject of recommendations to provide a timely response. This involves recording on the Coroners Court website the cases where a response has not been received from the relevant agency within the time provided for under the Act. Entities the subject of recommendations are advised by

53. See, eg, Aboriginal Legal Service (WA), Submission to the Inquiry into the Transport of Detained Persons (14 May 2010) 27.

54. VPLRC, *Coroners Act 1985 – Final Report* (2006) 407. The VPLRC also suggested that the mandatory response regime should extend to individuals, though it fell short of recommending that course. There is no indication in the Victorian parliamentary debates on the *Coroners Bill 2008* (Vic) as to why the government did not implement the VPLRC's recommendation to extend the mandatory response regime to private entities.

55. *Coroners Act 2008* (Vic) s 72(3). When read in conjunction with the definition of 'entity' in the *Interpretation of Legislation Act 1984* (Vic) s 38 'entity includes a person and an unincorporated body'.

56. Other Australian jurisdictions permit coroners to make recommendations to individuals, though there is no mandatory response requirement. See, eg, *Coroners Act 2009* (NSW) s 82 which specifically refers to a person the subject of a recommendation. The Coroners Acts of Queensland, South Australia and Tasmania do not specify to whom a coroner's recommendation may be made, leaving it at the discretion of the coroner.

57. The Commission also notes that this can very easily be made a requirement of the entity's contract with the relevant public agency or department.

letter that this action will be taken if they fail to respond to the coronial recommendations within the three-month time limit set by s 72(3) of the *Coroners Act 2008* (Vic).⁵⁸ The Commission has been informed that this process is extremely effective and that responses are usually provided within a very short time following publication of a failure to respond.⁵⁹ There is nothing to suggest that a similar regime in Western Australia would not have the same effect; however, the Commission seeks submissions on whether an offence should be created for failing to provide, within the required time, a response to coronial recommendations. If such an offence were created, then it would seem appropriate that it apply equally to private and public entities.

QUESTION G

Mandatory responses to coronial recommendations – penalty

Should there be an offence for failing to discharge reporting obligations under the Coroners Act? If so, what would be the appropriate penalty and should the penalty differ for public and private entities and individuals?

58. Samantha Hauge, Manager Coroners Prevention Unit, Coroners Court of Victoria, consultation (26 May 2011). The letter contains guidelines for responding to coroners' recommendations, which require an agency to specify, if a recommendation cannot be implemented, why and a range of possible solutions or interventions to resolve the issues identified by the coroner's findings and recommendations.
59. Ibid. As at 26 May 2011 there were no outstanding responses recorded on the Coroners Court of Victoria website that are outside the three-month time frame provided for by the *Coroners Act 2008* (Vic) s 72(3).

Chapter Seven

Role and Support of the Family in the Colonial Process

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Introduction

As discussed in Chapter One, the Commission published a Background Paper in September 2010 setting out the results of its initial consultations with experts and people intimately involved with the delivery of coronial services in Western Australia. The purpose of the Background Paper was to engage the public to ensure that the Commission's proposed reforms were informed by the views of those who ultimately are the 'users' of the coronial system; that is, the friends and families of those whose deaths had been reported to the coroner. In order to gain feedback from families who had experienced the coronial system in Western Australia the Commission placed advertisements in *The West Australian* and in the newsletters of a number of organisations that assist people during their time of bereavement. An online survey specifically aimed at eliciting responses from family members was created and 113 responses were recorded. In addition, the Commission received a number of telephone calls and visits from members of the public who wished to comment on their experience with the coronial system in Western Australia and to give their views on the matters discussed in the Commission's Background Paper.

This chapter examines the role of families in the coronial process, their rights under the *Coroners Act 1996 (WA)* ('the Coroners Act') and the systems that are in place to support families as they navigate the coronial process. The chapter begins by looking at how the coronial process can better cater for the culturally and linguistically diverse community that is Western Australia. It then examines how families can access coronial information and support, including the role of coronial counselling within the Office of the State Coroner. Next, it discusses the family's rights in respect of post mortem procedures and issues that have arisen in this respect and finally, it looks at the issue of release of bodies under control of the coroner.

While this chapter concentrates specifically on the rights and role of families of deceased in the coronial process, the Commission regards families as being of significant importance and, in consequence, the needs and concerns of families have been considered in respect of all proposals made in this Paper.

Catering for a culturally and linguistically diverse community

In its Background Paper the Commission noted that a number of Indigenous cultural concerns had been raised with the Commission regarding the coronial process. These included the reluctance of Aboriginal people to utilise coronial counselling services; the lack of Aboriginal staff or cultural liaison within the Office of the State Coroner; the communication of family rights in the coronial process, such as objection to post mortem; and cultural concerns about the naming of an Aboriginal deceased at inquest. These issues are discussed and addressed throughout this Paper.¹

Just as there is a need for attention to culturally appropriate delivery of coronial information to Indigenous people, the Commission has identified opportunities for reform to reflect similar needs in relation to other culturally and linguistically diverse (CaLD) groups within the Western Australian community.² With more than one quarter of the state's population born overseas, Western Australia has the largest proportion of people born overseas of any Australian state or territory.³ According to the Office of Multicultural Interests (OMI), nearly 12% of these 'were born in a non-main-English speaking country and more than 11% of people born overseas speak a language other than English at home'.⁴ 'People from more than 200 different countries live, work and study in Western Australia, speaking as many as 270 languages and identifying with more than 100 religious faiths'.⁵

In order to ensure that all cultural groups in Western Australia had the opportunity to

be heard in the consultation process, the Commission contacted 71 cultural and religious bodies for their input.⁶ The Commission's letter explained the nature of the project, made reference to the public survey and Background Paper,⁷ and invited comment on any cultural matters that should be taken into account by the Commission when drafting its proposals for reform of the coronial system. Among the matters that the Commission foreshadowed may be of interest to cultural organisations in preparing their submission were:

[C]ultural objections (if any) to internal post mortem examination; objections (if any) to external post mortem examination (see p 55 of the Background Paper for further explanation); the possible cultural impacts of delay in release of a body (eg, in relation to burial); and problems with understanding the coronial process and the family's rights in that process.⁸

The Commission received a very modest response to its letter and follow-up telephone contacts, with only seven of the 71 organisations contacted for comment providing a substantive response. The Commission thanks these organisations for their input and has taken their submissions into account in the preparation of this Discussion Paper. In addition, the Commission received a very helpful submission from the OMI which commented generally on ways to improve how the coronial system interacts with people from CaLD backgrounds by, among other things, the provision of cultural competency training and collection of cultural data. Other issues impacting on the accessibility of coronial information to CaLD communities and awareness of religious and cultural sensitivities to post mortem examination procedures are discussed elsewhere in this chapter.⁹

1. See, eg, Proposals 78, 87 and 90.
2. Two possible reforms were touted by the Commission in its Background Paper: the provision of information in different languages and the provision of interpreters to explain the rights of the family where necessary: see 'Information to be Provided to the Family', below.
3. Office of Multicultural Interests, 'Diversity Statistics' <http://www.omi.wa.gov.au/omi_diversity_statistics.cfm> (accessed 30 May 2011).
4. Office of Multicultural Interests, submission (March 2011).
5. Office of Multicultural Interests, 'Diversity Statistics' <http://www.omi.wa.gov.au/omi_diversity_statistics.cfm> (accessed 30 May 2011).

6. The Commission was assisted by the Office of Multicultural Interests in this process.
7. A copy of the Commission's Background Paper was included with the letter.
8. LRCWA, letter to cultural and religious bodies (13 January 2011).
9. See, eg, 'Translations of Important Coronial Information' and 'Use of Interpreters', below.

CULTURAL COMPETENCY TRAINING

As noted in the Commission's Background Paper, the lack of appropriate training has been identified as an issue across the entire coronial jurisdiction including for regional magistrates, coroners' registrars, lawyers, police and coronial contractors (such as body transporters).¹⁰ Professional training for lawyers, coroners and coroners' staff is addressed by proposals earlier in this paper.¹¹ Training for police officers (including cadets at the academy level and operational officers) has now been assumed by the Coronial Investigation Unit which appears to be professionalising the way it deals with coronial matters, including with the families of deceased.¹² However, the OMI submitted that because police are required to explain the contents of the 'When a Person Dies Suddenly' brochure to the next of kin, including their right to object to post mortem examination of the deceased, they also require 'cultural competency' training to ensure that they 'know how and when to obtain an interpreter and/or translator'.¹³ In addition, the OMI submitted that cultural competency training should be provided for all staff of the Office of the State Coroner who are required to deal with relatives of a deceased.¹⁴ This was considered to be of particular importance for coronial counsellors whose role includes speaking to family members about organ retention and post mortem examination issues, as well as providing support to families through the coronial process.

According to the OMI, cultural competency training addresses three elements: cultural self-awareness (understanding your own cultural background), cultural literacy (understanding the cultural background of other people), and cultural bridging (being able to negotiate cultural differences).¹⁵ In the coronial context cultural competency training might teach individuals to understand how different cultures respond differently to death and how to interact with

people of different cultures in this situation.¹⁶ The Commission is advised that the OMI is in the process of finalising a cultural competency package to be available online to the Western Australia public sector.¹⁷ In addition, the Commission is aware that there are cultural competency trainers who can tailor training to the specific organisation.

Proposal 85

Cultural competency training: police and coronial staff

1. That, in consultation with the Office of Multicultural Interests, the Office of the State Coroner establish cultural competency training for all staff who have dealings with the public. Such training should be tailored, as far as possible, to the organisational needs of the Office of the State Coroner.
2. That, in consultation with the Office of Multicultural Interests, the Coronial Investigation Unit (CIU) of the Western Australia Police establish cultural competency training for all staff and make information about dealing with different cultures during periods of grief available to police cadets and officers through CIU-run training.

COLLECTION OF CULTURAL DATA

The OMI submitted that cultural and linguistic data collected by the Office of the State Coroner should be expanded beyond Indigenous status to include other cultures.¹⁸ It was submitted that more-comprehensive cultural and language data would enable analysis of types of death by ethnicity and identification of any specific trends affecting people from CaLD backgrounds.¹⁹ For example, OMI suggested that:

10. LRCWA, *Review of Coronial Practice in Western Australia*, Background Paper (September 2010) 51.
11. See Proposals 12 & 72.
12. See also Proposal 38, 'Coronial Training for Major Crime Squad'.
13. Office of Multicultural Interests, submission (March 2011) 1-2. The issues of provision of interpreters and translated material are discussed further below.
14. Ibid.
15. Helen Maddocks, Principal Policy Officer, Office of Multicultural Interests, consultation (1 June 2011).

16. For example, only family members or associates generally touch a Sikh woman, even when she is grieving over a death, so it would not be appropriate for a person to seek to comfort a Sikh woman by any form of physical contact, such as hugging: Office of Multicultural Interests, 'Sikh information sheet' <http://www.omi.wa.gov.au/omi_guidelines.cfm> (accessed 1 June 2011).
17. Helen Maddocks, Principal Policy Officer, Office of Multicultural Interests, consultation (1 June 2011).
18. Office of Multicultural Interests, submission (March 2011) 1.
19. Ibid.

Analysis of the type of inquest/death by ethnicity would help identify specific areas of concern in relation to specific CaLD communities in areas such as mental health care, medical care, workplace injuries, motor vehicle accidents and suicide.²⁰

While no linguistic data is collected, the Commission notes that the National Coroners Information Service (NCIS) does collect data on country of birth and number of years in Australia. This would appear to be adequate for the analysis of type of death by ethnicity contemplated by the OMI.²¹

20. Ibid.

21. In addition, as suggested by the OMI, data collected by NCIS on how long the deceased has resided in Australia might assist in assessing the extent to which familiarity with issues such as road rules and workplace safety practices were a factor in the person's death.

Coronial counselling service

The provision of a coronial counselling service was a key recommendation of the 1992 Honey Inquiry which examined issues relating to coronial post mortem and informed the drafting of the *Coroners Act 1996* (WA) ('the Coroners Act').¹ The focus of the terms of reference of the Honey Inquiry 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. This focus can be seen in many of the Honey Inquiry's recommendations which, in addition to the provision of a counselling service, included 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.²

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'.³ There are three coronial counsellors (one senior counsellor/manager and two counsellors) currently employed by the Office of the State Coroner.⁴ These staff have qualifications in social work or psychology and provide short-term clinical counselling services for families of deceased persons,⁵ but their primary role is to provide information to families about the coronial process.⁶ This role

involves providing community information and training sessions; providing information about the progression of a coronial investigation; providing information about inquests; dealing with organ retention issues; negotiating objections to post mortem examinations;⁷ facilitating file viewings; providing information about the post mortem examination process; and, in certain cases, interpreting or explaining post mortem examination findings.⁸ 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.⁹

The Commission's consultations with counsellors revealed that the service was inadequately staffed¹⁰ – a resource issue highlighted by the State Coroner in 2008 when he declared that the service could no longer function as anticipated.¹¹ Although s 16 of the Coroners Act provides that 'any person coming into contact with the coronial system may seek the assistance of the counselling service', for many years such assistance had only been available to the immediate family of the deceased. Other services that the counsellors would otherwise wish to provide – such as home visits, support for mortuary viewings and support for family during inquests – had also been radically cut back to enable counsellors to deal with the day-to-day traffic of coronial liaison work.

1. *Report of the Committee of Inquiry into Aspects of Coronial Autopsies* (December 1992) recommendation 2.

2. *Ibid*, recommendations 4, 5 & 7.

3. The coronial counselling service was introduced ahead of the *Coroners Act 1996* (WA) commencing on 3 January 1995. Coronial counselling services had already been established in South Australia, New South Wales, Victoria and Queensland prior to this time (although none had a specific statutory basis): Parry A, et al, 'Counselling Services Attached to Coroner's Offices across Australia' (1996) 20(1) *Aboriginal and Islander Health Worker Journal* 9, 10.

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

5. Where it is appropriate the counsellors may refer relatives of deceased to community or government agencies for longer term counselling: Turnbull R, *The Coronial Process in Western Australia: A handbook for medical practitioners and medical students* (June 2010).

6. This has been described as the 'core business' of the coronial counselling unit: Merrick J, *Report on Coronial Counselling Service for the West Australian State Coroner* (2003) 5. The

State Coroner has also described the coronial counselling service as the 'interface between families of deceased persons and the coronial system': Office of the State Coroner (WA), *Annual Report 2006–2007* (2008) 6.

7. Counsellors are intimately involved in this process by speaking to families and explaining the benefits of post mortem examination in cases where an objection has been made.

8. 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).

9. 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.

10. Coronial Counsellors, consultation (22 August 2008).

11. Office of the State Coroner (WA), *Annual Report 2006–2007* (2008) 3.

Another area that had suffered was community education and training which, despite being a principal recommendation of the Honey Inquiry, had been neglected for many years. Further, as discussed below, there is effectively no coronial counselling offered to people outside the Perth metropolitan area, except by telephone.¹²

The addition of a third counsellor, after the Attorney General approved a temporary budget increase in August 2009,¹³ has enabled the coronial counselling service to resume some (but not all) of these functions, although the Commission is advised that the service remains 'mostly reactive rather than proactive'.¹⁴ The Commission was advised that the provision of a dedicated administrative assistant to the coronial counselling service would assist greatly with the maintenance of service statistics and community resources and by fielding calls that are information based and not related to sensitive matters.¹⁵ The Commission proposes below that this be considered, but notes that its Proposal 91 for the establishment of a secure online coronial information service for family members of deceased and Proposal 93 for the upgrading of information available on the Coroners Court website would, if implemented, assist considerably in taking some of the pressures of the coronial counsellors in respect of the provision of general information about the coronial process and specific information about the progression of a coronial case. In addition, the Commission's proposal to appoint dedicated regional coroners, whose staff would include a counsellor/liaison officer (Proposal 4), will also assist by taking care of regional education and training initiatives, regional coronial liaison, support for families during regional inquests and coordination of regional coronial counselling.

As noted in the Commission's Background Paper concerns were raised in consultations that some people (particularly Indigenous people) were reluctant to use the service when referred by coroners court registrars, police or others because of the stigma associated

with the term 'counselling'.¹⁶ It appears that in some Indigenous communities counselling is associated with mental health problems and any mention of counselling will be met with resistance because it is thought that if one submits to such 'treatment' they may 'end up in Graylands'.¹⁷ The term 'coronial liaison' was widely preferred by those consulted and, as can be seen from the description above, it is in fact more reflective of the range of services provided by the coronial counsellors. The Commission therefore proposes that the name of the service be changed from the Coronial Counselling Service to the Coronial Liaison Unit. This is a simple change but one that may have a substantial positive impact.

Proposal 86

Coronial Liaison Unit

1. That the coronial counselling service be renamed the Coronial Liaison Unit to remove any stigma that may attach to seeking 'counselling' for users of the service and to better describe the services provided.
2. That the Coronial Liaison Unit be constituted by 'coronial liaison officers' who are qualified counsellors.
3. That consideration be given to providing the Coronial Liaison Unit with a dedicated administrative assistant.

DELIVERY OF CORONIAL COUNSELLING IN THE REGIONS

Of particular concern to the Commission during consultations for this reference was the realisation that coronial counselling was not being effectively offered to people in regional areas of Western Australia. This was an issue identified and addressed by the Commission in its 2006 report on Aboriginal customary laws.¹⁸

12. See 'Delivery of coronial counselling in the regions', below.
13. This temporary increase was renewed in May 2010 and the May 2011 budget.
14. Kristine Trevaskis, Senior Counsellor, Office of the State Coroner, email (16 July 2010).
15. Coronial Counsellors, consultation (22 August 2008).

16. LRCWA, *Review of Coronial Practice in Western Australia*, Background Paper (September 2010) 55.
17. Collard S, et al, 'Counselling and Aboriginal People: Talking about mental health' (1994) *Aboriginal and Islander Health Worker Journal* 17, 18. See also Katherine Hams, Manager, Kimberley Aboriginal Medical Services Council, consultation (21 July 2010); Aboriginal Legal Service of Western Australia (Inc), submission (December 2010).
18. LRCWA, *Aboriginal Customary Laws: The interaction of Western Australian law with Aboriginal law and culture*, Project No 94, Final Report (September 2006) 256. The

Coronial counselling in the regions is currently delivered through provision of a freecall number to the coronial counselling service in Perth. There are no data available about the use of this service and its success as a strategy for meeting coronial counselling needs in regional areas is therefore unclear. However, the Commission received a letter from a barrister who has acted as counsel assisting the coroner and as a coroner in Western Australia which noted that one of the most common complaints he has heard from families relates to the unavailability of access to coronial counsellors in regional areas of Western Australia, especially during inquests.¹⁹ The Commission also notes the submission of the Aboriginal Legal Service that support during an inquest is important 'to ensure families are forewarned about any graphic or upsetting evidence and provided the opportunity to leave the courtroom to avoid exposure'.²⁰ The Commission's proposals to establish coronial regions with dedicated regional coroners and staff, including a coronial liaison officer, will assist with this complaint. It is expected that the coronial liaison officer will travel with the regional coroner to provide support for families during inquests and conduct training and information sessions for coronial service providers and those in peripheral industries (eg, healthcare) while in communities.

During its consultations in regional areas in the north of the state the Commission heard from coroner's registrars that they often had difficulty getting information (such as post mortem examination results and findings) to families. In the Kimberley, there is no postal delivery service (thus, in order to access mail it is necessary to collect mail from the nearest post office). Community members may reside some distance from the local post office (eg, Aboriginal people who reside in remote communities, farmers and station owners). These people are likely to collect their mail sporadically and therefore they may not receive information about the coronial process in a timely manner. In the past police had been

relied upon to deliver coronial letters; however, the Commission was told that police are now reluctant to take on duties beyond their core business. In any case, the Commission observes that it may be inappropriate for police to deliver such information; for example, where the death may have involved police or other authorities.

The coroner's registrar in Broome had taken the initiative by seeking to establish a contact register in communities so that there was someone allocated to receive mail (eg, Aboriginal Medical Service, nursing post, multifunction centre, council chairperson or an Aboriginal community Elder) and deliver it to the relevant person. The Commission is advised that attempts to create a comprehensive register have not been successful.²¹ It appeared that the concern was primarily for Aboriginal people who had limited means of contact and a proposal for improving the provision of counselling and information liaison to Aboriginal people in regional areas is discussed below. It was noted that non-Aboriginal people in the Kimberley often had telephone or email contact and coronial information could therefore be delivered to them more easily.

Catering for Aboriginal people

The coronial counsellors conceded that the freecall telephone service does not and cannot effectively cater for Aboriginal people, especially in remote communities that have no or limited access to a telephone.²² Both counsellors the Commission consulted had reservations about whether Aboriginal people would use the service in any case. The counsellors noted that they had had good results on occasion where a community health nurse or Aboriginal health worker had initiated contact and acted as a liaison between the Aboriginal family and the coronial counselling service. This was effected by putting the coronial counsellor on speaker-phone enabling the family to ask questions directly while the health worker remained to ensure that information was communicated correctly and to assist the family with counselling needs if necessary.²³

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 been implemented, reportedly due to lack of resources.

19. Dominic Mulligan, Barrister, Letter (28 July 2008) 4.

20. Aboriginal Legal Service of Western Australia (Inc), submission (December 2010) 12.

21. Owen Starling, Coroner's Registrar, Broome Magistrates Court, consultation (15 June 2011).

22. Coronial Counsellors, consultation (22 August 2008).

23. Ibid.

It has been noted by commentators that because of their knowledge of the community and established relationships, Aboriginal health workers are particularly well placed to understand particular behaviours associated with bereavement, know the culturally appropriate way to deliver coronial information and know when a counselling intervention is required.²⁴ The Commission therefore consulted with the Kimberley Aboriginal Medical Services Council (KAMSC) to see whether a formal arrangement was possible to provide communities with a link to coronial services via its health workers. The Manager of KAMSC was very supportive, indicating that she would be happy to discuss how KAMSC could assist the Coroners Court to extend coronial counselling and liaison services to Aboriginal communities in the Kimberley.²⁵ She also confirmed problems with postal delivery in the Kimberley and said there was no reason why letters should not be sent to KAMSC so that Aboriginal health workers could explain the post mortem examination results or coroner's findings to the bereaved in language or in a way the family can understand. It was noted that such information must be delivered in a culturally appropriate way, for example, avoiding naming the deceased.²⁶

The Commission suggests that the Office of the State Coroner make arrangements with KAMSC and with Aboriginal Medical Services or relevant community agencies in other regions to assist Aboriginal people to navigate the coronial process.²⁷ It is noted that this is not core business for Aboriginal Medical Services so health workers will need to be provided with training (from coronial counsellors) and may need to be compensated to assist the Coroners Court in this regard. Despite the potential for requiring additional resources, the Commission believes this is the best way to deliver coronial counselling and information liaison services to Aboriginal people in regional Western Australia and to discharge the court's obligations under s 16 of the Coroners Act. In addition the

24. Hunter E, 'Aboriginal Mental Health Awareness: Death, loss, dying and grieving' (1993) 17(6) *Aboriginal and Islander Health Worker Journal* 21, 26-7.

25. Katherine Hams, Manager, Kimberley Aboriginal Medical Services Council, consultation (21 July 2010).

26. *Ibid.*

27. In this regard, the Commission notes the supportive submission of the Aboriginal Legal Service of Western Australia (Inc), submission (December 2010) 11-12.

Commission proposes that the staff of the Office of the State Coroner and of dedicated regional coroners undergo Aboriginal-specific cultural awareness training to assist in the organisation and delivery of culturally appropriate services to Aboriginal people in Western Australia. Such training is particularly crucial for coronial counsellors, coroner's registrars, counsel assisting and coroners, all of whom may be required to deal with Aboriginal people and be aware of particular cultural sensitivities in the exercise of their coronial duties.²⁸

Proposal 87

Provision of coronial counselling and liaison to Aboriginal people

1. That the Office of the State Coroner make arrangements with the Kimberley Aboriginal Medical Services Council and with Aboriginal Medical Services or relevant community agencies in other regions to enable Aboriginal health workers to provide coronial counselling and information liaison services to Aboriginal people. Aboriginal health workers should be provided with adequate training and resources to provide these services on behalf of the Office of the State Coroner.
2. That the staff of the Office of the State Coroner and of dedicated regional coroners undergo Aboriginal-specific cultural awareness training to assist in the organisation and delivery of culturally appropriate services to Aboriginal people in Western Australia.

COMMUNITY AWARENESS OF CORONIAL PROCESS

During the passage of the Coroners Act through Parliament the Attorney General stated:

Honey's findings in 1992 were that there was no public understanding of the coronial or forensic autopsy and there was a level of failure to communicate, particularly to relatives, about what will happen and when, the time involved, the extent of the examination and the integrity of the body.²⁹

28. *Ibid* 12.

29. Western Australia, *Parliamentary Debates*, Legislative Assembly, 22 November 1995, 11310 (Ms Edwardes, Attorney General).

A primary recommendation of the Honey Inquiry was that the coroner be resourced to develop and implement a public education program about the coronial process.³⁰ The delivery of general education and awareness programs has been a role traditionally undertaken by the coronial counselling service. However, in recent years this function has been neglected because of the pressures placed on the service in coping with the volume of work in delivery of coronial information to families. In the interim, the Manager of the Office of the State Coroner has been called upon to give presentations to community groups, aged care facilities and healthcare workers. This has, in turn, taken the Manager away from the increasing demands of his own role within the Coroners Court and is unsustainable. The Commission understands that since the provision of extra resources to the Office of the State Coroner and the allocation of an extra counsellor the general education function has been, to some extent, resumed by the coronial counselling service;³¹ however, there appears to be no comprehensive education and training strategy in place.

During the Commission's widespread consultations for this reference it became apparent that public knowledge of the coronial process and particularly about coronial post mortems remains limited.³² As the Honey Inquiry noted, 'this is hardly surprising given that most members of the community have no information until or unless they become personally involved in a coronial inquiry relating to a relative or close friend'.³³ Perhaps more surprising is the lack of knowledge of coronial matters with some people who play important peripheral roles in the process. As part of this reference, the Commission ran a separate survey for people involved in the funeral industry. When asked whether there was anything that the Coroners Court could do to help the funeral industry better understand the coronial process, all respondents

said that the frequency of information and training sessions given by the Coroners Court should be increased and that they be held at the state mortuary involving mortuary staff. The Commission has already discussed in this Paper the gaps in knowledge of some lawyers, police and healthcare professionals. Funeral directors noted that those who have the first point of contact with the family, such as police and doctors, need to be more aware of the time it may take for certain post mortem procedures and for organising the release of a body so that families do not have unrealistic expectations about how quickly the funeral may be held following a death.³⁴ It was noted by many of those consulted that forensic science dramas on television (such as CSI) can create false assumptions that the coronial process in discovering a medical cause of death is very quick and that this places unrealistic pressures on those involved in the process. As noted earlier in this Paper, some forensic pathology procedures (eg, neuropathology) can take a considerable time and sometimes a cause of death is unascertainable.³⁵

The Commission has earlier proposed that there be a specialist healthcare-related death investigation team within the Office of the State Coroner and that the functions of this team should include development of education and others strategies to improve health professionals' understanding of the coronial process.³⁶ Further, as discussed in Chapter Four, training for police has now been assumed by the Coronial Investigation Unit which has specialised knowledge of the coronial process.³⁷ This type of targeted training run by professionals is important to ensuring that the information is relevant and taken seriously. The coronial counselling service has a perhaps more difficult task in attempting to reach members of the public and those involved in peripheral industries which have relatively high exposure to coronial deaths, such as aged and palliative

30. *Report of the Committee of Inquiry into Aspects of Coronial Autopsies* (December 1992) recommendation 9.

31. 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).

32. As noted earlier this was also a key finding of the 1992 Honey Inquiry: *Report of the Committee of Inquiry into Aspects of Coronial Autopsies* (December 1992) 19.

33. *Ibid.*

34. It was noted that this was a particular problem with regional police who sometimes rely on the direction of coronial body transport contractors about the coronial process.

35. See Chapter Four, 'Forensic Medical Examination'.

36. Proposal 41.

37. See Chapter Four, 'Training of Police Coronial Investigators'. In light of the comments above, the Commission suggests that the Office of the State Coroner ensure that CIU pay attention to making officers aware of all the steps in the coronial process and timeframes for the process so that families are not given wrong information.

care providers, funeral directors, Aboriginal health workers, body transport contractors and community grief counselling services. In addition, the Commission suggests that training be extended to specialist investigators who may have dealings with families of deceased including mining inspectors, WorkSafe inspectors and any relevant staff. In the Commission's opinion the Office of the State Coroner needs to establish a comprehensive training and education strategy including the development of presentations targeted to specific industries and packaged materials that can be used in industry training. As discussed in Chapter Two, under the Commission's proposal for a dedicated regional coroner system, it is expected that the two regional coroners will be provided with a small staff that includes a coronial liaison officer (counsellor) who is responsible, among other things, for conducting education and training sessions throughout regional areas.

Ensuring that those in peripheral industries who come into contact with bereaved families are sufficiently trained and are armed with accurate information about coronial processes and timeframes is fundamental to bridging the gap between the Coroners Court and the public, and to combating misinformation and unrealistic expectations. In addition, the Commission's proposals for the establishment of a dedicated secure online coronial information service for families³⁸ and for the development of a more informative Coroners Court website³⁹ (discussed below) will assist in getting important messages about the coronial process to the general public. As the coronial counsellors noted in their consultation with the Commission, 'information is so important for people to understand what's going to happen, how long it's going to take and why something is happening'.⁴⁰ As discussed below, inadequate information and communication was one of the key messages that the public gave to the Commission about the coronial process, and the proposals in this and the following section seek to address this fundamental concern.

Proposal 88

Community awareness education and training

1. That the Office of the State Coroner be sufficiently resourced to establish a comprehensive training and education strategy and to conduct targeted training and education for people involved in peripheral professions including aged and palliative care providers, funeral directors, community grief counselling services, Aboriginal health workers, coronial body transport contractors, and specialist investigators (such as mining inspectors and WorkSafe investigators) who have dealings with families of deceased.
2. That the Office of the State Coroner develop an information package that can be distributed to relevant industries and included, where possible, in industry training initiatives.

38. Proposal 91.

39. Proposal 93.

40. Coronial Counsellors, consultation (22 August 2008).

Access to coronial information

INFORMATION TO BE PROVIDED TO FAMILY

Section 20 of the *Coroners Act 1996* (WA) ('the Coroners Act') sets out the information to be provided to any of the deceased person's next of kin:

- (1) A coroner who has jurisdiction to investigate a death must, as soon as practicable after assuming that jurisdiction, provide to any of the deceased person's next of kin under section 37(5) the following information—
 - (a) that the body is under the control of the coroner investigating the death;
 - (b) that a post mortem examination is likely to be performed on the body under section 34;
 - (c) that while the body is under the control of the coroner investigating the death, any of the deceased person's next of kin under section 37(5) may touch the body, unless the coroner determines that it is undesirable or dangerous to do so;
 - (d) that there is a right under section 35 to request that a doctor chosen by the senior next of kin be present at the post mortem examination;
 - (e) that if tissue is to be removed from the body under section 34(3)(b), then there is a right to view the written permission of the deceased;
 - (f) that while the body is under the control of the coroner investigating the death, it may be viewed by any of the deceased person's next of kin under section 37(5);
 - (g) that there is a right under section 37 to object to the post mortem examination, and a right under section 36 to request that a post mortem examination be performed;
 - (h) that there is a possibility that tissue may be retained after the completion of the post mortem examination, where it is necessary to do so in order to investigate the death, in accordance with section 34;
 - (i) a brief summary stating the manner in which objection under section 37 may be made; and
 - (j) that a counselling service is available.

- (2) The information provided under subsection (1) must be in writing, where practicable, and in a language and form likely to be understood by the person to whom it is provided.

The information set out in s 20 is provided in the Coroners Court brochure 'When a Person Dies Suddenly', which is delivered to the deceased's next of kin by police when informing the family of the death.¹

Translations of important coronial information

Although s 20(2) requires that the information must be delivered in writing 'in a language and form likely to be understood by the person to whom it is provided', the Coroners Court did not have translations of this brochure until March 2011 when, in response to the Commission's Background Paper, the brochure was translated into five common languages spoken in Western Australia: Farsi, Arabic, Chinese, Vietnamese and Italian. This is an excellent step forward in catering for persons from these communities; however, it is noted that the brochures are not in a prominent position on the website and that reference to the brochures on the website is in English rather than the language of the brochure. This may be of assistance to police seeking a brochure to supply to an Arabic family, but it will do little to assist an Arabic family seeking information directly from the website.²

The Commission has consulted with the Office of Multicultural Interests (OMI) which suggests that the range of languages in which key information is provided on the Coroners Court website (in particular, the brochure 'When a Person Dies Suddenly') should be expanded.³ It is notable, for example, that no African languages are catered for despite a growing

1. See Appendix C for a copy of this brochure.
2. The Office of the State Coroner should ensure that police are aware that translations of the 'When a Person Dies Suddenly' brochure are available from the Coroners Court website.
3. Helen Maddocks, Principal Policy Officer, Office of Multicultural Interests, consultation (1 June 2011).

population of migrants from that continent.⁴ The Commission notes that the Department of Transport has translated drivers licence information into several African languages including Amharic, Dinka, Kirundi and Swahili as well as catering for people who read Arabic, Burmese, Chinese, Dari, Farsi, Serbian and Vietnamese. According to the OMI, it is important to target translated material to those communities who are most in need.⁵ In many instances these will be communities of newly settled migrants rather than communities who have been settled in Australia for many years. Further, it is suggested that the homepage of the Coroners Court website should provide links in those languages to the translated information (including the brochure) available on the website. In the Commission's opinion these are simple but important advances to assist members of culturally and linguistically diverse communities in Western Australia to navigate what may be quite a foreign process in a time of grief.

Because of the oral nature of many Aboriginal languages the Commission appreciates the difficulty of providing translations of the Coroners Court brochure in the many Aboriginal languages spoken in Western Australia. This fact makes it crucial that interpreters are used when delivering key coronial information to Aboriginal people who do not speak English as their first language.⁶ The use of interpreters for this purpose is discussed below.

Proposal 89

Expand available translations of important coronial information

1. That the Coroners Court expand the range of languages in which key information (including, but not limited to, the brochure 'When a Person Dies Suddenly') is provided on its website.
2. That the Coroners Court provide links in the relevant language on the homepage of its website to translations of key coronial information.

4. The Office of Multicultural Interests advised that the top seven countries of birth for humanitarian entrants to Western Australia during 2005–2010 were Burma, Sudan, Afghanistan, Thailand, Zimbabwe, Sri Lanka and Kenya: *ibid*.

5. *Ibid*.

6. See 'Use of Interpreters', below.

Use of interpreters

The State Coroner's Guidelines for Police direct that 'all reasonable steps should be taken to ensure [the next of kin] understands the rights contained in the brochure, [including] providing for a translator if necessary'.⁷ This is an important matter because the rights referred to—such as the right to object to a post mortem examination—must be exercised within a short time of receiving the 'When a Person Dies Suddenly' brochure.⁸ The Commission's consultations with police in metropolitan and regional areas revealed that interpreters and translators are rarely, if ever, used by police when communicating this important information.⁹ Instead, it appears that police generally rely upon a family member or bystander who speaks English and the language of the senior next of kin to translate the brochure and gain assurances that the senior next of kin understands his or her rights.

The use of family members or friends as interpreters is not without risk. A Commonwealth Ombudsman report warns that using friends or family as interpreters represents serious risks for while they

may 'speak the same language' they may lack the specialist terminology required to accurately interpret what is being said or be too emotionally involved to interpret impartially. There is also a risk that they may deliberately or inadvertently block out parts of the message to the client or change the client's message.¹⁰

The Kimberley Interpreting Service sends a similar message about the use of friends or family as interpreters in Aboriginal language noting that untrained interpreters can easily make mistakes.¹¹

7. State Coroner of Western Australia, 'Guidelines for Police' (undated) guideline 5.

8. 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 in the brochure: Coroners Court of Western Australia, 'When a Person Dies Suddenly' (August 2007). See also State Coroner of Western Australia, 'Guidelines for Coroners' (undated) guideline 9.

9. Although the Commission is aware that interpreters are sometimes used to obtain statements or witness accounts from family members at a later stage in the investigation process.

10. Commonwealth Ombudsman, 'Use of Interpreters (March 2009) 16.

11. Kimberley Interpreting Service, 'Frequently Asked Questions', <<http://www.kimberleyinterpreting.org.au/faq.html>> (accessed 1 June 2011).

They are not trained to seek clarification about unfamiliar language or obscure terminology and they are not bound by a professional code of ethics. They may inadvertently prompt or give advice to the client, or speak for them.¹²

The Western Australian Language Services Policy dictates the circumstances in which professional or competent interpreters and translators should be used and these include where people:

- need to be informed of their legal rights and obligations;
- need to give informed consent;
- are required to enter into a legally binding contract or agreement with the State and are not required to engage their own interpreter or translator;
- require essential information to fully participate in decisions or proceedings relating to their rights, health and safety; or
- require essential information to protect their rights, health and safety.¹³

The sensitive and emotional context of the notification of a next of kin about their legal rights in the coronial process and the very short window of opportunity they have to exercise those rights makes the accurate delivery of this information very important. It is crucial that police officers do not rely entirely on the translated brochures as the senior next of kin may not be literate in the language of the brochure and may be too traumatised by the recent death or too embarrassed to make that clear to the officer. The same must be said for Coroners Court staff, such as counsellors, who are required to discuss organ retention and may be required to obtain informed consent from a senior next of kin under s 35 of the Coroners Act. Failure to deliver key coronial information with the assistance of an interpreter may constitute a breach of the requirements of s 20(2) of the Coroners Act and guideline 9 of the State Coroner's 'Guidelines for Police'.

It is particularly important, both for informing the senior next of kin of their rights in the coronial process and for the investigation of the death (including at inquest)¹⁴ that Aboriginal

language interpreting services are utilised where they are required and available.¹⁵ Because of the historic relationship of distrust between Aboriginal people and government authorities there is a risk that important information about the death (eg, concerns about hospital care or deaths in police presence) may not be relayed to police. The cultural competency training referred to earlier in this chapter (Proposal 85) should assist police officers and Coroners Court staff to assess the English language proficiency of relevant persons and understand when an interpreter is required.¹⁶ Although on-site interpreting is preferred because of the sensitive context, telephone interpreting services are available for emergency situations and for rural and regional areas where it may be difficult to obtain the services of a qualified interpreter. The Commission anticipates that the Office of the State Coroner and Western Australia Police will plead a lack of resources to fund the provision of interpreters and it appreciates this position; however, the Western Australian Language Services Policy states that:

Government agencies are required to have policies for funding and delivering translating and interpreting services that take account of relevant Government policy, legal circumstances and the needs of current and potential clients. This includes determining situations where interpreters and translators 'must', 'should' or 'may' be used, based on the legislative requirement, particular service provided and/or the level of risk to clients' rights, health or safety.¹⁷

In light of the government's commitment to 'providing accessible and responsive services to all Western Australians'¹⁸ and the important nature of the rights and obligations to be conveyed to next of kin under the Coroners Act, the Commission makes the following proposal.

explored in Chapman S, 'The Coroner's Exercise of Discretion: Are Guidelines Needed' (2008) 12 *Australian Indigenous Law Review* 103, 106-7.

12. Ibid.
13. Office of Multicultural Interests, *Western Australian Language Services Policy* (2008) 9.
14. The problems that can arise when an appropriate interpreter is not provided for families and witnesses at an inquest is

15. For Aboriginal people, especially from remote areas, English may be their second, third or fourth language and they may be unable to comprehend the terminology used in the Coroners Act. The *Western Australian Language Services Policy* warns that 'there is a perception among service providers that Aboriginal people are more fluent in English than many of them actually are', so it is important to avoid assumptions about English language proficiency: *ibid* 7.

16. Questionnaires for assessing the English language proficiency of Aboriginal people and migrants are also appended to the *Western Australian Language Services Policy*, *ibid*, appendix 1.

17. *Ibid* 7.

18. *Ibid*.

Proposal 90

Use of interpreters

1. That, when delivering key information about the coronial process, including the rights of the senior next of kin under the Coroners Act, and when seeking information to assist the coronial investigation, police officers and Coroners Court staff should assess the need for a professional language interpreter and provide such an interpreter if required.
2. That family and friends should not be used to interpret and communicate key coronial information (including the right to object to a post mortem examination) to the senior next of kin, unless all reasonable avenues to obtain a professional language interpreter have been exhausted.
3. That Coroners Court staff should consider the need for provision of an interpreter to assist families to participate in inquest proceedings. The family or their representative should be consulted to ensure that an interpreter in the correct language and dialect is engaged.

Communication of coronial case information

A principal issue driving the introduction of the Coroners Act was inadequate communication between the Coroners Court and families. During parliamentary debates on the Bill it was said that:

People should not have to grovel, write or phone; information should come as of right to them and it should empower them.¹⁹

This was no doubt the intention behind s 20 of the Coroners Act, which sets out the information that must be provided to families. However, the results of the Commission's public survey showed that lack of information about the process continued to be a concerning feature for many people who had dealings with the coronial system. Almost three-quarters (74.5%)

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. When asked, 'What, if anything, could the Coroners Court have done differently to help you through the coronial process?' the replies included:

Regular updates. It is the not knowing what is happening that is hard to deal with.

Communicate more when there are delays in assigning an officer for police investigation. I have had to phone repeatedly.

Communicate in some way – any way – as to the progress of the case. You are just left waiting and haven't any idea when you will get a result.

Returned my phone calls at a bare minimum. Communicated to myself and my family about the progress of the inquest. We received nothing!

More frequent information.

Communication from the Coroner's Office re when (if at all) an inquest was going to be conducted was poor and intermittent. Each year our family would initiate contact; nothing would happen; no progress occurred.

More personal contact rather than just by letter so questions could be asked by me at each stage; eg, by telephone.

Just more information without me having to chase it.

No contact unless initiated by family. At one stage rang coroner weekly for information but nothing in response.

They need to communicate better – why don't they inform people as a matter of course about the progress of the case? The only information I got was when I contacted the coroner to chase it up. Nothing was initiated by them.

Keep you more informed about what is happening. You should not have to phone up all the time for answers.

Communicated!!!!

The frustration of families having such little communication initiated by the Office of the State Coroner is clearly evident in these comments. Usually there is an initial letter from the coroner to the senior next of kin sent within 21 days of the post mortem examination to communicate the cause of death or, if no cause of death has been established, to inform that further testing

19. Western Australia, *Parliamentary Debates*, Legislative Assembly, 19 October 1995, 9498 (Mr Taylor).

will be done.²⁰ A family whose relative has died of natural causes (and where no inquest is to be held) will often have no further communication from the Office of the State Coroner until the administrative finding is completed. At this time a copy of the finding is enclosed with a letter advising that the particulars needed to register the death have been forwarded to the Registrar of Births, Deaths and Marriages. In the context of current delays this correspondence may be several years after the death.²¹ In cases where the cause of death is non-natural (eg, suicide, workplace death, traffic accident, etc) the counselling service will also send a letter to the senior next of kin offering assistance with any queries the family may have in regard to the ongoing investigation. Again, unless special circumstances apply,²² there will usually be no further communication initiated by the Office of the State Coroner until a finding has been made.

It appears that much of the coronial liaison between families and the Office of the State Coroner is done by letter and there may be as few as two contacts initiated by the office during the life of a coronial case. The Commission's public survey showed an overwhelming preference for more immediate communications such as by telephone (42.6%), email (12.8%) and face-to-face meetings (29.8%), with only 6.4% stating letter as their preferred means of communication.²³ It appears from the comments above that the primary reason for preferring more immediate communications is the ability to ask questions and become more informed about the process and the progress of the deceased's case through the coronial system. When the Commission met with the coronial counselling service early in the consultation process, the counsellors stated that this was one area that they would like to see changed.²⁴ They said that they would like to have the ability to contact families more frequently by telephone,

but this was simply not possible because of staffing issues.²⁵ Further, because the coronial counselling unit is understaffed, telephone calls from relatives seeking information are often fielded by clerical staff who, while dedicated and well intentioned, may not be sufficiently trained to deal with questions from grieving families who may also be quite angry about the delay and lack of information from the Office of the State Coroner.

One submission to the Commission's public survey stated that it would be helpful if there was a secure online service that families could access through a password, which notified them of the stage of the process that the deceased's case was at and what stages it had yet to go through. Such a service should anticipate the questions families might have by providing information about what happens at each stage in the process and providing answers to frequently asked questions about each stage. For example, if the progress update shows that the coroner is awaiting toxicology or neuropathology results the site could feature a link explaining why these tests are usually required and how long they would be expected to take in an ordinary case.²⁶ This would appear to be a useful way of helping families to be more informed about their relative's case giving them the option to access the site whenever they felt the need and to avoid talking to somebody if they did not feel up to it. Such a service would also obviously relieve some of the pressure currently placed on clerical and counselling staff of the office who may then be free to deal with those family members who have a need for support rather than information, or for those who do not have access to the internet. The Commission believes this initiative is worth investigating and makes the following proposal.

20. This letter also invites the senior next of kin to contact the coronial counsellor if 'you have concerns about the coronial process or if you wish to discuss the death'.

21. See Chapter Three, 'Impacts of Delay in Death Registration'.

22. A coronial counsellor will contact the senior next of kin by telephone if there is an issue relating to organ retention or the cause of death is particularly sensitive (such as a baby death) or where a post mortem examination has returned an unascertainable cause of death after a long investigation.

23. 8.5% specified other means such as a mix of the listed communication methods.

24. Coronial Counsellors, consultation (22 August 2008).

25. Until earlier this year this service consisted of only two counsellors responsible for the entire state and these counsellors are on call 24 hours a day.

26. It is noted that on introducing the Coroners Bill 1996 into Parliament, the Attorney General said that 'One of the most common concerns expressed by family members who have come into contact with the [coronial] system, relates to the level of involvement in the process. These concerns have mainly related to the lack of information provided about the post mortem procedure': Western Australia, *Parliamentary Debates*, Legislative Assembly, 22 June 1995, 5702 (Ms Edwardes, Attorney General).

Proposal 91

Coronial information service

That the Office of the State Coroner investigate ways to provide families with regular updates about the progress of the deceased's case through the coronial process and accessible information about each stage of the coronial process, including the provision of a secure online service that is able to be accessed by families.

Access to post mortem examination report

Section 26A of the Coroners Act provides:

If the senior next of kin of a deceased person asks a coroner for access to evidence obtained for the purpose of investigating the death, the coroner is to give that person access to that evidence, unless the coroner believes it is not desirable or practicable to do so.

In addition reg 19 of the *Coroners Regulations 1997* (WA) provides that:

- (1) Before the completion of an investigation into a death, a coroner may direct that part or all of the record of the investigation of the death be made available to such persons or class of persons as the coroner directs.
- (2) After the completion of an inquest into a death the coroner's record of the investigation of the death is to be open to public access unless the coroner orders otherwise.

The Commission received a number of submissions from members of the public stating that they wanted better access to documents about their deceased relative, in particular the post mortem examination report. The Commission has been told that families may request to see the post mortem examination report of the deceased. In these situations, the Office of the State Coroner will either invite them to view the report along with the coronial file (which has been 'sanitised' by a coroner to remove photos, internal advice, correspondence and sometimes, personal information) in the company of a counsellor or will offer to fax the post mortem examination report to the person's general practitioner (GP). These arrangements

are made so that families can have assistance in interpreting the post mortem examination report and support in the event that they are upset by the post mortem examination report.

The Commission received two main complaints in relation to this practice. The first related to the qualifications of the coronial counsellors to interpret the post mortem examination reports. In this regard the Commission notes that while the coronial counsellors are not medically qualified (rather, they have social work or psychology qualifications), they do have significant experience in the coronial area. In addition, they have access to the medical adviser to the State Coroner who, in particularly difficult cases, will speak to the family to assist them to understand the post mortem results. The Commission feels that this is appropriate and observes that the family may also seek interpretation of post mortem examination results through their GP if necessary.

The second complaint, which was heard from a number of sources (including community counselling and support services), was that copies of the post mortem examination report were not made available to family either when viewing the file in the office or after consultation with the person's GP. It was argued that after a death, families often wish to 'gather together' all the parts of the deceased's story and the post mortem examination report was seen as an important final part of the story. The Commission appreciates that a post mortem is a medical examination undertaken for coronial purposes and is not, therefore, the property of the family; however, the Commission can see little reason for withholding this report from families after it has been properly explained by a medically qualified person or coronial counsellor. One of the major benefits of a post mortem examination, as promoted by the Office of the State Coroner, is that it may uncover genetic conditions or other medical information that may be relevant to other members of the family. While this information may be relayed to the family by coronial counsellors, the family should be provided with a copy of the report for their records in case this information is sought by future generations.

Section 115(1)(a) of the *Coroners Act 2008* (Vic) provides that, 'unless otherwise ordered by the coroner, the principal registrar must provide the senior next of kin of a deceased person with any reports given to a coroner as a result of a medical examination performed on the deceased'. The Commission believes that a similar section should be enacted in Western Australia. It is noted that in the rare cases where the post mortem examination report is simply too graphic or distressing or contains information that should remain confidential to the deceased, a decision may be made by a coroner to withhold a report.

Proposal 92

Release of post mortem examination report

1. That unless otherwise ordered by the coroner, the Office of the State Coroner must provide the senior next of kin of a deceased person with any reports given to a coroner as a result of a medical examination performed on the deceased.
2. That where a post mortem examination report is sent to a medical practitioner to assist the family of a deceased to interpret the findings, a second copy of the report is to be given to the medical practitioner along with instructions that the medical practitioner is to provide the copy of the report to the family after the contents of the report have been interpreted and explained.

WEBSITE

In addition to a secure online service for families wishing to monitor the progress of their relative's case through the coronial process, there is also a need for a more informative web presence for the Coroners Court. The present website of the Coroners Court provides limited information about the process, which is helpful but is clearly not addressing the needs of families and other users, such as lawyers, researchers and health professionals.²⁷ The Queensland

Coroners Court website is an exemplar of what a quality Coroners Court website should provide.²⁸ It contains fact sheets for families dealing with such matters as burials assistance and what to expect at an inquest as well as links to community counselling and support organisations. It also provides fact sheets addressed to professionals in the healthcare sector and funeral industry, as well as detailed guidelines addressing all aspects of the coronial investigation process. Lawyers are assisted by links to key judicial decisions in the coronial jurisdiction both in Queensland and elsewhere and researchers are catered for by the provision of findings and recommendations in addition to information about the National Coroners Information Service. For family members who are dissatisfied with the outcome of a coronial inquest there is information about what can be done, including a prominently positioned link to the application form for re-opening of an inquest.²⁹

The Victorian Coroners Court website, though not as easy to navigate as the Queensland website, is another good example of provision of information to families and others in the coroner process. In particular the Victorian site provides full findings and responses to recommendations, which the Commission has proposed be available on the Western Australian Coroners Court website.³⁰ In addition, the Victorian site provides copies of rulings made by the State Coroner and other coroners under the Act.³¹ Because coronial matters are rarely appealed, the provision of rulings gives lawyers some indication (and precedent) as to how the court interprets certain aspects of the coronial role and the legislation as well as providing information for journalists about cases in which non-publication orders have been made.

by the Medical Adviser to the State Coroner is a significant advance in the information available to health professionals on the Coroners Court website.

28. Coroners Court Queensland, <<http://www.courts.qld.gov.au/129.htm>> (accessed 4 June 2011).

29. The Commission has proposed that a person may apply to the Coroners Court for an order that some or all of the findings of a coroner be set aside and the investigation or inquest into the death be re-opened in certain circumstances and that a form for such application be created and featured prominently on the Coroners Court website: see Proposals 47 & 48.

30. Proposals 79 & 84.

31. Coroners Court of Victoria, 'Case Rulings' <<http://www.coronerscourt.vic.gov.au/wps/wcm/connect/justlib/Coroners+Court/Home/Case+Rulings/>> (accessed 5 June 2011).

27. Although the Commission notes that the recently uploaded Handbook for Medical Practitioners and Students compiled

One submission to the Commission's public survey suggested that 'a run-through court visit to introduce the process of an investigation' would assist in helping families to understand the coronial process. While this may represent an unreasonable burden on the court's resources, the South Australian Coroners Court website provides a useful virtual tour which enables people (through photographs and text) to familiarise themselves with the court and registry as well as the people (such as counsel assisting) that they might encounter at an inquest and their role.³² Such a feature would be easy to provide on the Coroners Court website and would clearly assist people to understand what to expect from an inquest and also to know in advance what the building and courtroom look like.

Another submission, from a journalist, stated that 'reporting coronial matters is part of the idea of open justice; however, it is very difficult to get detailed information from the court regarding upcoming inquests'. The Commission notes that the Coroners Court relies upon the media, to a significant extent, to assist in spreading the death prevention messages that can come out of inquests, including following up on whether coronial recommendations have been implemented by government agencies. Unlike other Western Australian courts there is no public information officer who can deal with queries from media, so journalists must take up the valuable time of Coroners Court staff to discover the most basic of public information, such as what is listed for inquest. In an office where the human resources are apparently already stretched to their limit this is an unnecessary burden placed upon staff, and yet it is one that can be so easily removed. As discussed elsewhere in this Paper,³³ the present website of the Coroners Court appears to be very infrequently updated; in particular, the inquest list page has not been updated for at least 18 months.³⁴ Obviously this must be updated on a regular basis to assist all

32. Coroners Court of South Australia, <<http://www.courts.sa.gov.au/courts/coroner/index.html>> (accessed 5 June 2011).

33. See, eg, Chapter Five, 'Notification of Inquest'.

34. At the time of writing the page only featured inquests for January and February 2010: Coroners Court of Western Australia, 'Court Lists', <http://www.coronerscourt.wa.gov.au/C/court_lists.aspx?uid=3561-7318-3097-8183> (accessed 4 June 2011).

users of the coronial system to be aware of court dates as far in advance as possible. The Commission has already dealt with this matter in Chapter Five (Proposal 67).³⁵ The Queensland Coroners Court website also provides additional information about upcoming inquests through notices for pre-inquest hearings. An example of such a notice, detailing the matters to be investigated at inquest, can be found in Chapter Five³⁶ and the Commission proposes that such notices also be published on the Coroners Court website in Western Australia (Proposal 68). Using the Coroners Court website to publish basic information about upcoming inquests will satisfy the needs of journalists as well as provide essential information for family, witnesses, lawyers and interested parties who may be able to inform the coroner's findings and recommendations.

Proposal 93

Coroners Court website

1. That the Office of the State Coroner review the content of Coroners Court websites in Queensland, South Australia and Victoria with a view to improving the Coroners Court website in Western Australia.
2. That the Coroners Court website provide, at a minimum, information sheets for families, healthcare professionals, witnesses, researchers and lawyers; copies of all State Coroner's guidelines and public forms; regularly updated inquest and pre-inquest hearing lists including, where practicable, information about the matters to be investigated at the inquest; copies of coronial findings, comments and recommendations following an inquest; responses to coronial recommendations; and links to community counselling and support organisations.

35. See Chapter Five, 'Notification of Inquest'.

36. See Chapter Five, 'Pre-Inquest Hearings'.

GUIDELINES AND FORMS

State Coroner's guidelines

Section 58 of the Coroners Act provides:

- (1) The State Coroner must issue guidelines with respect to the principles, practices and procedures of the State coronial system, but those guidelines must not be inconsistent with this Act or any other written law.
- (2) Without limiting the generality of subsection (1), the State Coroner may issue guidelines relating to—
 - (a) the administration of the State coronial system;
 - (b) forms that are to be used and the circumstances when a particular form is appropriate;
 - (c) the general desirability of enabling any next of kin of the deceased under section 37(5) to view and to maintain as much contact with, and control over, the body as is practicable;
 - (d) the establishment and functions of an advisory ethics committee;
 - (e) the functions of coroners, coroner's clerks and coroner's investigators and the manner in which those functions are to be carried out;
 - (f) tissue removed under section 34(2).

As part of its research for this reference, the Commission asked the Coroners Court to provide a copy of all guidelines issued by the State Coroner pursuant to s 58 of the Coroners Act. The Commission received guidelines directed to police, corrective services employees (for deaths in custody), coroners and metropolitan body transport contractors.³⁷ With the exception of the guidelines for body transport contractors, all guidelines were created in 1997 and have not been updated since that time.³⁸ Notably, although the State Coroner is obliged to issue guidelines under s 58(1) with respect to the principles, practices and procedures of the state coronial system, there are no guidelines directed to lawyers,

37. The Commission was also given a copy of some 'Additional Guidelines for Coroners Court Staff' dated 19 July 2004; however, the Office of the State Coroner was unable to locate the original guidelines for Coroners Court staff to which these were additional.

38. Manager, Office of the State Coroner (WA), email (9 March 2011). The 'Guidelines for the Contractor Administering the Contract for Removal of Bodies to Morgues in the Perth Metropolitan Area' were issued in August 2002. The Commission also has a copy of some 'Additional Guidelines for Police attached to the Coroners Court' dated July 2004.

witnesses or others appearing in the Coroners Court.³⁹ In a jurisdiction where both the State and Deputy State Coroners have bemoaned the lack of understanding of coronial practice and procedure by lawyers trained in the 'traditional adversarial system' this would appear to be a missed opportunity.⁴⁰

Proposals have been made throughout this Paper for review and updating of the State Coroner's guidelines, as well as matters that should be dealt with which are not currently addressed in guidelines.⁴¹ These include:

- guidelines for police investigating possible mental health-related deaths;⁴²
- guidelines to assist healthcare professionals and others to determine whether a death is a reportable death;⁴³
- guidelines outlining the circumstances in which a coroner may authorise a medical practitioner to issue a cause of death certificate in relation to a reportable death;⁴⁴
- guidelines that specify by example the types of cases that fall into the definition of 'person held in custody' and 'person held in care' in the Coroners Act;⁴⁵
- guidelines to assist coroners in the exercise of their discretion as to whether or not to hold an inquest and the matters to be considered by coroners in the exercise of their discretion as to whether or not to hold a joint inquest;⁴⁶ and
- guidelines relating to the conduct of inquests and pre-inquest hearings and the use of concurrent expert evidence in the Coroners Court.⁴⁷

As noted throughout this paper, currently the Western Australian State Coroner's guidelines are not public and, as a result, not all people who should be aware of them (including regional

39. Unlike other courts, practice directions issued by the State Coroner appear generally to be addressed to internal staff and relate to such matters as listings and access to inquest files. None of the practice directions are available publicly.

40. State Coroner and Deputy State Coroner, consultation (20 August 2008). For further discussion, see Chapter Two, 'An Inquisitorial Jurisdiction'.

41. See, eg, Proposals 18, 19, 22, 26, 37, 56, 61, 71 & 73.

42. Proposal 18

43. Proposal 19.

44. Proposal 22.

45. Proposal 56.

46. Proposals 61 & 64.

47. Proposals 71 & 73.

coroners) have knowledge of their existence. The Commission raised this issue in its 2005 Discussion Paper on Aboriginal customary laws where it proposed that a dedicated website be established for the Coroners Court to enable public access to coronial guidelines, procedures, protocols and findings.⁴⁸ Following the release of the Discussion Paper, the current Coroners Court website was established; however, coronial guidelines were never placed on the website and the findings that were available have since been taken down.⁴⁹ In response to this Discussion Paper, the State Coroner formally submitted to the Commission that all coronial guidelines will be available on the site 'in the near future'.⁵⁰ Taking this advice at face value the Commission wrote in its Final Report:

Undoubtedly there is a need to update the guidelines and this is the reason for the delay [in placing the guidelines on the Coroners Court website]. The Commission is satisfied that access to coronial guidelines will be available on the Coroners Court website in the near future and suggests that a link to relevant legislation on the State Law Publisher's website also be included. The Commission does not feel that it is necessary to formalise its proposal in light of these developments.⁵¹

Over five years have passed since the State Coroner made that submission to the Commission and the guidelines have neither been updated nor placed on the Coroners Court website. The Commission therefore reiterates its 2005 proposal that the guidelines be made publicly available. In addition, the Commission proposes that all guidelines be reviewed, updated and added to in the manner described in proposals throughout this Discussion Paper. The Commission commends the Queensland State Coroner's Guidelines as a model for issues that coronial guidelines should cover. The Queensland State Coroner's Guidelines are consolidated in a document that is publicly available from the Queensland Coroners Court website.⁵²

48. LRCWA, *Aboriginal Customary Laws*, Project No 94, Discussion Paper (December 2005) Proposal 59.

49. For discussion, see Chapter Five, 'Publication of Inquest Findings, Comments and Recommendations'.

50. Alastair Hope, State Coroner, Project No 94, Submission No 6 (7 March 2006) 5.

51. LRCWA, *Aboriginal Customary Laws*, Project No 94, Final Report (September 2006) 256.

52. Queensland State Coroner's Guidelines (December 2003) <<http://www.courts.qld.gov.au/Factsheets/M-OSC-StateCoronersGuidelines.pdf>> (accessed 15 February 2010).

Proposal 94

State Coroner's guidelines: review, update and publish

1. That, in addition to issuing guidelines about the specific matters addressed in proposals throughout this Discussion Paper, the State Coroner review and update all existing guidelines and consider guidelines that should be made to discharge the obligation under s 58(1) of the Coroners Act.
2. That, at the earliest opportunity, all State Coroner's guidelines be publicly available for download from the Coroners Court website.

Coronial forms

There are a number of forms used in the coronial jurisdiction in Western Australia,⁵³ however, none appear to have been created for the use of senior next of kin or others when exercising rights under the Act. Both the Queensland and Victorian Coroners Court websites provide a comprehensive set of forms for the public and others involved in the coronial process (such as funeral directors). The Commission has proposed in this paper that forms be developed for, among other things, affidavits for use in coronial investigations and for application to the court for an investigation or inquest to be re-opened. In the Commission's opinion, forms that are for the use of the public or coronial related professions should be available for download on the Coroners Court website. Forms that should be developed for public use or otherwise made available on the website should include forms for:

- applying for an inquest to be held;⁵⁴
- applying for an investigation or inquest to be re-opened by the coroner;⁵⁵
- requesting that a post mortem examination be ordered;⁵⁶

53. See, eg, the forms appended to the *Coroners Regulations 1997* (WA).

54. *Coroners Act 1996* (WA) s 24(1).

55. Proposal 47.

56. *Coroners Act 1996* (WA) s 36 and *Coroners Regulations 1997* (WA) reg 8.

- requesting that an independent doctor be present at the post mortem examination;⁵⁷
- affidavits for use in the coronial jurisdiction;⁵⁸
- objecting to an exhumation;⁵⁹
- applying for leave to appear as an interested person;
- applying for approval from the Coronial Ethics Committee to access coronial records or data; and
- applying for release of a body and for permission to cremate or bury a body.

A number of other forms that may not be required to be made publicly available on the website will also need to be reviewed or developed as a consequence of the Commission's proposals, including the Death in Hospital and Medical Cause of Death forms; the National Police Form; requests for documents or prepared statements; and the record of coronial investigation into death.

Proposal 95

Coronial forms

1. That forms to assist families and others to exercise their rights or discharge their obligations under the Coroners Act be developed and made available on the Coroners Court website.
2. That forms to assist professionals (including lawyers, medical practitioners and funeral directors) in their dealings with the coronial system be developed and made available on the Coroners Court website.

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

58. Proposal 75.

59. *Coroners Act 1996* (WA) s 38(3) and *Coroners Regulations 1997* (WA) reg 11.

Post mortem rights and issues

SENIOR NEXT OF KIN

Senior next of kin is an important concept in the *Coroners Act 1996* (WA) ('the Coroners Act'). It governs who of a deceased person's family may exercise certain substantive rights under the Coroners Act. Section 37(5) provides that the senior next of kin in relation to the deceased person 'means the first person who is available from the following persons in the order of priority listed'—

- (a) a person who, immediately before death, was living with the person and was either—
 - (i) legally married to the person; or
 - (ii) of or over the age of 18 years and in a marriage like relationship (whether the persons are different sexes or the same sex) with the person;
- (b) a person who, immediately before death, was legally married to the person;
- (c) a son or daughter, who is of or over the age of 18 years, of the person;
- (d) a parent of the person;
- (e) a brother or sister, who is of or over the age of 18 years, of the person;
- (f) an executor named in the will of the person or a person who, immediately before the death, was a personal representative of the person; or
- (g) any person nominated by the person to be contacted in an emergency.¹

In its reference on Aboriginal Customary Laws the Commission considered the definition of senior next of kin as it relates to Aboriginal people. The Commission observed that the above definition of senior next of kin follows a Western family construct and does not allow for the broader notion of Aboriginal kinship or for recognition of senior kin under Aboriginal customary law.² It was noted that the Coroners Acts of the Australian Capital Territory,

1. The *Coroners Act 1996* (WA) s 59(2)(c) provides that regulations may prescribe 'who is to be the "senior next of kin" in prescribed circumstances or in relation to a prescribed group or class of persons'. However, no regulation has ever been made under this section.
2. LRCWA, *Aboriginal Customary Laws: Discussion Paper*, Project No 94 (December 2005) 306–7.

Queensland, Tasmanian and Northern Territory embrace a broader concept of family, providing specifically for Aboriginal and Torres Strait Islander cultural concepts of kin.³ Submissions were sought on whether there was a need to amend the definition of senior next of kin in the Coroners Act to allow for a person to apply to the coroner to be recognised as senior next of kin having regard to the Aboriginal customary law of the deceased.⁴

The State Coroner argued against any amendment on the basis that any legislative change to the definition of senior next of kin could have significant negative impact upon the certainty of the current system.⁵ His submission to the Commission's Aboriginal customary laws reference stated that he had sought the views of Aboriginal people, but that the response he consistently received was that the list provided in the s 37(5) definition was considered to be acceptable. He stated that he 'received no indication from any person to the effect that the list should be changed or that there was an important need to recognise a different person in the order of priority'.⁶ It was also pointed out by the State Coroner that:

It is usually only in cases where there is a dispute among family members when there is a significance in determining who is to be the senior next of kin and in these cases there is often a dispute as to the extent to which customary law applies.⁷

The Commission agreed that a change to the legislative definition to accommodate persons of significance under the deceased's customary

3. *Coroners Act 1997* (ACT) s 3; *Coroners Act 2003* (Qld) sch 2; *Coroners Act 1995* (Tas) s 3; *Coroners Act 1993* (NT) s 3.
4. LRCWA, *Aboriginal Customary Laws*, Discussion Paper, Project No 94 (December 2005), Invitation to Submit 11. The Commission's invitation to submit was based on a recommendation of the 1999 Chivell review of the Coroners Act: Chivell W, *Report on Review of the Coroners Act 1996* (WA) (May 1999) 23.
5. Office of the State Coroner, 'Response to Report on the Review of the Coroners Act 1996 (WA)' (30 August 1999) 3.
6. Alastair Hope, State Coroner, Project No 94, Submission No 6 (7 March 2006) 4.
7. *Ibid* 5.

law would not assist in resolving intra-family conflict and may indeed inflame such disputes at a time of heightened emotions associated with grief. Ultimately, the Commission was convinced by submissions received from both the State Coroner and the Deputy State Coroner that the Coroners Court appreciates the nature of the Aboriginal kinship system and that, in practice, the views of extended family members are taken into account.⁸ The Commission also recognised the importance of having legislative certainty about the identity of the senior next of kin to facilitate police in advising the right person of a death and in ensuring that that person is aware of his or her rights in the coronial process. Since it received no submissions from Aboriginal people commenting on this matter, the Commission determined that it was not appropriate to recommend amendment to the definition of senior next of kin. However, the Commission did recommend that generally, peoples' cultural, spiritual or customary beliefs should be taken into account by coroners when deciding whether to order a post mortem examination⁹ and this recommendation is reiterated below.¹⁰

RIGHT TO VIEW AND TOUCH THE DECEASED

Section 30(2) of the Coroners Act provides that:

While a body is under the control of the coroner investigating the death, the coroner is to ensure that any of the deceased person's next of kin under section 37(5) who wish to view the body are permitted to do so and any of those persons who wish to touch the body are permitted to do so, unless the coroner determines that it is undesirable or dangerous to do so.

The Commission understands that it is relatively rare for a coroner to make an order directing that the deceased's body may not be touched. Such orders will, however, be made in some cases of potential homicide (where evidence may be contaminated by permitting family to touch the deceased) and in cases where infection or putrefaction dictates that it is unsafe to touch

the body. In these circumstances families will usually be permitted to view the body through the mortuary glass window.¹¹ The Commission heard from a victims' advocate that viewings from behind mortuary glass can be very traumatic for families who have lost a loved one to homicide.¹² It was suggested that there was a need for coronial counsellors to be available to better prepare families for the viewing or identification, to talk them through the reasons why the body cannot be touched and to enable them to view the body without the impediment of glass. It was noted that in some jurisdictions a waist-high barrier or partition was used in these circumstances so that the family could be in the presence of the deceased without the ability to touch them.

Although s 30(2) states that any of the deceased's next of kin, as set out in s 37(5), who wish to view the body must be permitted to do so, the Commission was told that in circumstances where a family is divided (eg, where the deceased has a de facto partner that is not accepted by the family or where a separation has occurred) some next of kin have been excluded from viewing the deceased.¹³ In these types of cases a mortuary viewing may be the only chance for such next of kin to say farewell to the deceased, especially if they are not included in the family's funeral arrangements. It was suggested that the Office of the State Coroner ensure that staff at the state mortuary are made aware of the requirements under s 30(2) to ensure that all next of kin are permitted to view the body. Such viewings must, of course, be done within the hours allocated by the state mortuary.

Another issue raised during consultations by a regional body transport contractor was the conduct of mortuary viewings in regional areas.¹⁴ In some areas the body transport contractor is well known as a funeral director (sometimes the only funeral director in the area) and is one of few people who have access to the hospital morgue. In these circumstances body transport contractors may be approached

8. Ibid 4–5; Evelyn Vicker SM, Deputy State Coroner, Project No 94, Submission No 19 (27 April 2006) 8–10.
9. LRCWA, *Aboriginal Customary Laws*, Final Report, Project No 94 (September 2006) recommendation 76.
10. See 'Factors to Consider in Ordering a Post Mortem Examination', below.

11. Although it is noted that not all mortuaries or morgues are equipped with a viewing room.
12. Ann O'Neill, Angelhands, consultation (21 August 2008).
13. Lynnette Gillam, CEO, The Compassionate Friends WA, consultation (5 January 2011).
14. Fay Zavazal, Okuri Funeral Services, Broome, consultation (20 July 2010).

by families to organise viewings at the hospital morgue before a body is transported to Perth for post mortem examination. In addition, the Commission understands that regional police sometimes ask body transport contractors to conduct viewings for the families. To the Commission's knowledge such viewings are not covered by the body transport contract and body transport contractors are not paid for this service. Further, no written requests for viewings are generally given to the contractor to show whether a coroner has determined that it is 'undesirable or dangerous' to permit family to touch the body.¹⁵ The Commission proposes that the Office of the State Coroner immediately review its arrangements for viewing and touching of bodies while under the control of the coroner in regional area morgues.

Proposal 96

Viewing and touching the deceased

1. That the Office of the State Coroner ensure that staff at the state mortuary are aware that all next of kin are permitted to view and touch the body of a deceased while the body is under the control of the coroner, unless the coroner determines that it is undesirable or dangerous to do so.
2. That the need for greater availability of coronial counsellors for families viewing or identifying coronial deceased be recognised and resourced.
3. That in cases where touching the deceased is not permitted consideration be given, where appropriate, to allowing families to decide whether they would prefer to view the deceased through glass or from behind a barrier.
4. That the Office of the State Coroner review the arrangements for viewing and touching of bodies while bodies are under the control of the coroner in regional area morgues including, the inclusion in contracts for body removal and transport of a separate fee for conducting a viewing and the provision of written authority to anyone requested or required to conduct a viewing.

15. Fay Zavazal, Okuri Funeral Services, Broome, consultation (20 July 2010).

POST MORTEM EXAMINATION

An integral part of many coronial investigations is the post mortem examination, which is undertaken at PathWest in Perth.¹⁶ Under s 34 of the Coroners Act if a coroner 'reasonably believes that it is necessary for an investigation of a death, the coroner may direct a pathologist or a doctor to perform a post mortem examination on the body'. As discussed in Chapter Four, in the vast majority of coronial cases, unless there has been a successful objection lodged by the senior next of kin, a full (that is, internal) post mortem examination will be performed.¹⁷ Pursuant to s 35 of the Coroners Act the senior next of kin has a right under the Coroners Act to ask the coroner to allow an independent doctor to be present at the post mortem examination.¹⁸

Under s 36 of the Coroners Act any person may request that the coroner direct that a post mortem examination be performed on the body. Such a request must be in writing and specify the reason why a post mortem examination is sought.¹⁹ If the coroner refuses the person's request, written reasons must be given to the person and to the State Coroner.²⁰ The person may then apply to the Supreme Court for de novo review of the coroner's decision. Sections 36(3)–(4) govern the review process:

- (3) Within 2 clear working days after receiving notice of a refusal, or before the end of any extension of time granted by the Supreme Court, the person may apply to the Supreme Court for an order that a post mortem examination be performed.
- (3a) The Supreme Court may grant an extension of time within which a person may apply to the Court for an order that a post mortem examination be performed if it is satisfied that exceptional circumstances exist so that it is necessary or desirable in the interests of justice to grant the extension.

16. Chapter Four, 'Forensic Medical Investigation'.

17. For a description of what a full post mortem examination involves, see Chapter Four, 'Forensic Medical Investigation: Post mortem examination'.

18. This right (along with other rights regarding the post mortem examination) is communicated to the next of kin via the coroner's brochure 'When a Person Dies Suddenly': see Appendix C. The Commission understands that this right is rarely exercised.

19. *Coroners Regulations 1997* (WA) reg 8.

20. *Coroners Act 1996* (WA) s 36(2).

- (4) If the Supreme Court is satisfied that it is desirable in all the circumstances, it may make an order—
- (a) directing the State Coroner to require a pathologist or a doctor to perform a post mortem examination; and
 - (b) prohibiting burial, cremation or other disposal of the body until the post mortem examination has been conducted, or, if the body has been buried, directing that the body be exhumed.

The Commission has reviewed the provisions of the Coroners Act in respect of requesting a post mortem examination and Supreme Court review of a coroner's refusal to order a post mortem examination. In the Commission's opinion these provisions are appropriate and do not require change.

External or preliminary post mortem examinations

Western Australia has a very high autopsy rate with the Chief Forensic Pathologist estimating that up to 95% of coronial cases are subject to a full internal post mortem examination.²¹ In other states the number of coronial cases subject to a full post mortem examination is generally between 70% and 75%.²² The very high rate of internal autopsies in Western Australia has implications on available resources (both economic²³ and human²⁴) and may also impinge

21. Dr Clive Cooke, Chief Forensic Pathologist, consultation (26 November 2009). As discussed below, the only circumstances in which a coronial deceased will not be subject to full internal post mortem examination in Western Australia is when an objection has been made by the senior next of kin.
22. Carpenter B, et al, 'Issues Surrounding a Reduction of Internal Autopsy in the Coronial System' (2006) 14 *Journal of Law and Medicine* 199, 206. The percentage of coronial deaths where the body was subject to full internal post mortem examination in 2001 were 71.4% in New South Wales and 74.6% in Victoria. These jurisdictions have since gone through coronial reforms to introduce less invasive procedures that will have more than likely reduced these figures further. Since coronial reforms in Queensland the percentage has dropped from 95% to just under 70%: Carpenter B, et al, 'The Coronial System in Queensland: The effects of new legislation on decision-making' (2008) 16 *Journal of Law and Medicine* 458, 465.
23. The Commission notes that the significant cost for conducting post mortem examinations is currently taken from the Coroners Court budget and that this is an issue for the Coroners Court, both in respect of adequacy of the budget and of management of that budget consuming human resources in the Coroners Court. The Commission understands that in most other Australian jurisdictions the budget for pathology in coronial cases is separate from the Coroners Court: Manager, Office of the State Coroner (WA), email (12 June 2011).
24. Forensic pathologists are medical doctors who have undertaken significant postgraduate training. The Commission was informed that there are as few as 40 forensic pathologists in Australia. It is understood that there are currently five forensic pathologists in Western Australia with two nearing retirement age. During consultations the Chief Forensic Pathologist advised that to maintain routine levels of post mortem examination for coronial cases five-and-a-half

on the cultural and religious beliefs of Western Australians. It has been argued that because of their lack of medical background (and sometimes lack of experience in death investigation) there is an over-reliance by legally trained coroners on internal post mortem examination to support coronial investigations.²⁵ It has further been argued that this prioritisation of medical over legal evidence can discourage the gathering of evidence to establish circumstances of death.²⁶

As noted above, s 34 requires the coroner to base his or her direction to perform a post mortem examination on whether such examination is reasonably believed to be necessary for the investigation of a death. However, it appears in practice that, unless there is an objection to post mortem examination under s 37, there is a presumption of a full internal post mortem examination in all cases and no consideration is given to whether the cause of death can be determined without an internal examination.²⁷ This is despite the observations of the State Coroner that 'it is a rare case in which there are no external factors which would give some insight into a likely cause of death'.²⁸

During consultations the question was raised whether an internal post mortem examination was required in every case given the trend toward less invasive post mortem examination procedures in other jurisdictions.²⁹ This was also a matter highlighted by the Barnes report.³⁰ The *Coroners Act 2008* (Vic) provides that if a coroner sends a deceased body to a forensic pathologist that action authorises the forensic pathologist to perform a preliminary

- forensic pathologists were required: Dr Clive Cooke, Chief Forensic Pathologist, consultation (26 November 2009).
25. Carpenter B, et al, 'The Coronial System in Queensland: The effects of new legislation on decision-making' (2008) 16 *Journal of Law and Medicine* 458, 459; United Kingdom, Death Certification and Investigation in England, Wales and Northern Ireland: The report of a fundamental review ('the Luce Report'), Final Report (Cmd 5831, June 2003) 19.
26. Carpenter B, et al, 'Issues Surrounding a Reduction of Internal Autopsy in the Coronial System' (2006) 14 *Journal of Law and Medicine* 199, 207.
27. Directions to conduct a post mortem examination under s 34 are presently delegated to coroner's registrars with coroners only becoming involved if an objection to post mortem examination is received. There is effectively a standing direction to order a full internal post mortem examination in all cases once the objection period has passed: Manager, Office of the State Coroner, consultation (9 June 2011).
28. Office of the State Coroner, *Annual Report 2007-2008* (2008) 7.
29. Most notably Queensland, Victoria and New South Wales: see 'Use of less-invasive post mortem procedures', below.
30. Barnes M, *Review of the Coroners Act 1996* (WA) (August 2008) 25.

examination on the deceased.³¹ Preliminary examination is defined as any of the following procedures:

- (a) a visual examination of the body (including a dental examination);
- (b) the collection and review of information, including personal and health information relating to the deceased person or the death of the person;
- (c) the taking of samples of bodily fluid including blood, urine, saliva and mucus samples from the body (which may require an incision to be made) and the testing of those samples;
- (d) the imaging of the body including the use of computed tomography (CT scan), magnetic resonance imaging (MRI scan), x-rays, ultrasound and photography;
- (e) the taking of samples from the surface of the body including swabs from wounds and inner cheek, hair samples and samples from under fingernails and from the skin and the testing of those samples;
- (f) the fingerprinting of the body;
- (g) any other procedure that is not a dissection, the removal of tissue or prescribed to be an autopsy.

In practice, in Victoria, a CT scan of the deceased is performed in all cases.³² A forensic pathologist then 'examines the deceased and the CT scans, as well as available records and police reports, and advises the coroner as to whether an autopsy is necessary'.³³ In Queensland a similar process is used and the coroner places significant emphasis on the provision of detailed information from police about the scene and circumstances of the death.³⁴ This information is reported to the coroner on the Queensland equivalent of the national police form. The Commission has proposed that such a form be adopted in Western Australia to ensure that as much initial information as possible is gathered about the circumstances of the death to inform the decision-making of the coroner.³⁵ In addition, the Commission has highlighted the need for the timely provision of a deceased's medical records to the forensic

31. *Coroners Act 2008* (Vic) s 23(2).

32. See Victorian Institute of Forensic Medicine, <<http://www.vifm.org/forensics/medico-legal-death-investigation/what-happens-when-someone-is-admitted-to-the-vifm/>> (accessed 8 June 2011).

33. *Ibid.*

34. Carpenter B, et al, 'The Coronial System in Queensland: The effects of new legislation on decision-making' (2008) 16 *Journal of Law and Medicine* 458; Carpenter B, et al, 'Issues Surrounding a Reduction of Internal Autopsy in the Coronial System' (2006) 14 *Journal of Law and Medicine* 199, 205.

35. See Proposal 27.

pathologist to inform his or her advice to the coroner regarding the need for a full internal post mortem examination following an initial external examination.³⁶

Taking into account all these matters and the developments in Australian jurisdictions that have undergone recent coronial reform, the Commission proposes that a coroner may order that an external post mortem examination be performed, either as a preliminary examination to inform the coroner's decision whether to direct that an internal post mortem examination be performed or as a complete post mortem examination. The Commission reiterates that the decision whether to order an internal post mortem examination remains the sole responsibility of the coroner and will be taken on the best advice available from the forensic pathologist and after having considered the factors set out in Proposal 99.

Proposal 97

Coroner may order external or preliminary post mortem examination

1. That a coroner may direct a forensic pathologist or doctor to perform an external post mortem examination for the purposes of determining, if possible, a medical cause of death.
2. That a coroner may direct a forensic pathologist or doctor to perform a preliminary post mortem examination to assist the coroner to determine whether or not to order a full internal post mortem examination or to perform any other function in respect of the death.
3. That an external post mortem examination and a preliminary post mortem examination be defined as:
 - (a) a visual examination of the body (including a dental examination);
 - (b) the collection and review of information, including personal and health information relating to the deceased person or the death of the person;

36. See Chapter Four, 'Provision of Information to Forensic Pathologists'.

- (c) the taking of samples of bodily fluid including blood, urine, saliva and mucus samples from the body and the testing of those samples;
- (d) the imaging of the body including the use of computed tomography (CT scan), magnetic resonance imaging (MRI scan), x-rays, ultrasound and photography;
- (e) the taking of samples from the surface of the body including swabs from wounds and inner cheek, hair samples and samples from under fingernails and from the skin and the testing of those samples;
- (f) the fingerprinting of the body;
- (g) any other procedure that is not a dissection, the removal of tissue or prescribed by regulation to be an internal post mortem examination.

Use of less-invasive post mortem procedures

Imaging technology has advanced significantly in recent years, but it appears to be far less used in Western Australia than in other jurisdictions to determine whether a cause of death can be determined without resort to a full internal post mortem examination. Western Australia's Chief Forensic Pathologist has made clear that in his opinion all coronial deceased should be subject to a full internal post mortem examination.³⁷ He argued that a less than full examination could only ever provide a cause of death expressed in terms of being 'consistent with' (eg, 'consistent with hanging', 'consistent with carbon monoxide poisoning' or 'consistent with stroke').³⁸

While the Commission acknowledges that a full internal post mortem examination is the optimal method for establishing a medical cause of death, it does not necessarily follow that the information gained from less-invasive procedures such as scans, x-rays, toxicology and histopathology³⁹ will return a less-precise

37. Dr Clive Cooke, Chief Forensic Pathologist, PathWest, consultation (19 August 2008)

38. *Ibid.*

39. For example, of biopsied cells or tissue taken in a preliminary post mortem examination procedure.

finding in every case. An examination of Western Australian post mortem examination findings on the National Coroners Information Service database shows that there are many cases of internal post mortem examination that return a 'consistent with' finding. The Commission acknowledges that the use of less-invasive procedures is a compromise, but in cases that appear non-contentious if the data that can be provided by a limited examination are sufficient for the coronial purpose the least-invasive procedure should be considered as an option. Such an approach, which shows respect for the dignity of the deceased and for his or her cultural and religious beliefs,⁴⁰ has been enshrined in legislation in New South Wales.⁴¹ In the Commission's opinion, Western Australia should follow the New South Wales example and it makes the following proposal.

Proposal 98

Conduct of post mortem examinations

That the following principles governing the conduct of a post mortem examination be inserted into the Coroners Act:

1. When a post mortem examination or other examination or test is conducted on the remains of a deceased person under this Part, regard is to be had to the dignity of the deceased person.
2. If more than one procedure is available to a person conducting a post mortem examination to establish the cause and manner of a deceased person's death, the person conducting the examination is to endeavour to use the least invasive procedures that are appropriate in the circumstances.
3. Without limiting subsection 2, examples of procedures that are less invasive than a full post mortem examination of the remains of a deceased person include (but are not limited to) the following:

40. The Commission notes the submission of the Jewish Community Council of Western Australia which stated that the practice of external examinations, including radiological examinations and blood tests, to establish (where possible) a cause of death 'would naturally be the preferred method as far as the Jewish community is concerned': Jewish Community Council of Western Australia (Inc), submission (26 February 2011).

41. *Coroners Act 2009* (NSW) s 88.

- (a) an external examination of the remains;
- (b) a radiological examination of the remains;
- (c) blood and tissue sampling; and
- (d) a partial post mortem examination.

Factors to consider in ordering a post mortem examination

Unlike other jurisdictions – notably New Zealand and Queensland⁴² – there is currently no statutory guidance for Western Australian coroners considering whether to direct that a post mortem examination be conducted. Limited guidance is contained in the State Coroner’s guidelines as follows:

In deciding whether a post mortem examination should be conducted, a Coroner must take 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.

A coroner should also take account of any known views of any other relatives of the deceased and any person who, immediately before death, was living with the deceased.⁴³

In the context of its Aboriginal customary laws reference, the Commission explored whether these guidelines were sufficient to provide assurance that the cultural, spiritual and customary views of the deceased and the deceased’s family were considered in a determination whether or not to order an internal post mortem examination.⁴⁴ In its Final Report on that reference the Commission noted that commentators had stressed that internal administrative guidelines, such as the ones relied upon in Western Australia, are not acceptable because they ‘may easily be changed without public knowledge’, in particular in circumstances where such guidelines are

not publicly available.⁴⁵ The Commission therefore recommended that there be a legislative requirement that coroners consider any known or communicated cultural, spiritual or customary beliefs of the deceased or the deceased’s family in deciding whether or not to order a post mortem examination.⁴⁶ It was observed that, if nothing else, such a direction would make it clear to the family of a deceased that their cultural and spiritual beliefs had been considered in the decision-making process and that currently a family must pursue an overruled objection through the Supreme Court to obtain the same assurance.⁴⁷ The Commission made clear that the same principles apply to the cultural and religious beliefs of all deceased and their surviving relatives.⁴⁸

In its *Review of the Coroners Act 1985*, the Victorian Parliamentary Law Reform Committee (VPLRC) summarised a number of cultural and religious beliefs that might impact upon a determination to order a post mortem examination.

Some members of the community have particular cultural or religious prohibitions on autopsies. For example, Aboriginal customary law may prohibit the mutilation of the body so as not to harm the spirit of the deceased. Jewish, Islamic, Taoist-Buddhist, Hmong and certain indigenous beliefs entail the need for speedy burial of the person who died. Jewish religion views surgical autopsy as a violation of the sanctity of the body. Jewish customary law also requires a specially appointed guardian to attend the deceased until burial. Under Islamic precepts the body of the person who died must be handled with the utmost respect and should only be handled by a person of the same sex. Fijians traditionally view post-mortems as unthinkable and believe the dead should not be tampered with. Samoans and Tongans regard autopsies as an indignity to the person who died. Buddhists believe in reincarnation and therefore many will want the body to be kept ‘whole’ so that it will be reborn complete. These are examples of some of the cultural issues that may arise in relation to autopsies. Many other ethnic groups also have strong feelings about the intrusion on a community member’s body that an autopsy

42. *Coroners Act 2006* (NZ) s 30; *Coroners Act 2003* (Qld) s 19(5).

43. Coroner’s Court of Western Australia, ‘Guidelines for Coroners’ (undated) guidelines 12 and 13.

44. LRCWA, *Aboriginal Customary Laws: The interaction of Western Australian law with Aboriginal law and culture*, Project No 94, Final Report (September 2006) 253-55.

45. Ibid 254, citing Vines P & McFarlane O, ‘Investigating to Save Lives: Coroners and Aboriginal deaths in custody’ (2000) 4(27) *Indigenous Law Bulletin* 8, 12.

46. LRCWA, *ibid*, recommendation 76.

47. Ibid 255. See also, Chapman S, ‘The Coroner’s Exercise of Discretion: Are Guidelines Needed’ (2008) 12 *Australian Indigenous Law Review* 103, 105.

48. LRCWA, *ibid*.

represents. The Committee notes that many members of the general community who do not have particular religious or cultural issues concerning delay of burial and integrity of bodies nonetheless are passionately opposed to the conduct of an autopsy.⁴⁹

The VPLRC recommended that coroners should be required by statute to have regard to a number of factors including the extent to which an internal post mortem examination may assist in establishing the findings required by the Coroners Act; the spiritual cultural and customary beliefs of family members and the desires of any member of the immediate family.⁵⁰ Other factors that should be considered include the potential benefits of an internal post mortem examination for the family of the deceased (eg, the possibility of discovery of a genetically inherited disease or condition that may have contributed to the death)⁵¹ and the community (eg, where the information obtained from the post mortem examination could assist authorities to understand the nature and progress of a new infectious disease).⁵²

Having regard to the above, the consultations undertaken for the current reference and its previous recommendation,⁵³ the Commission believes that the Coroners Act should require coroners to consider certain factors in exercising their discretion to order an internal post mortem examination. In making the following proposal, the Commission highlights that in cases where a coroner requires medical assistance in making this decision he or she may take advice from the medical adviser to the State Coroner on the basis of an analysis of the medical records of the deceased and the coroner's own analysis of information and evidence surrounding the death, thereby possibly obviating the need for any post mortem examination of the body of the deceased. Further, the coroner may (under Proposal 97) order a preliminary post mortem examination to assist him or her in making

a determination as to whether an internal post mortem examination is required. Under Proposal 100, such an examination may not be the subject of an objection.

Proposal 99

Factors that coroners must consider in ordering an internal post mortem examination

That the Coroners Act provide that in making a decision whether or not to order an internal post mortem examination of a deceased a coroner must consider:

1. the extent to which an internal post mortem examination of the deceased will assist the coroner to make the relevant findings under the Coroners Act in the context of the information and evidence already available to the coroner or arising from investigations or examinations (such as an external post mortem examination) ordered by the coroner;
2. the potential for the death to have occurred in circumstances that suggest a serious criminal offence or a threat to public health or safety;
3. the potential healthcare benefits of an internal post mortem examination for the deceased's family or the community;
4. any known or communicated cultural, spiritual or customary beliefs of the deceased or the deceased's family;
5. any concerns raised by a family member, or another person with a sufficient interest, in relation to the type of post mortem examination to be conducted;
6. any advice provided by a medical adviser to the coroner following an analysis of medical records of the deceased; and
7. any advice provided by a pathologist or doctor who has undertaken an external or preliminary post mortem examination of the deceased at the direction of a coroner.

49. VPLRC, *Coroners Act 1985 - Final Report* (2006) 498 (footnotes omitted).

50. *Ibid*, recommendation 100.

51. Obviously, this consideration will be given less weight in deaths caused by mechanical or external means such as suicides, workplace deaths and motor vehicle accidents.

52. Ranson D, 'The Value of an Autopsy' (2005) 13 *Journal of Law and Medicine* 19, 19-20.

53. LRCWA, *Aboriginal Customary Laws: The interaction of Western Australian law with Aboriginal law and culture*, Project No 94, Final Report (September 2006) recommendation 76.

OBJECTION TO POST MORTEM EXAMINATION

Under s 37 of the Coroners Act the senior next of kin of the deceased person (as defined earlier) may object to a post mortem examination being performed on the deceased. Section 37 provides:

- (1) If the senior next of kin of the deceased asks a coroner not to direct a post mortem examination but the coroner decides that a post mortem examination is necessary, the coroner must immediately give notice in writing to the senior next of kin and to the State Coroner.
- (2) Unless the coroner believes that a post mortem examination needs to be performed immediately it must not be performed if a request has been made under subsection (1) until 2 clear working days after the senior next of kin has been given notice of the decision or until after the end of any extension of time granted by the Supreme Court under subsection (3a).
- (2a) The coroner may direct that a post mortem examination be performed if a senior next of kin who has asked the coroner not to direct a post mortem examination withdraws the request.
- (3) Within 2 clear working days after receiving notice of the decision, or before the end of any extension of time granted by the Supreme Court, the senior next of kin may apply to the Supreme Court for an order that no post mortem examination be performed.
- (3a) On the application of the senior next of kin, the Supreme Court may grant an extension of time within which the senior next of kin may apply to the Court for an order that no post mortem be performed if the post mortem examination has not been performed and it is satisfied that exceptional circumstances exist so that it is necessary or desirable in the interests of justice to grant the extension.
- (4) The Supreme Court may make an order that no post mortem examination be performed if it is satisfied that it is desirable in the circumstances.

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 post mortem examination process and how it may 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 descendents of the deceased.⁵⁴ 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.⁵⁵ When asked what had influenced the decision to withdraw an objection, respondents to the public survey cited delays to the release of the body for funeral and the stressful nature of the objection process as influencing their decision.

During consultations, the coronial counsellors raised the issue that, because what constitutes a post mortem examination is not explained in the Coroners Act, an objection to a post mortem examination would be taken as an objection to an external post mortem examination as well as an internal post mortem examination.⁵⁶ This, it was said, put unnecessary pressures on the coronial process because without the ability to view and touch the body or take blood and urine samples it was impossible for the coroner to discharge the obligation to find, if possible, the cause of death of the deceased. The counsellors noted that in cases where the family objected to an external examination as well as an internal examination, the coroner would usually overrule the objection immediately.⁵⁷ It was argued that an external examination should be permitted in every case to enable the coroner to fulfil his or her obligations to the deceased. This is presently the case in Victoria⁵⁸ and was also a recommendation of Michael Barnes in his 2008 review of the Act, who noted that if objection was limited to internal autopsy this 'would encourage coroners to utilise external examinations when they will suffice'.⁵⁹ The Commission agrees and makes the following proposal. It is noted that the coroner's brochure 'When a Person Dies Suddenly' will require amendment to communicate this change to families.

54. Coronial Counsellors, consultation (22 August 2008).

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

56. Unless the family had specified otherwise.

57. Coronial Counsellors, consultation (22 August 2008).

58. Under the *Coroners Act 2008* (Vic) s 26, objections may only be made to autopsy which is defined to exclude a preliminary examination.

59. Barnes M, *Review of the Coroners Act 1996 (WA)* (August 2008) 25.

Proposal 100

Objection may only be made to internal post mortem examination

That the right of the senior next of kin to object to a post mortem examination of the deceased under the Coroners Act be limited to the undertaking of an internal post mortem examination.

Time for objection to coroner

No time period for objection is stated in the Coroners Act but in practice 24 hours including one full working day (known as 'the objection period'), is usually given before a direction to perform a post mortem is made by the coroner or his or her delegate.⁶⁰ 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).⁶¹ 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.

During consultations for this reference the Commission heard that the 24-hour time period in which to make an objection was too short. It was noted that people may not be able to make informed decisions about whether to exercise their right to object in circumstances where they have just been told about the death by a police officer. This issue also came up in the Commission's Aboriginal customary laws reference where it was argued that in respect of Aboriginal families the cultural aspects of grief are even more disabling. For example, in the Kimberley area when an Aboriginal person dies, close relatives will immediately show their grief by 'hitting themselves with a billy can, rock or bottle until they make themselves

bleed'.⁶² This practice shows respect for the dead person, but can also affect a person's emotional and physical state, so much so that they cannot make an informed decision about whether or not they should object to a post-mortem examination of their deceased relative. In these circumstances relatives may fail to register, within the allotted time of 24 hours, an objection to post-mortem based on their genuinely held cultural or spiritual beliefs. The fact that the immediate family is overwhelmed by grief and may not take in the information contained in the coroner's brochure may be compounded by language difficulties.

Although the State Coroner's guidelines direct police officers notifying a next of kin of a death to explain the person's rights and to take all reasonable steps to ensure that the person understands them,⁶³ this may be extremely difficult in the circumstances described above.⁶⁴ This is particularly so where coronial counselling is not available in the regions and where language interpreters are not usually employed to explain the coroner's brochure. Believing it is important that people are given the opportunity to make an informed decision about whether or not they wish to object to a post-mortem examination of their deceased relative, the Commission recommended in its Aboriginal customary laws Final Report that the objection period be extended to 48 hours, including one full working day.⁶⁵ It was noted that this extension would better accommodate grieving families and give them time to access any necessary advisory services, including translation and counselling services. The Commission is aware that the Coroners Court brochure setting out the senior next of kin's objection rights is not always given to the person who may exercise those rights, but rather to whoever is available at the time of notification. This is appropriate to ensure certainty in the process but an extra

60. 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 State Coroner of Western Australia, 'Guidelines for Coroners' (undated) guideline 9.

61. Ibid, guideline 8.

62. Karrayili Adult Education Centre (Fitzroy Crossing), *Tell Me More About the People I Work With* (undated) 25.

63. State Coroner of Western Australia, 'Guidelines for Police' (undated) guideline 5.

64. For this reason those notifying Aboriginal people of a death should take advice from Aboriginal non-relatives to ensure that the right person is told about the death and in circumstances where they cannot harm themselves: see Karrayili Adult Education Centre (Fitzroy Crossing), *Tell Me More About the People I Work With* (undated) 25.

65. LRCWA, *Aboriginal Customary Laws: The interaction of Western Australian law with Aboriginal law and culture*, Project No 94, Final Report (September 2006) recommendation 75. This recommendation has not been implemented.

24 hours to allow the information to filter through the family to the right person or for family members to ensure that the senior next of kin understands his or her rights may in some cases be crucial to ensuring that the right to object is meaningful.

The only argument the Commission has heard against extending the time for objection is the potential for bodies to decompose. This is not usually an issue where good refrigeration facilities are available,⁶⁶ but it may be a concern in some regional areas and with the bodies of small babies (which may decompose at a faster rate than the bodies of adults).⁶⁷ Although an increase to 48 hours will have a beneficial impact on families by reducing the pressure placed upon them in the first 24 hours following a death, the Commission highlights that, in many cases, increasing the objection period to 48 hours including one full working day will have no real impact upon the time that a post mortem examination would otherwise be performed. For example, under the current guidelines, stipulating an objection period of 24 hours and one working day, if the person died on a Thursday the objection period would require that the post mortem examination could not be performed until Monday (with Friday being the full working day). This would be no different under the Commission's proposal because an objection period of 48 hours and one working day would have elapsed. In addition, because (under Proposal 100) families cannot object to an external post mortem examination, such examination may be ordered by the coroner (and bodies may be transported to Perth for that purpose) in cases where the chances of substantial decomposition are considered to be high. It is observed that a 48-hour objection period exists in other jurisdictions where a preliminary examination that is not subject to objection may be performed.⁶⁸

The Commission therefore reiterates its previous recommendation in the following proposal. In making this proposal the Commission notes that at all times the coroner retains the discretion to order that the post mortem be performed if he or she believes that it must be done

66. Though it is emphasised that refrigeration can only retard decomposition rather than prevent it.

67. Coronial Counsellors, consultation (22 August 2008).

68. See, eg, *Coroners Act 2008* (Vic) s 26(2).

without delay. The Commission also notes that such extension of time will not unduly affect those families who have no objection to post-mortem examination and/or wish to have the body released as soon as possible for burial. In these cases the guidelines direct that the coroner should have written confirmation (or be otherwise satisfied) that the senior next of kin does not object before ordering the post-mortem which can then be performed without delay.⁶⁹

Proposal 101

Time for objection to post-mortem examination

1. That the State Coroner's guidelines provide that in cases where a post-mortem examination does not have to be conducted immediately, a coroner should ensure that no post mortem examination is conducted until at least a period of 48 hours including one full working day has elapsed from the time when the coroner's brochure 'When a Person Dies Suddenly' is provided to a next of kin.
2. That the coroner's brochure 'When a Person Dies Suddenly' be amended to reflect the increase in time for objection to 48 hours.

Supreme Court review

If, after considering an objection to post mortem examination, the coroner determines that a post mortem examination should be performed on the deceased he or she must give notice of the determination to the senior next of kin. Under s 37(3) of the Coroners Act the senior next of kin may then apply (within two working days)⁷⁰ to the Supreme Court for an order that no post mortem examination be performed. Pursuant to Supreme Court Practice Direction 9.7, every endeavour will be made to

69. State Coroner of Western Australia, 'Guidelines for Coroners' (undated).

70. On application of the senior next of kin, the Supreme Court may grant an extension of time in which to apply for an order that no post mortem examination be held provided that exceptional circumstances can be shown: *Coroners Act 1996* (WA) s 37(3a).

list an application within three days of filing.⁷¹ Applications are heard on affidavit evidence,⁷² reducing the need for parties in rural or remote areas to travel to the hearing, and an order is generally made at the conclusion of the hearing or the following day.

The Commission has considered the superior court review provisions of other Australian jurisdictions and finds that they are comparable to that in Western Australia. In the Commission's opinion these provisions are appropriate and do not require change. However, the Commission heard comments from some lawyers suggesting that because applications for Supreme Court review of coroners' decisions are rare there is little precedent and that more could be done to assist lawyers and unrepresented applicants to make such applications. The Commission observes that the process has become somewhat easier for legal representatives since the consolidation of the Supreme Court's practice directions in 2009 which clearly set out the requirements and process for applications under the Coroners Act.⁷³

The Commission notes that the Supreme Court website has a page providing information for self-represented applicants including information about waiver of fees⁷⁴ and links to external websites such as the Aboriginal Legal Service and Legal Aid WA.⁷⁵ Given that neither Legal Aid nor the Aboriginal Legal Service are resourced to assist families in respect of applications under the Coroners Act, the Commission suggests that the Supreme Court provide a link on its website

71. Supreme Court of Western Australia, *Consolidated Practice Directions* (2009) [3]. Although, the Commission is advised that in practice such applications are dealt with in less than the three days specified in the practice direction.

72. Although in exceptional circumstances the court may dispense with the requirement for filing of an affidavit and permit oral evidence to be given in support of the Notice of Originating Motion: *ibid* [5].

73. *Ibid*.

74. The Commission notes the concerns expressed by coronial counsellors in a 1999 review of the *Coroners Act 1996* (WA) that 'financial reasons may prevent the "vast majority" of Western Australians from exercising their right to pursue a case if an objection [to post mortem examination] is overruled': Chivell W, *Report on Review of the Coroners Act 1996 (WA)* (May 1999) 34. Under the *Supreme Court (Fees) Regulations 2002* (WA) filing fees are waived for holders of Commonwealth pension and health care cards and in cases of demonstrated financial hardship.

75. The Legal Aid website has information about the law, including very basic information about post mortem examinations and objections: Legal Aid Western Australia, 'Information About the Law: Birth, life death', <<http://www.legalaid.wa.gov.au/InformationAboutTheLaw/BirthLifeandDeath/Mattersafterdeath/Pages/Afterdeath.aspx>> (accessed 6 June 2011).

to basic application and process information (like that provided for the probate jurisdiction) to assist self-represented applicants to negotiate the Supreme Court application process. Such information should include reference to the relevant practice directions and links to forms required for applications under the Coroners Act.⁷⁶

Proposal 102

Supreme Court of Western Australia website

That the Supreme Court of Western Australia consider providing a link on its website page for 'self-represented persons' to basic application and process information including the relevant practice directions and links to forms required for applications under the Coroners Act.

EXHUMATION

Section 38 of the Coroners Act provides that the State Coroner may order that a body be exhumed if it is thought reasonably necessary for an investigation into a death. If an exhumation order is made, at least two clear working days notice must be given to the senior next of kin of the deceased person and to the relevant authority or owner of the place where the body is buried.⁷⁷ Under the Coroners Act, the senior next of kin has a right to object to the exhumation. Sections 38(3)–(9) govern the objection and superior court review process:

- (3) If the senior next of kin asks the State Coroner not to exhume the body, the body must not be exhumed until 2 clear working days after the request has been made.
- (4) A request referred to in subsection (3) must be made within 2 clear working days after the senior next of kin receives notice that the State Coroner has made an order that the body be exhumed.
- (5) Where the State Coroner rejects a request by the senior next of kin that

76. The Aboriginal Legal Service and Legal Aid WA websites should provide links to this information provided on the Supreme Court website.

77. Unless the State Coroner is satisfied that it is not possible to do so, or if the State Coroner considers it is not appropriate to do so: *Coroners Act 1996* (WA) s 38(2).

the body not be exhumed, he or she must ensure that written notice of that decision is given to the senior next of kin immediately.

- (6) Where notice is given under subsection (5), the exhumation of the body must not take place—
 - (a) until 2 clear working days after that notice is received by the senior next of kin; or
 - (b) if an application for an extension of time has been made, until the application is refused or the application for an order that the body not be exhumed is dealt with.
- (7) Within 2 clear working days after receiving notice of the decision to reject a request that the body not be exhumed under subsection (5), or before the end of any extension of time granted by the Supreme Court, the senior next of kin may apply to the Supreme Court for an order that the body not be exhumed.
- (7a) The Supreme Court may grant an extension of time within which a person may apply to the Court for an order that the body not be exhumed if the exhumation has not taken place and it is satisfied that exceptional circumstances exist so that it is necessary or desirable in the interests of justice to grant the extension.
- (8) The Supreme Court may make an order that a body not be exhumed if it is satisfied that it is desirable in the circumstances.
- (9) This section does not apply if the Supreme Court by order under section 36(4)(b) directs that a body be exhumed.

The Commission is advised that only two exhumations have been ordered under s 38 since the passage of the Coroners Act. One was ordered to enable DNA testing to be carried out on the body of an unidentified male, the subject of a 1979 homicide to determine whether the deceased's identity could be established. The other involved the exhumation of a newborn baby buried in 1969, who later became the subject of a homicide charge. The Commission knows of no application ever having been made under s 38 objecting to the exhumation of a deceased. However, noting that the Supreme Court review process is substantially the same as that for review of objections to post mortem examination under s 37 and that the timeframes are the same as provided for

in other jurisdictions,⁷⁸ the Commission finds that the provisions of the Coroners Act are appropriate and do not require change.

OTHER POST MORTEM ISSUES

Removal and retention of organs

In May 1992, amidst growing community concern about post mortem practices and 'dealings with body parts in particular',⁷⁹ 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 (forensic pathologist) and Dominic Bourke (lawyer). The terms of reference for the inquiry (known as 'the Honey 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'.⁸⁰ 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.⁸¹ Among other recommendations, the Honey Inquiry 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.⁸²

As noted in Chapter Six, Western Australia is the only Australian jurisdiction to have a Coronial Ethics Committee recognised by statute.⁸³ While the committee was conceived as a means of reviewing applications for tissue research by the medical profession,⁸⁴ it appears that such

78. All jurisdictions that provide for an objection to exhumation provide 48 hours in which to appeal to the Supreme Court for an order that the body not be exhumed: *Coroners Act 2008* (Vic) s 81; *Coroners Act 1995* (Tas) s 39(4); *Coroners Act* (NT) s 24(4).

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

80. *Ibid* 1.

81. *Ibid* 2.

82. *Ibid* 24–5.

83. While the Committee is not established by the *Coroners Act 1996* (WA) its potential is recognised in s 58(2)(d) which states that the State Coroner may issue guidelines relating to 'the establishment and functions of an advisory ethics committee'.

84. Western Australia, *Parliamentary Debates*, 12 December 1995 (Mr P Foss QC, Attorney General).

applications are not usually considered by the committee because the use of tissue for research is adequately covered by the Coroners Act.⁸⁵ Section 34 of the Coroners Act provides:

- (1) If a coroner reasonably believes that it is necessary for an investigation of a death, the coroner may direct a pathologist or a doctor to perform a post mortem examination on the body.
- (2) The coroner may direct the pathologist or doctor performing the post mortem examination to cause to be removed from the body, for such period as the coroner directs, any tissue which it appears necessary to remove in order to investigate the death.
- (3) The pathologist or doctor performing the post mortem examination may cause tissue to be removed from the body—
 - (a) in accordance with a direction under subsection (2);
 - (b) in accordance with the written permission of the deceased; or
 - (c) subject to subsection (5)(b), in accordance with the written informed consent, in the prescribed form, of the senior next of kin of the deceased specifying the tissue which may be removed and the purpose (therapeutic, medical, teaching or scientific) for which the tissue may be removed.
- (4) The coroner may direct the pathologist or doctor performing the post mortem examination not to cause tissue to be removed as authorised under subsection (3)(c) if the coroner is satisfied that the removal would be contrary to or inconsistent with wishes expressed in writing by the deceased.
- (5) Where a post mortem examination is performed under this Act a person who causes tissue to be removed from the body—
 - (a) otherwise than as authorised under subsection (3); or
 - (b) contrary to a direction of a coroner under subsection (4), commits an offence.
Penalty: \$10 000.
- (6) Tissue removed under subsection (2) is to be dealt with in accordance with the coroner's directions and any relevant guidelines.
- (7) Where tissue is to be removed as authorised under subsection (3)(b), the coroner is to ensure that before the tissue is removed,

85. Turnbull R, *The Coronial Process in Western Australia: A handbook for medical practitioners and medical students* (June 2010).

the senior next of kin of the deceased is informed in writing what tissue is to be removed and the purpose for which it is to be removed and is given a chance to view the written permission of the deceased.

The Commission received few comments about organ retention during its consultations. Some people, in particular, funeral directors noted the need for clearer explanations about organ retention. Understandably, post-funeral returns of organs (such as the brain) can be very emotional for families and the Commission heard stories of brains being returned some years after burial where families had not understood that the brain was not buried with the body.⁸⁶ There was no indication of how often this happened or whether such events were recent. Notably, there were no criticisms about organ retention made in the Commission's public survey.

The Commission is advised that brains are retained in approximately one sixth of all cases for examination by the neuropathologist.⁸⁷ As noted earlier in this paper, there are significant delays in neuropathology, both because Western Australia only has one specialist forensic neuropathologist and because it can take several weeks to harden the brain to allow for gross examination then a further period if microscopy is required.⁸⁸ It is possible, therefore, that a brain retained for neuropathological examination will not be returned to the body prior to the funeral. The Commission is aware that this is one area that occupies much of the time of coronial counsellors who are required to telephone next of kin to discuss organ retention in each case. The Commission was advised that coronial counsellors provide details about the organ to be retained, the probable duration of the retention and the reason for retention, and obtain instructions from the family about the disposal of the organ.⁸⁹ This may include the organ being returned to the

86. Brain retention was also a significant concern in a New South Wales inquiry undertaken in 2001: see Ranson D, 'Law, Ethics and the Conduct of Forensic Autopsies' (2001) 9 *Journal of Law and Medicine* 153, 153.

87. Dr Clive Cooke, Chief Forensic Pathologist, consultation (26 November 2009).

88. *Ibid.* As noted previously, there are two neuropathologists in Western Australia with one working in the clinical field and one doing both clinical and forensic work. It appears that the earliest one can expect a report following neuropathological examination would be four weeks, but reporting times have been known to blow out to over 12 months in certain circumstances.

89. Office of the State Coroner, *Coronial Counselling Service Work Value Report* (undated), provided by Kristine Trevaskis (2 September 2008).

body or subsequently cremated by the funeral director or mortuary. These negotiations with families are conducted while funerals are being planned and when these families are still highly traumatised from the sudden death of their loved one.⁹⁰ It is understandable that on occasion messages about the organ retention process are not understood by family and that they may be shocked some time later to receive a call from the mortuary seeking to return a retained organ according to the family's instructions. The Commission has not heard anything about this area that requires reform; however, it invites submissions from interested people on this subject.

Question H

Removal and retention of organs

Are there any issues the Commission should be aware of in relation to organ retention and return practices in Western Australia, particularly in the past five years?

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 re-fix 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.⁹¹ In particular, it was noted that 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.

As a result of these initial comments and initial responses from funeral directors to the public survey, the Commission developed a separate online survey directed to funeral industry workers in Western Australia. The Australian Funeral Directors Association distributed the survey to its metropolitan and regional members in Western Australia and it received a modest response with nine representatives from funeral homes in Perth and regional areas providing comment. Comments with respect to the condition of bodies following release from the State Mortuary after post mortem examination included:

The return of bodies is in some cases excellent, and other cases very poor. This obviously comes down to the care of the technician involved, but the main concerns are poor suturing, in some cases needing re-suturing, and damage to carotid arteries which makes embalming very difficult. Some cases the arteries are very much intact, in others they are destroyed making the embalming process almost impossible. The majority of coronial deaths are tragic/sudden and in these cases it is most important for the families to have the chance to see the person both emotionally and psychologically. It is very difficult to present the person in a good manner if the technician has done a poor job.

Our technicians do blame seepage etc for a lot of wrongs.

Two things – good, tight suturing, avoiding getting hair caught in the suture across the scalp [and] take much more care when making incisions near the carotid arteries. That is all we need to give the person back to the family in the best condition possible.

Take more time and care.

It should be remembered that the body is important to a family. It is not just a forensic specimen. "Y" incisions and more thought for the preparation for viewing should be considered.

Make sure technicians understand the possibility of the need for embalming.

Following release of the Commission's Background Paper in which comments about

90. Ibid.

91. Unlike funeral directors in Perth, very few funeral directors in regional areas have premises with body storage and preparation facilities. In most cases, the Commission understands, bodies are prepared for viewing and funeral in the local hospital morgue.

the condition of bodies following post mortem examination were featured, a newspaper reported that PathWest were looking into the issue.⁹² The Commission is not aware of the outcome of any internal investigation made by PathWest, but in light of the further comments from funeral directors it is apparent that, in at least some cases, bodies are released without adequate attention to embalming and transport requirements.

Proposal 103

Preparation of bodies for release from the State Mortuary

That technicians preparing bodies for release from the State Mortuary in Perth take care to ensure that bodies are released in good condition with due care and attention paid to the potential need for embalming and to measures to be taken to prevent seepage of bodily fluids during transport.

Conditions 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. There was no reception for families attending to view or identify a body and the Commission was witness to the confusion this caused in one extremely distressed gentleman attending to identify his recently deceased daughter.

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. The Commission found that 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.⁹³

The Commission expressed its concern about the condition of the State Mortuary in its Background Paper.⁹⁴ In a newspaper article following its release a PathWest spokesperson reportedly said that he was aware of the 'sub-optimal waiting and viewing conditions' and noted that there were plans for a new facility in stage 2 of the redevelopment of the QEII Medical Centre site in Nedlands.⁹⁵ The new PathWest facility currently under construction and discussed in Chapter Four⁹⁶ is stage 1 of the QEII redevelopment and does not include provision for a new State Mortuary and viewing area. The Commission is advised that these are included in planning for PathWest in stage 2 but as yet there is no firm timeline for when construction of stage 2 is likely to begin.⁹⁷ In the interim, to address the concerns raised by the general public, the funeral industry and the Commission, a business case has been prepared for an upgrade to the existing State Mortuary which has been presented to Treasury and is pending approval.⁹⁸ In anticipation of

92. Banks A, 'Morgue in Firing Line Over Autopsies', *The West Australian* (16 October 2010).

93. 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).

94. LRCWA, *Review of Coronial Practice in Western Australia*, Background Paper (September 2010) 57.

95. Banks A, 'Morgue in firing line over autopsies', *The West Australian* (16 October 2010).

96. See Chapter Four, 'Centre for Forensic Medicine'.

97. Leesa Ivey, Acting General Manager PathWest, email (14 June 2011).

98. *Ibid.*

funds being approved an architect has been engaged to prepare a schematic design. The design includes refurbishment of the existing facility to increase the body storage area from a capacity of 80 to 150 bodies and construction of a new ground level building (away from the sounds and smells of the mortuary) to provide a modern facility for viewing and identification of bodies.⁹⁹ The Commission has viewed a schematic floorplan of the proposed temporary facility. It includes three viewing rooms with waiting areas, counselling rooms, toilet facilities and a separate reception area. The Commission has been advised that the Office of the State Coroner will have an opportunity to review the plans for the facility once funding has been approved.

Since its Background Paper the Commission has received many more comments from members of the public and from funeral directors about the traumatic experience of visiting their loved one at the State Mortuary for viewing or identification. For many people this will be the last time they will see their loved one. The Commission appreciates that as much as possible is being done by PathWest to improve the situation; however, it is hamstrung until such time as Treasury approves funding for a temporary facility. The Commission suggests that the funding proposal be urgently considered so that construction can be expedited to address the problems raised above.

Proposal 104

Need for urgent attention to State Mortuary

That the state government urgently consider PathWest's application for funding for the construction of a temporary facility to accommodate coronial viewings with a view to expediting construction.

⁹⁹. This new temporary facility is to be located between the existing J and K blocks occupied by PathWest: *ibid*.

Release of bodies by coroner

Section 30 of the *Coroners Act 1996* (WA) ('the Coroners Act') gives control of a body the subject of a coronial investigation to the coroner but there is no provision in the Act explicitly governing its release. Instead a body is effectively released when the coroner, or his or her delegate,¹ issues a certificate under s 29 authorising disposal of the body by burial or cremation. Section 29 provides:

- (1) A coroner investigating a death must issue as soon as reasonably possible a certificate in the prescribed form permitting burial, cremation or other disposal of the body or any parts of the body.
- (2) A certificate under subsection (1) must not be issued until—
 - (a) an application made under section 36(3) is disposed of;
 - (b) the time specified in section 36(3) for making an application has expired;
 - or
 - (c) if the coroner investigating the death has notice that an application has been made under section 36(3a) for an extension of time, the application is disposed of or any extension of time granted under section 36(3a) has expired.
- (3) If the Supreme Court makes an order under section 36(4) a coroner, other than the State Coroner, must not issue a certificate under subsection (1).²

In practice, to release a body from the State Mortuary following a coronial investigation a funeral director must fax a 'request for removal' of the body on behalf of the person 'authorising'³ the funeral to the Office of the State Coroner.⁴

1. The issuing of certificates for disposal of a body is currently delegated to coroner's registrars.
2. Section 36 refers to an application for a post mortem examination.
3. The person 'authorising the funeral' is the person who has engaged the funeral director. The person 'authorising' the funeral does not need to be the senior next of kin of the deceased and if it is not the senior next of kin no investigation is undertaken by the Coroners Court to determine whether the senior next of kin has authorised that person to organise the funeral. Sometimes more than one request for release will be lodged which acts as a signifier for a possible body dispute: Manager, Office of the State Coroner (WA), email (15 June 2011).
4. Usually the funeral director will have already been in contact with the Coroners Court by telephone to confirm that the

The request is not an official form under the Coroners Regulations but one created by the Office of the State Coroner to streamline procedures. It notes the details of the funeral director, the person on whose behalf the funeral director is acting (and their relationship to the deceased) and whether a date has been set for the funeral. Once the pathologist has finished the post mortem examination he or she will send an interim post mortem examination report to the Office of the State Coroner. The interim report contains a checkbox specifying whether the body can be released immediately or whether it is required for further testing.⁵ When the Office of the State Coroner receives permission from the pathologist to release the body, a coroner's delegate (usually a registrar or the Manager of the Office) will issue the certificate authorising disposal of the body. The certificate, which does not specify to whom the body is released,⁶ is faxed to the funeral director who requested removal and is then taken by the funeral director to the State Mortuary to effect their claim of the body. Once this is done the coroner ceases to have control of the body. Any disputes about who has the right to dispose of a body after this time must be taken to the Supreme Court.

DETERMINING DISPUTES ABOUT RELEASE

Although there is nothing in the *Coroners Act 1996* (WA) ('the Coroners Act') governing the release of bodies under control of the coroner to a particular party, it sometimes falls to the coroner to arbitrate disputes regarding the release of a body where family members disagree and the coroner is made aware of

deceased is a coronial case and the timing of the post mortem examination: Manager, Office of the State Coroner (WA), consultation (13 June 2011).

5. In approximately 90% of cases a body is authorised for release on the same day as the post mortem examination, but on occasion where an organ is retained for further testing this may delay release of the body: Ibid.
6. See *Coroners Regulations 1997* (WA) Form 4.

the disagreement. The coroner cannot make a legally binding determination about to whom a body may be released under the current Act, but the Office of the State Coroner does provide assistance to families to reach a mediated outcome through the coronial counselling service.⁷ If no compromise can be reached through mediation, the coroner will consider evidence provided in whatever form by the parties to arrive at a decision (on the papers) as to whom the body should be released to.⁸ The Commission has been advised that on occasions a coroner has called the disputants into court to hear evidence from both parties. In these cases the coroner will give reasons for a decision and issue a certificate for disposal under s 29(1) of the Coroners Act.⁹

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. In Western Australia there is no legislative guidance on the question of who has the right to determine the manner and place of a deceased's disposal and such disputes are resolved by the Supreme Court through the application of principles developed by the common law.¹⁰ The Commission examined this issue in a different context in the course of its Aboriginal customary laws reference where it laid out the relevant principles applicable to such disputes in Western Australia as follows:¹¹

- (1) When a person dies testate (having left a valid will), the deceased's executor has the right to arrange the disposal of the deceased. The wishes of the deceased's executor will therefore prevail over the wishes of the deceased's family and this priority will not be displaced by a more meritorious claim.¹²
- (2) Where a person dies intestate (without having left a valid will), the right to bury the deceased will lie with the person who has the highest entitlement to the

deceased's estate (and therefore the right to administer the deceased's estate) under the *Administration Act 1903* (WA). The highest entitlement lies with the surviving spouse (or alternatively, the deceased's de facto partner) followed by the children of the deceased, the deceased's parents, the deceased's siblings then other specified family members.¹³

- (3) The right of the surviving spouse or de facto partner will be preferred to the right of children.¹⁴
- (4) Where a de facto partner is not living with the deceased at the time of death (ie, a former de facto partner), the person with the next highest entitlement to apply for letters of administration in respect of the deceased's estate will have the right to dispose of the body.¹⁵
- (5) Where two people have an equally ranking entitlement to administration—for example, two parents in respect of a deceased child—the right to dispose of a body will be decided according to the practicalities of disposal without unreasonable delay.¹⁶ Relevant considerations may include 'where the deceased resided prior to death, the length of the deceased's residence in that area ... convenience of family members in visiting the body of the deceased [and] whether the deceased left any directions in relation to the disposal of his or her body'.¹⁷

7. The Commission understands that the Manager of the Office of the State Coroner also plays a large role in the mediation of such disputes: Manager, Office of the State Coroner (WA), email (14 June 2011).
 8. Manager, Office of the State Coroner (WA), consultation (13 June 2011).
 9. Ibid.
 10. The starting point in any dispute relating to disposal of bodies is that there is no property in a dead body: *Burrows v Cramley* [2002] WASC 47, [15] citing *Williams v Williams* (1882) 20 Ch D 659.
 11. LRCWA, *Aboriginal Customary Laws*, Project No 94, Discussion Paper (December 2005) 314–15.
 12. *Re Boothman; ex parte Trigg* (Unreported, Supreme Court of Western Australia, Lib No BC 990031, Owen J, 27 January 1999).

13. See *Administration Act 1903* (WA) ss 14, 15. The de facto partner must have been living with the deceased for two years immediately preceding the death. For further statement of the principle, see *Smith v Tamworth City Council* (1997) 41 NSWLR 680, 693–94.
 14. *Smith v Tamworth City Council*, ibid 693–4. See also the more recent Western Australian cases of *Ugle v Bowra & O'Dea* [2007] WASC 82; *Reece v Little* [2009] WASC 30 and *Spratt v Hayden* [2010] WASC 340.
 15. In *Burnes v Richard* (Unreported, Supreme Court of New South Wales, Cohen J, 6 October 1993) it was decided that although the relationship between the deceased and her former de facto husband had endured for 17 years, the de facto had no right to disposal of the body of the deceased because the relationship had ended shortly before the deceased's death. Accordingly, the deceased's daughter won the right to dispose of the body. However, 'if the de facto relationship between the deceased and the defendant had existed at the date of death, the defendant would have been entitled under the relevant legislation to seek letters of administration with a consequent right to the body for the purposes of burial': see Editorial, 'Who Can Insist on Where to Bury a Body?' (1994) 68 *Australian Law Journal* 67. See also *Jones v Dodd* [1999] SASC 125.
 16. *Smith v Tamworth City Council* (1997) 41 NSWLR 680, 693–4.
 17. Queensland Law Reform Commission, *Review of the Law in Relation to the Final Disposal of a Dead Body*, Information Paper No 58 (June 2004) 37–8. See also *Calma v Sesar* (1992) 106 FLR 446 where there was a burial dispute between both Aboriginal parents of a deceased born in Port Hedland in Western Australia. The mother made arrangements for a Roman Catholic burial in Darwin where the deceased had been killed whilst the deceased's father made arrangements for burial in the deceased's Aboriginal homelands. Because an apparently equal right to administration existed, the Court decided on the basis of practicalities, including the need for expeditious burial. The Court therefore held in favour of the

- (6) Where the deceased dies intestate and there is no estate to administer, regard should be had to the cultural and spiritual values of the deceased in determining who has the right to dispose of the deceased's body as well as the practicalities of disposal without unreasonable delay.¹⁸
- (7) The person with the right to dispose of the deceased is expected to consult with other stakeholders, but is not legally obliged to do so.¹⁹
- (8) Although a deceased's signed burial instructions should (where possible)²⁰ be followed, such directions are not legally binding upon the executor of a will, the administrator of a deceased estate or a court in deciding who has the right to disposal of the deceased's body.²¹ In contrast, it is the executor's or administrator's statutory duty to ensure that all reasonable endeavours are made to carry out the wishes of a deceased where a deceased has left written and signed instructions to cremate his or her body.²²

Consultations for the Aboriginal customary laws reference revealed that the current court process needed to be more accessible in the event that a mediated resolution could not be reached by the coroner.²³ The Commission made a series of recommendations regarding the observation of burial instructions of a deceased and mediation to assist in determining burial disputes over Aboriginal deceased.²⁴ The Commission also recommended that consideration be given to permitting the Magistrates Court to deal with

burial disputes to improve accessibility to a binding determination for Aboriginal people in regional areas.²⁵ None of these recommendations have yet been implemented.

In its consultations for the current reference, the Commission heard submissions that a greater role should be played by the coroner in the first instance in deciding to whom a body should be released. It was argued that if there was a clear power for the coroner to specify to whom a body was released and to arbitrate disputes, the problems (in terms of time, accessibility and expense) of applying to the Supreme Court for such an order could be obviated. Since the Commission completed its reference on Aboriginal customary laws the role of the coroner in determining disputes has been formalised in the *Coroners Act 2008* (Vic), which replaces the issuing of a certificate of disposal with an order specifying to whom the body is to be released for disposal. Section 47 of the *Coroners Act 2008* (Vic) provides:

- (1) The coroner may order that a body under the control of the coroner be released if—
 - (a) the coroner is satisfied that it is no longer necessary for the coroner to have control of the body in order to exercise his or her functions under this Act; or
 - (b) the coroner has determined that the death was not a reportable death or a reviewable death.
- (2) An order made by the coroner under subsection (1)—
 - (a) must specify a person to whom the body is to be released; and
 - (b) may contain any terms or conditions that the coroner considers necessary.

Section 48 of the *Coroners Act 2008* (Vic) then gives the coroner explicit power to determine disputes over the release of a body.

- (1) A person (the applicant) may apply to a coroner for a body to be released to the applicant.
- (2) If 2 or more applicants apply for release of the body, the coroner must determine the person to whom the body is to be released on the basis of who has the better claim;

mother because the deceased's body was in Darwin and suitable arrangements had been made for burial there.

18. *Jones v Dodd* [1999] SASC 125. See also *Mourish v Wynne* [2009] WASC 85 where due to conflicting evidence cultural beliefs were considered by the court to be neutral and, in the absence of an estate to administer (the deceased was 15 years old), the court found that practical considerations should decide the claim.
19. *Smith v Tamworth City Council* (1997) 41 NSWLR 680, 693–4.
20. Those that argue for the burial directions of the deceased to be upheld also note that in some cases carrying out these instructions may be impossible. Heather Conway notes that 'individual autonomy may need to be restricted in the public interest, and judges would almost certainly have to impose some form of limitation to curb the whims and idiosyncrasies of more eccentric testators': Conway H, 'Dead, But Not Buried: Bodies, burial and family conflicts' (2003) 23 *Legal Studies* 423, 434.
21. The principle that a person cannot, by will, dispose of his or her own body is well established: *Williams v Williams* (1882) 20 Ch D 659. See also Conway H, *ibid*, 430–4. In *Ugle v Bowra & O'Dea* [2007] WASC 82, [16] the judge considered that considerable weight should be given to the wishes of the deceased although in that case they were found to be contradictory. See also *Manktelow v Public Trustee* [2001] WASC 290 [30].
22. *Cremation Act 1929* (WA) s 13.
23. LRCWA, *Aboriginal Customary Laws: The interaction of Western Australian law with Aboriginal law and culture*, Project No 94, Final Report (September 2006) 263.
24. *Ibid*, recommendations 78 & 79.

25. *Ibid*, recommendation 79.1.

- (3) In determining who has the better claim, the coroner must have regard to the following principles—
- (a) if the person named in the will as an executor is an applicant, the body of the deceased should be released to the executor;
 - (b) if a person specified under paragraph (a) is not an applicant, the body should be released to the senior next of kin;
 - (c) if there appear to be 2 or more applicants who are the senior next of kin of the deceased, the coroner should determine to whom the body is to be released having regard to any principles of common law relating to the release and disposal of a body of a deceased person;
 - (d) if no person referred to in paragraph (a) or (b) is an applicant, the coroner should determine to whom the body is to be released having regard to the principles of common law relating to the release and disposal of a body of a deceased person.

As can be seen the legislative guidance in the above provision follows the principles of the common law that would otherwise be applied by the Supreme Court in addressing a dispute about rights to dispose of a body. In the Commission's opinion the Victorian scheme provides much-needed clarity about to whom a body may be released and makes the power of the coroner explicit in providing a first instance determination where a dispute exists.²⁶ The Commission notes that with its proposal for dedicated regional coroners the problems of access to a court to make a binding determination that were stressed in its Aboriginal customary laws reference fall away. In addition, in many cases the substantial fees (and need for legal representation) associated with a Supreme Court application will be avoided. The Commission therefore proposes that the current certification for disposal provisions found in s 29 of the Coroners Act be replaced by a provision specifying that the coroner may order that a body be released to a specified person if he or she is satisfied that it is no longer necessary to have control of the body for the purposes of coronial investigation. In cases where more than one application is made for release of the body the Commission

26. In all other cases the coroner will simply release the body to the senior next of kin or whoever makes the claim for release.

proposes that the coroner determine the person to whom the body is to be released on the basis of who has the better claim with guidance provided modelled on s 48 of the *Coroners Act 2008* (Vic). As with the Victorian Act²⁷ the Commission believes there should be the right, within 48 hours of such a determination, for a person to apply to the Supreme Court for review of the coroner's decision on the basis of an error of law only. Because of the need for expedition in resolving disputes about the release of a body, the Commission believes it is appropriate that such appeal lie to a single judge of the Supreme Court. The Commission notes that this is also the case in Victoria where the State Coroner is a District Court judge.

Proposal 105

Release of body by a coroner

1. That the provision for certifying disposal of a body in the Coroners Act (currently s 29) be repealed and replaced by a provision specifying that the coroner may order that a body under the control of the coroner be released if the coroner is satisfied that it is no longer necessary for the coroner to have control of the body in order to exercise his or her functions under the Coroners Act.
2. That an order for release made under the Coroners Act must specify a person to whom the body is to be released and may contain any terms and conditions that the coroner thinks necessary.
3. That an order for release may not be made until any application for a post mortem examination (currently s 36) is disposed of or the time for making such application, including any extension of time granted by the Supreme Court, has expired.
4. That consequential amendments be made to the *Cremation Act 1929* (WA) and any other relevant Act to change references to coroner's certification permitting disposal of a body to an order of a coroner permitting release of the body.

27. *Coroners Act 2008* (Vic) s 85.

Proposal 106

Application for release of body by a coroner

That the Coroners Act provide that:

- (1) A person (the applicant) may apply to a coroner for a body to be released to the applicant.
- (2) If 2 or more applicants apply for release of the body, the coroner must determine the person to whom the body is to be released on the basis of who has the better claim.
- (3) In determining who has the better claim, the coroner must have regard to the following principles—
 - (a) if the person named in the will as an executor is an applicant, the body of the deceased should be released to the executor;
 - (b) if a person specified under paragraph (a) is not an applicant, the body should be released to the senior next of kin;
 - (c) if there appear to be 2 or more applicants who are the senior next of kin of the deceased, the coroner should determine to whom the body is to be released having regard to any principles of common law relating to the release and disposal of a body of a deceased person;
 - (d) if no person referred to in paragraph (a) or (b) is an applicant, the coroner should determine to whom the body is to be released having regard to the principles of common law relating to the release and disposal of a body of a deceased person.

Proposal 107

Supreme Court review of coroner's decision to release a body

That the Coroners Act provide that a person may apply to a single judge of the Supreme Court for review of a determination for release made pursuant to Proposal 106 on the basis of an error of law. That such application must be made within 48 hours of the determination being made by the coroner.

Practical issues surrounding release

As noted above, to release a body from the State Mortuary a funeral director must 'apply' by faxing a claim for release of the body on behalf of the family to the Office of the State Coroner. The Commission was told 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. Given current limitations on the storage space for bodies at the State Mortuary, it is appropriate that the Office of the State Coroner address this issue by advising the senior next of kin of their responsibility to appoint a funeral director to obtain release of the body without delay. In the Commission's opinion this information should be included in the 'When a Person Dies Suddenly' brochure and on the Coroners Court website. The Commission therefore makes the following proposal.

Proposal 108

Providing information about release to families

That the Office of the State Coroner advise the senior next of kin in writing of their responsibility to appoint a funeral director to obtain release of the body without delay and that this information be included in the 'When a Person Dies Suddenly' brochure and on the Coroners Court website.

Appendices

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Appendix A: Proposals & questions

PROPOSAL 1

[page 13]

Objects of the Coroners Act

That the Coroners Act feature a section which articulates the following primary objects of the Act:

- (a) to require the reporting of particular deaths;
- (b) to establish the procedures for investigations and inquests by coroners into reportable deaths;
- (c) to establish a coordinated coronial system for Western Australia with defined coronial regions and dedicated coroners including a State Coroner as head of jurisdiction;
- (d) to contribute to a reduction in the incidence of preventable deaths and injury by the findings and recommendations made by coroners and by the timely provision by coroners of relevant data to appropriate authorities and research bodies;
- (e) to facilitate the timely provision of relevant information to family members of a deceased person the subject of a coronial investigation; and
- (f) to provide a counselling service to family members, friends and others associated with a death the subject of a coronial investigation.

PROPOSAL 2

[page 23]

No *ex officio* coroners

That magistrates should no longer hold automatic contemporaneous *ex officio* appointments as coroners.

PROPOSAL 3

[page 26]

Establish coronial regions

That three coronial regions be established being the metropolitan region (encompassing metropolitan Perth as defined by the electoral boundaries), the northern region (encompassing the circuit regions covered by magistrates based in Broome, Kununurra, Carnarvon, Geraldton and South Hedland) and the southern region (encompassing the circuit regions covered by magistrates based in Albany, Bunbury, Kalgoorlie and Northam).

PROPOSAL 4

[page 26]

Dedicated regional coroners

That sufficient resources be assigned to establish and support a dedicated coroner to service and be based in the northern region, and a dedicated coroner to service and be based in the southern region (as defined in Proposal 3).

PROPOSAL 5

[page 28]

Status and tenure of the State Coroner

1. That the State Coroner of Western Australia be a judge of the District Court appointed by the Governor upon the recommendation of the Attorney General made after consultation with the Chief Judge of the District Court.
2. That the appointment of the State Coroner be for an initial term of not more than five years and may be renewed once for a term of not more than five years.
3. That service in the office of State Coroner be taken for all purposes to be service in the office of a judge of the District Court of Western Australia.

PROPOSAL 6

[page 28]

Status and tenure of the Deputy State Coroner

1. That the Deputy State Coroner of Western Australia be a magistrate of the Magistrates Court appointed by the Governor upon the recommendation of the Attorney General made after consultation with the State Coroner and the Chief Magistrate of the Magistrates Court.
2. That the appointment of the Deputy State Coroner be for an initial term of not more than five years and may be renewed once for a term of not more than five years.
3. That service in the office of Deputy State Coroner be taken for all purposes to be service in the office of a magistrate in the Magistrates Court of Western Australia.

PROPOSAL 7

[page 29]

Status and tenure of other coroners including dedicated regional coroners

1. That a magistrate may be appointed coroner by the Governor upon the recommendation of the Attorney General made after consultation with the State Coroner and the Chief Magistrate of the Magistrates Court.
2. That a person, who is eligible to be appointed as a magistrate, may be appointed coroner by the Governor upon the recommendation of the Attorney General made after consultation with the State Coroner and that such person shall simultaneously be appointed as a magistrate.
3. That the appointment of a coroner be for an initial term of not more than five years and may be renewed once for a term of not more than five years.
4. That service as a coroner be taken for all purposes to be service in the office of a magistrate in the Magistrates Court of Western Australia.

PROPOSAL 8

[page 29]

Oath of office

1. That a person appointed as coroner under the Coroners Act must, before commencing to act as a coroner, take before a judge of the Supreme Court, an oath or affirmation of office.
2. That the prescribed form of the oath or affirmation of office for a coroner be specific to the duties as coroner, and be developed in consultation with the State Coroner and Deputy State Coroner.

Delegation from the State Coroner to a coroner's registrar

1. That the State Coroner may, in writing, delegate to a coroner's registrar any function or power of a coroner other than the functions or powers listed in subsection (2).
2. The following functions or powers of the State Coroner or a coroner cannot be delegated to a coroner's registrar (not including the Principal Registrar):
 - (a) the power of delegation in subsection (1);
 - (b) directing a forensic pathologist or medical practitioner to perform an internal post mortem examination;
 - (c) ordering an exhumation;
 - (d) releasing a body;
 - (e) ordering an inquest;
 - (f) making final determinations on any application under this Act;
 - (g) making findings or reviewing findings;
 - (h) making practice directions;
 - (i) authorising the restriction of access to an area; and
 - (j) such other functions as are prescribed by regulation.

PROPOSAL 10

Principal Registrar

1. That the position of Principal Registrar of the Coroners Court of Western Australia be established.
2. That the Principal Registrar be a suitably qualified person who is eligible to be appointed to the Magistrates Court of Western Australia.
3. That the Principal Registrar have such powers and functions as are prescribed under the Coroners Act or delegated in writing by the State Coroner.
4. That a decision of the Principal Registrar be capable of review by the State Coroner on its merits.

PROPOSAL 11

Strategic review of the Office of the State Coroner

That a strategic review of the Office of the State Coroner be conducted by a suitably qualified independent person or persons. The review should include, but not be limited to:

1. an evaluation of administrative systems and processes;
2. an evaluation of infrastructure and human resourcing needs;
3. a review of the functions and supervision of administrative staff within the Office of the State Coroner;
4. a review of the office's risk management plans;
5. consideration of the implementation of administrative, policy and procedural recommendations of the Law Reform Commission of Western Australia; and
6. the development of a strategic plan for the efficient and effective delivery of coronial services.

Consultation with relevant stakeholders including the Registry of Births Deaths and Marriages, PathWest, Western Australia Police, the Office of Safety and Quality within the Department of Health, regional coroners and registries may also be required to inform the evaluation of administrative procedures that affect or involve those entities.

PROPOSAL 12

[page 35]

Training of coroners and coroners' registrars

1. That the State Coroner provide for persons appointed as coroners to receive specific training in the coronial jurisdiction which, among other things, addresses the differences between the adversarial and inquisitorial systems of law; the prevention role of the coroner; guidance in the formulation of meaningful coronial recommendations; and training in cultural awareness.
2. That persons appointed as coroners registrars, or for whom a delegation of power under the Coroners Act is made, receive specific training about coronial practices and processes in Western Australia and in cultural awareness.

PROPOSAL 13

[page 42]

Coroner's jurisdiction

1. That the section of the Coroners Act governing the jurisdiction of the coroner to investigate a death (currently s 19) explicitly refer to the 'death of a person' in order to bring the Coroners Act into conformity with the definition of 'When death of a person occurs' in s 13C of the Interpretation Act 1984 (WA).
2. That the Coroners Act stipulate that a stillbirth, as defined in s 4 of the Births, Deaths and Marriages Registration Act 1998 (WA), is not a death for the purposes of the Act.

PROPOSAL 14

[page 44]

Increase penalties for failure to report a death

That the penalties for all three offences of failure to report a reportable death currently contained in s 17 of the Coroners Act be increased to \$10,000 or 12 months' imprisonment.

PROPOSAL 15

[page 44]

Obligation to report a suspected death

That the Coroners Act provide that where a police officer has reasonable cause to suspect that a missing person has died and that the death would be reportable, the police officer must report the suspected death to the coroner.

PROPOSAL 16

[page 46]

Removal of specific categories of anaesthesia-related deaths

That the categories that specify reportability of a death during an anaesthetic or as the result of an anaesthetic be removed from the Coroners Act.

PROPOSAL 17

[page 48]

Reportability of healthcare-related deaths

That the definition of reportable death in the Coroners Act include a 'healthcare-related death' with a definition to be modelled on s 10AA of the *Coroners Act 2003* (Qld).

PROPOSAL 18

[page 49]

State Coroner's guidelines: investigation of possible mental health-related deaths

That the State Coroner produce guidelines for police requiring that in all cases of death by suicide, drug overdose or deaths in suspicious circumstances, the police should liaise with the Office of the Chief Psychiatrist to determine whether the deceased had any contact with mental health services in the five years preceding the death and if so, that the police should seek a report from the relevant mental health service about the condition and treatment of the deceased.

PROPOSAL 19

[page 52]

State Coroner's guidelines: reportable deaths

That the State Coroner, in consultation with medical advisers, develop comprehensive guidelines explaining the role of the coroner, detailing the categories of reportable deaths under the Coroners Act, interpreting key provisions or terms of the Coroners Act and providing examples of types of deaths that may fall into each of the categories of reportable death under the Coroners Act.

PROPOSAL 20

[page 52]

Informing medical practitioners of relevant changes to the Coroners Act

That the Office of the State Coroner work together with the Office of Safety and Health in the Department of Health and the Royal Australian College of General Practitioners to develop ways of appropriately delivering to Western Australian medical practitioners information about any relevant changes to their obligations under the Coroners Act.

PROPOSAL 21

[page 55]

Authorisation to issue a cause of death certificate

That notwithstanding that a death is a reportable death under the Coroners Act, a coroner be permitted to authorise a medical practitioner to issue a cause of death certificate, without any post mortem examination being undertaken, if—

- (a) the death is not a death of a person held in care or a person held in custody; and
- (b) the cause of the death is sufficiently certain; and
- (c) the coroner is satisfied that no further investigation of the death is warranted.

PROPOSAL 22

[page 56]

State Coroner's guidelines: authorisation to issue a cause of death certificate

That the State Coroner, in consultation with medical advisers, produce guidelines outlining the circumstances in which a coroner may authorise a medical practitioner to issue a cause of death certificate in relation to a reportable death including any procedures that must be observed by medical practitioners seeking authorisation to certify a death.

Review of Death in Hospital and Medical Cause of Death forms

1. That the State Coroner, in conjunction with the Department of Health and relevant stakeholders, should review the current 'Death in Hospital' form to incorporate changes to reporting requirements under the Coroners Act, and to provide for a requirement that a doctor obtain input from family members about any concerns regarding events leading to hospitalisation and the treatment of the deceased in hospital.
2. That the State Coroner should review the current 'Medical Certificate of Cause of Death' (Form BDM 202) to provide, among other things, for the certifying doctor to note, in the case of a reportable death, on whose authority the cause of death certificate was issued.

QUESTION A

Requirements in relation to death certification

1. The Commission seeks submissions on whether the cause of death certificate should require a certifying doctor to:
 - (a) Undertake an external examination of the deceased's body, where practicable, and note any observations on the death certificate.
 - (b) State (if the death was a hospital death) that he or she is satisfied that the care provided by the attending doctor was reasonable and had no bearing on the death.
 - (c) State why, in his or her opinion, the death is not reportable to the coroner under the terms of the Coroners Act.
 - (d) Acknowledge that he or she is aware that it is an offence to fail to report a reportable death under the Coroners Act.
2. Should any other requirements be placed upon a doctor seeking to issue a cause of death certificate?

PROPOSAL 24

Coroner to inform Registrar of Births, Deaths and Marriages of certain information

That, in addition to the name, age and date of death of a deceased who is the subject of a coronial inquiry, the Office of the State Coroner or regional coroner's registry inform the Registrar of Births, Deaths and Marriages to whom the deceased's body is released.

PROPOSAL 25

Provision of interim coronial determinations to the Registrar of Births, Deaths and Marriages

That the Office of the State Coroner consider reviving its practice of providing interim determinations under s 28(2) of the Coroners Act with as much detail as possible about the circumstances and cause of death so as to enable the issuing of a death certificate at the earliest opportunity to facilitate the timely settlement of insurance and superannuation claims in certain coronial cases.

PROPOSAL 26

[page 70]

State Coroner's guidelines: police

That the State Coroner review and update the Guidelines for Police.

PROPOSAL 27

[page 71]

Adoption of the National Police Form

That the Western Australia Police and the Office of the State Coroner (in consultation with PathWest, ChemCentre, the National Coroners Information System and relevant death prevention research bodies) develop and implement an electronic variant of the national police form for use throughout Western Australia for initial reports of coronial deaths.

PROPOSAL 28

[page 73]

Restriction of access to area

That the power to restrict access to an area under the Coroners Act (currently contained in s 32) provide that:

1. A coroner, or coroner's investigator, investigating a death may take reasonable steps to restrict access to the place where the death occurred, or the place where the event which caused or contributed to the death occurred.
2. A restriction imposed by a coroner's investigator ceases to have effect 6 hours after it is imposed unless approved in writing by a coroner or a senior police officer of the rank of sergeant or above.
3. A restriction that has been approved by a senior police officer ceases to have effect 24 hours after it is imposed unless a continuance of the restriction is approved by a coroner in writing.
4. A prescribed notice may be put up at the place to which access is to be restricted.
5. A person must not without good cause enter or interfere with an area to which access is restricted under this section.

Penalty: \$10,000 or 6 months' imprisonment

6. A coroner is to ensure that access to an area is not restricted for any longer than necessary.
7. Any person aggrieved by the operation of this section may apply to the State Coroner and the State Coroner may order the variation or removal of the restriction.

PROPOSAL 29

[page 75]

Penalty for obstructing a coroner or coroner's investigator

That the penalty for delaying, obstructing or otherwise hindering a coroner or a coroner's investigator exercising a power of entry, inspection and possession under the Coroners Act (currently s 33) be increased to a fine of \$10,000 or 6 months' imprisonment.

Coroner may require medical practitioner to report

1. That the Coroners Act provide that a coroner or coroner's investigator investigating a death under the Act may, by written notice, require a medical practitioner who—
 - (a) was responsible for a person's medical care immediately before that person's death; or
 - (b) was present at or after the person's death; or
 - (c) is nominated by the hospital in which the person died;to give the coroner a written report relating to the deceased person.
2. That the notice specify the provision of the Coroners Act under which the notice is served, the information required by the coroner and a reasonable time period for compliance.
3. That the penalty for failure to comply, without lawful excuse, with such a request within the period specified in the notice is a fine of \$2,000.
4. That the Coroners Regulations be amended to provide for a fee for the provision of a medical report requested by the coroner pursuant to this power.

PROPOSAL 31

[page 78]

Power to request documents or prepared statements

1. That the Coroners Act provide that if a coroner is of the opinion that a document is required for the purposes of the coronial investigation into a death a coroner may require, by written notice in a form prescribed by regulation, a person to provide the document to the coroner within a reasonable period of time specified in the notice.
2. That the Coroners Act provide that if a coroner is of the opinion that a prepared statement is required for the purposes of the coronial investigation into a death a coroner may require, by written notice in a form prescribed by regulation, a person to prepare a statement addressing matters specified in the notice and provide the statement to the coroner within a reasonable period of time specified in the notice.
3. That the penalty for failure to comply, without lawful excuse, with such a request within the period specified in the notice is a fine of \$2,000.

PROPOSAL 32

[page 79]

Penalty for failure to provide information to a coroner

That the penalty for failure to provide information to a coroner investigating a death by a person who reports a death or by a member of the Western Australia Police who has information relevant to the investigation (currently found in s 18 of the Coroners Act) be increased to \$5,000.

PROPOSAL 33

[page 81]

Cooperation between workplace safety inspectors and coronial police

That the Coronial Investigation Unit and workplace safety agencies (ie, WorkSafe, EnergySafety and the Department of Mines and Petroleum) consider the development of cooperative protocols to facilitate communication between parties investigating workplace fatalities in the interests of avoiding unnecessary duplication during investigations of workplace deaths.

PROPOSAL 34

[page 83]

Avoidance of unnecessary duplication

That the Coroners Act provide that in the interests of avoiding unnecessary duplication of investigations and to expedite coronial or other investigations where appropriate, coroners should take reasonable measures to liaise and cooperate with bodies undertaking specialist investigations into deaths also the subject of coronial investigation, and be authorised to obtain information from and provide information to other investigative agencies.

QUESTION B

[page 83]

Ombudsman review of deaths of disabled people in residential care facilities

Should deaths of disabled people that occur in residential care facilities be subject to review by the Ombudsman to enable the identification of possible systemic issues?

PROPOSAL 35

[page 86]

Police to seal body bags

That the Western Australia Police take action to ensure that, where bodies are transported to Perth from regional areas by body transport contractors, retrieval of bodies should be overseen and body bags sealed by police to prevent tampering or contamination of evidence prior to post mortem examination.

PROPOSAL 36

[page 90]

Department of Corrective Services Policy Directive 30

1. That the Department of Corrective Services amend its Policy Directive 30 to provide for immediate notification of the coroner upon the discovery of a death in custody.
2. That the Department of Corrective Services amend its Policy Directive 30 to provide for prioritisation of notification of Major Crime Squad police upon the discovery of a death in custody.

PROPOSAL 37

[page 90]

State Coroner's guidelines: deaths in custody

That the State Coroner review and update the guidelines for the investigation of deaths in custody.

PROPOSAL 38

[page 92]

Coronial training for Major Crime Squad

That the Coronial Investigation Unit develop a targeted training module for Major Crime Squad detectives to raise awareness about the coroner's requirements for investigations into deaths in custody where no actionable criminality is detected.

PROPOSAL 39

[page 92]

Joint attendance with Coronial Investigation Unit for deaths in custody

That the Major Crime Squad and Coronial Investigation Unit jointly attend the scene of a death in prison custody to ensure that the coronial aspects of the investigation are adequately addressed.

PROPOSAL 40

[page 93]

Collaboration with the Office of the Inspector of Custodial Services

That the State Coroner develop a collaborative information sharing relationship with the Office of the Inspector of Custodial Services with a view to receiving independent information about Western Australian prisons and better informing coronial recommendations that impact systemically across the prison system.

QUESTION C

[page 96]

Oversight of police-related deaths by the Corruption and Crime Commission

Should police-related deaths be subject to independent oversight by the Corruption and Crime Commission? It is envisaged that such oversight would involve the embedding of Corruption and Crime Commission investigators from the beginning of a police-related death investigation to ensure the integrity of the investigation is monitored and that the requirements of the coroner are properly addressed.

It would preserve the role of senior police detectives in investigating the death on behalf of the coroner and of Internal Affairs providing internal and disciplinary oversight in relation to the investigation of police officers being investigated in relation to the death. The Corruption and Crime Commission investigators may, among other things, provide a separate report to the coroner about the integrity, depth and nature of the investigation.

PROPOSAL 41

[pages 101]

Specialist healthcare-related death investigation team

That a specialist healthcare-related death investigation team comprising of the current medical advisers to the State Coroner, a medical liaison administrative officer, and at least three investigators be established within the Office of the State Coroner. The functions of this team should include:

- investigation of deaths in hospitals;
- provision of medical advice to the coroner including an initial assessment of whether a case may warrant further investigation at inquest;
- assistance in informing the coroner about the appropriateness and formulation of proposed recommendations impacting the healthcare sector; and
- development, in collaboration with the Office of Safety and Quality in Healthcare in the Department of Health, of education and other strategies to improve health professionals' understanding of the coronial system and enhance cooperation between the Coroners Court and the healthcare sector.

PROPOSAL 42

[page 102]

Investigation of deaths in mental health facilities

That the Western Australia Police Coronial Investigation Unit, in consultation with the Office of the Chief Psychiatrist, develop protocols for police investigation of deaths in mental health facilities.

PROPOSAL 43

[pages 103–4]

Assistance to and from coroners in other jurisdictions

That the following provision be inserted in the Coroners Act (in place of the present s 31):

- (1) The State Coroner may request in writing that the person holding a corresponding office in another state or a territory provide assistance in connection with the exercise by the State Coroner or another coroner of any power under this Act.
- (2) The State Coroner, at the written request of the person holding a corresponding office in another state or a territory, may provide assistance to that person or a coroner of that state or territory in connection with the exercise of a power under the law of that state or territory.
- (3) For the purpose of providing assistance, the State Coroner or a coroner may exercise any of his or her powers under this Act irrespective of whether he or she would, apart from this section, have authority to exercise that power.
- (4) If the Attorney General so directs, the State Coroner must use any of the powers of a coroner under this Act to help a coroner of another state or a territory to investigate a death.
- (5) For the purposes of this section, this Act applies as if the matter that is the subject of the request or direction was the subject of an investigation under this Act.

QUESTION D

[page 104]

Assistance to coroners in other countries

Should the provision for assistance to other coroners set out in Proposal 43 extend to coroners (or someone who performs a role that substantially corresponds to that of a coroner) in another country?

PROPOSAL 44

[page 111]

Coroners' discretionary comment function

That the power of coroners to make discretionary comments (currently s 25(2)) be confined to any matter connected with a death investigated at an inquest that relates to—

- (a) public health or safety;
- (b) the administration of justice; or
- (c) the prevention of future deaths in similar circumstances.

Statement of referral in record of investigation

1. That the Coroners Act authorise the coroner to make a short statement of fact as to whether the death the subject of an inquest has been referred to the Director of Public Prosecutions or the Commissioner of Police for consideration as to whether an offence may have been committed in respect of the death of the deceased.
2. That the statement must not name an individual or individuals who may be implicated in a possible offence.
3. That the relevant form for the record of investigation (currently Form 3) make clear that the position of such a statement be at the end of the record before the signature of the coroner.

PROPOSAL 46**Re-opening of investigation or inquest on coroner's initiative**

That a section be inserted into the Coroners Act to provide:

1. That the State Coroner or a coroner who conducted an investigation or inquest into a death may, on his or her own initiative, re-open the investigation or inquest into the death if satisfied that there is new information that casts doubt on the earlier findings and that it is appropriate to re-open the investigation or inquest.
2. That the State Coroner, or another coroner, who has re-opened an investigation or inquest under this section may treat any of the evidence given at the earlier investigation or inquest as being given in the re-opened investigation or inquest.

PROPOSAL 47**Application to coroner to re-open investigation or inquest**

That a section be inserted into the Coroners Act to provide:

1. That a person may apply to the Coroners Court (in a form prescribed by regulation) for an order that some or all of the findings of a coroner after an investigation or inquest be set aside and, if the court considers it appropriate, that the investigation or inquest into the death of the deceased be re-opened.
2. That the Coroners Court may only make such an order if it is satisfied that there is new information that casts doubt on the earlier findings and that it is appropriate to re-open the investigation or inquest.
3. That for the purposes of such an application the Coroners Court must be constituted by the coroner who conducted the original investigation or inquest, unless that coroner no longer holds office or there are special circumstances.

That the decision of the Coroners Court in respect of such an application must be in writing.

PROPOSAL 48**Form of application to coroner to re-open investigation or inquest**

That the Coroners Regulations prescribe the form in which an application to a coroner for the re-opening of an investigation or inquest should be made and that such form be prominently featured and made available for download on the Coroners Court website.

Superior court review of coroner's findings

1. That, whether or not an application based on the same or substantially the same grounds or evidence has been refused by the Coroners Court, any person may apply to a single judge of the Supreme Court (in respect of the findings of a coroner or Deputy State Coroner) or to the Court of Appeal (in respect of the findings of the State Coroner) for an order that some or all of the findings of a coroner's inquest or investigation be set aside.
2. That the superior court may set aside a finding and order that the inquest or investigation be re-opened to re-examine the finding or order a new inquest or investigation if satisfied that the coroner has made an error of law in making the findings or there was evidence not adduced at the inquest or considered by the coroner during the investigation which casts doubt on the correctness of the findings.

PROPOSAL 50

[page 117]

Power to correct errors in records of investigation

That a section modelled on s 76 of the *Coroners Act 2008* (Vic) enabling the correction of clerical errors and defects of form in a coroner's record of investigation be inserted into the Coroners Act.

PROPOSAL 51

[page 119]

Non-narrative findings

1. That the Coroners Act contain a section modelled on s 67 of the *Coroners Act 2008* (Vic) enabling a coroner to make an administrative finding consisting of the identity of the deceased, the manner and cause of death and the particulars required to register the death (that is, excluding the narrative of circumstances attending the death).
2. That the above section only applies in cases where no inquest has been held, where the deceased was not a person held in care or a person held in custody (under Proposals 54 and 55), and where the coroner determines that there is no public interest to be served in including in the finding a narrative as to the circumstances attending the death.

PROPOSAL 52

[page 121]

Power of coroner to discontinue investigation in certain cases

1. That a provision modelled on s 17 of the *Coroners Act 2008* (Vic) be inserted into the Coroners Act to provide that in cases where a forensic pathologist has examined the body of a deceased and has expressed an opinion that the death was due to natural causes and the coroner determines that, other than the fact that the death of the person was unexpected, the death is not a reportable death, a coroner may discontinue the coronial investigation into the death and report the particulars required to register the death to the Registrar of Births, Deaths and Marriages.
2. That a coroner may not discontinue a coronial investigation in cases where the deceased was a person held in care or a person held in custody or where the death was during or following and causally connected to a medical procedure.
3. That the power to discontinue a coronial investigation into a death in the circumstances described above may be delegated by the State Coroner to the Principal Registrar.

Two categories: persons held in custody and persons held in care

1. That the definition of 'person held in care' in the Coroners Act be separated into two categories: 'person held in custody' and 'person held in care'.
2. That deaths of persons falling within the definition of 'person held in custody' (defined in Proposal 54) and that deaths of persons falling within the definition of 'person held in care' (defined in Proposal 55) be reportable deaths for the purposes of the Coroners Act.
3. That deaths of persons falling within the definition of 'person held in custody' (defined in Proposal 54) be the subject of a mandatory inquest.
4. That deaths of persons falling within the definition of 'person held in care' (defined in Proposal 55) be the subject of a mandatory inquest only if, in the coroner's opinion, the circumstances of the death raise issues about the deceased person's care.

Definition of person held in custody

That the definition of **person held in custody** include:

- (1) a person under, or escaping from, the control, care or custody of —
 - (a) the Chief Executive Officer of the department of the Public Service principally assisting the Minister administering the *Prisons Act 1981* in its administration; or
 - (b) a member of the Western Australia Police;
- (2) a person for whom the CEO as defined in the *Court Security and Custodial Services Act 1999* is responsible under section 10, 13, 15 or 16 of that Act, whether that person is at a custodial place as defined in that Act, is being moved between custodial places or escapes, or becomes absent, from a custodial place or during movement between custodial places;
- (3) a person detained under the *Young Offenders Act 1994*;
- (4) a person who is the subject of a hospital order or a custody order or who has been granted a leave of absence under the *Criminal Law (Mentally Impaired Accused) Act 1996*;
- (5) a person who is an involuntary patient within the meaning of the *Mental Health Act 1996* and is detained in an authorised hospital under Part 3, Division 2 of that Act or a person who is apprehended or detained under Part 3, Division 1 of that Act;
- (6) a person detained under the authority of an Act of the Commonwealth.

Definition of 'person held in care'

That the definition of **person held in care** include:

- (1) a person under, or escaping from, the control, care or custody of the CEO as defined in section 3 of the *Children and Community Services Act 2004*;
- (2) a person admitted for residential treatment to a centre under the *Alcohol and Drug Authority Act 1974*;
- (3) a person who is the subject of a community treatment order under Part 3, Division 3 of the *Mental Health Act 1996*; and
- (4) a person who is living in a residential care facility operated by or wholly or partly funded either directly or indirectly by the Disability Services Commission.

PROPOSAL 56

[page 129]

State Coroner's guidelines: person held in custody and person held in care

That the State Coroner produce guidelines that specify by example the types of cases that fall into the definition of 'person held in custody' and 'person held in care' in the Coroners Act.

PROPOSAL 57

[page 129]

Informing people about relevant changes to the definitions of person held in custody and person held in care

That the Office of the State Coroner should work together with relevant departments or agencies (including the Department of Corrective Services, the Department for Child Protection, the Mental Health Commission, the Drug and Alcohol Office, the Disability Services Commission and the Western Australia Police) to develop ways of appropriately delivering information about any relevant changes to their obligations under the Coroners Act.

PROPOSAL 58

[page 130]

Removal of mandatory inquest for suspected deaths

That the requirement that a suspected death be the subject of an inquest hearing be removed from the Coroners Act.

PROPOSAL 59

[page 130]

Removal of standard of proof for suspected deaths

That the requirement that the coroner be satisfied that the death of the person has been established beyond reasonable doubt be removed from the Coroners Act.

PROPOSAL 60

[page 135]

Guidance for coroners on when an inquest should be held

That the following provision be inserted into the Coroners Act:

- (1) An inquest may be held into a reportable death if the coroner investigating the death is satisfied it is necessary or desirable in the interests of justice to hold the inquest.
- (2) In deciding whether it is necessary or desirable in the interests of justice to hold an inquest, the coroner may consider—
 - (a) the extent to which drawing attention to the circumstances of the death may prevent deaths in similar circumstances happening in the future; and
 - (b) the extent to which the powers of a coroner at inquest would facilitate the investigation as to justify the use of the judicial forensic process; and
 - (c) any guidelines issued by the State Coroner about the issues that may be relevant for deciding whether to hold an inquest for particular types of deaths.

PROPOSAL 61

[page 135]

State Coroner's guidelines: when inquest should be held

That the State Coroner issue guidelines for coroners to assist them in the exercise of their discretion as to whether or not to hold an inquest.

PROPOSAL 62

[page 136]

Application to coroner for inquest

That an application for inquest form be developed and made available for download from the Coroners Court website. The form should provide clear fields for the information required by a coroner to make a decision pursuant to the Coroners Act whether or not to hold an inquest.

PROPOSAL 63

[page 137]

Superior court review of coroner's decision to refuse inquest

1. That where an application to hold an inquest has been refused by a coroner the person who made the application may, within 30 days of receiving the notice of refusal, apply to a single judge of the Supreme Court (in the case of a decision of a coroner or Deputy State Coroner) or the Court of Appeal (in the case of the State Coroner) for an order that an inquest be held.
2. That where a reply to an application for an inquest to be held has not been given within three months after the application was made, the person who made the application may apply to a single judge of the Supreme Court (in the case of a decision of a coroner or Deputy State Coroner) or the Court of Appeal (in the case of the State Coroner) for an order that an inquest be held.
3. That the Supreme Court may make such an order if it is satisfied that it is necessary or desirable in the interests of justice that an inquest be held.

PROPOSAL 64

[page 138]

Joint inquests

1. That the Coroners Act provide that any coroner may hold a joint inquest into two or more deaths arising from the same incident or from separate incidents with apparently similar circumstances.
2. That the State Coroner issue guidelines stating the matters to be considered by coroners in the exercise of their discretion as to whether or not to hold a joint inquest.

PROPOSAL 65

[pages 140–1]

Interested persons

1. That the section of the Coroners Act governing who may appear at an inquest (currently s 44) include those persons who the Coroners Court considers have a sufficient interest in the inquest or those persons prescribed by regulation and that the rights of appearance of those persons include the right to examine or cross examine witnesses and make submissions.
2. That where the Coroners Court considers a person to have sufficient interest in an inquest solely because it is in the public interest (eg, a special interest advocacy group or a government or community entity which has no direct connection with the death being investigated), the rights of appearance are limited to making submissions on the matters on which a coroner may comment or make recommendations and examining or cross-examining witnesses with the court's leave.

Inquest brief to be provided by Coroners Court

1. That, unless otherwise ordered by the coroner, the Principal Registrar must provide an interested party with a copy of the inquest brief being a brief of evidence that is prepared for an inquest and contains the following (if available)—
 - (a) a statement of identification by an appropriate person;
 - (b) any reports given to a coroner as a result of a medical examination;
 - (c) reports and statements that the coroner investigating the death believes are relevant to an inquest;
 - (d) other evidentiary material that the coroner investigating the death or believes is relevant to the inquest;
 - (e) any material prescribed by the regulations.
2. That an inquest brief does not include any part of a medical file that the coroner considers to be irrelevant to the inquest.
3. That, unless leave is given for another purpose, information provided as part of the inquest brief shall only be used for proceedings under the Coroners Act.

PROPOSAL 67

Notification and publication of inquest dates

1. That reasonable notice (between 4 and 6 months) is given to interested persons of dates set down for the hearing of an inquest.
2. That as soon as dates are set for the hearing of an inquest they are immediately published on the Coroners Court website.
3. That unless the State Coroner otherwise directs, a coroner must, at least 28 days before an inquest, publish in a daily newspaper circulating generally in the state, the date, time, place and subject of the inquest.

PROPOSAL 68

Pre-inquest hearings

1. That a section modelled on s 34 of the *Coroners Act 2003* (Qld) be inserted into the Coroners Act to provide for pre-inquest hearings for the purposes of deciding the issues to be investigated at the inquest; the witnesses who will be required; the evidence that will be required; the interested persons who may appear at the inquest; whether it is appropriate that a specialist adviser be appointed to sit with a coroner at inquest; how long the inquest will take; and, where appropriate, the dates for the hearing of the inquest.
2. That interested persons and witnesses identified by the Coroners Court be advised in writing of the date for the pre-inquest hearing and the issues the coroner intends to investigate at the inquest.
3. That the Coroners Court may publish a notice of a pre-inquest hearing at least 28 days in advance of the hearing to notify potential interested persons of the inquest. Such notice should be published in a daily newspaper circulating generally in the state, as well as on the Coroners Court website.
4. That Coroners Court may order a person concerned with the investigation to attend the pre-inquest hearing.

PROPOSAL 69

[page 146]

Identifying interested parties

That reasonable efforts be made by the Coroners Court to identify and notify persons whose interests may be affected by the conduct and outcome of an inquest or who may be required to appear as a witness at an inquest of the court's intention to hold an inquest prior to inquest hearing dates being set.

PROPOSAL 70

[page 147]

Funding of legal representation at inquest

That the Western Australian government fund Legal Aid WA, the Aboriginal Legal Service of Western Australia and community legal centres to provide legal representation and assistance to families for the purposes of an inquest where such representation is in the public interest.

PROPOSAL 71

[page 148]

State Coroner's guidelines: conduct of hearings

1. That the authority in the Coroners Act of the State Coroner to issue guidelines (currently s 58) include that the State Coroner may issue guidelines relating to the conduct of inquests and pre-inquest hearings.
2. That the State Coroner's guidelines contain a statement to the effect that the purpose of an inquest is to investigate the circumstances and cause of death and not the forum in which the allocation of blame is considered or determined, that counsel appearing at an inquest should bear the purpose of an inquest in mind in the questioning of any witness and that a failure to do so may result in questions being disallowed.

PROPOSAL 72

[page 149]

Enhance legal professional education

That the Law Society of Western Australia and the Western Australian Bar Association, in conjunction with the Office of the State Coroner, consider offering ongoing education (as part of the compulsory Continuing Professional Development program) to lawyers about the inquisitorial functions, procedures and culture of the Coroners Court.

QUESTION E

[page 152]

Expert advice to coroners at inquest

Should there be facility for a person with appropriate expertise to sit with the coroner at inquest to assist them in understanding and testing complex, technical evidence? If so, should any advice the specialist adviser gives to the coroner be available to the interested persons appearing at the inquest? Alternatively, should the specialist adviser have a decision-making role (similar to the role of a panel member in the State Administrative Tribunal)?

PROPOSAL 73

[page 153]

Use of concurrent expert evidence at inquest

1. That coroners consider the use of concurrent expert evidence during inquests, where appropriate and practicable.
2. That the State Coroner issue guidelines for the use of concurrent expert evidence in the Coroners Court.
3. That coroners may hold pre-inquest hearings for the purposes of taking submissions from interested persons as to whom should be called to give evidence as an expert.

PROPOSAL 74

[page 174]

Extend protection against self-incrimination

That a certificate given under the Coroners Act (currently s 47) extend to provide protection for a witness against the use of evidence given at an inquest in subsequent criminal or civil proceedings, or in proceedings before a tribunal or person exercising powers and functions in a judicial manner against the person other than on a prosecution for perjury.

PROPOSAL 75

[page 155]

Use of affidavits at an inquest

1. That the section in the Coroners Act dealing with affidavits (currently s 15) expressly provide for the acceptance and use of affidavits at inquest.
2. That the Coroners Regulations be amended to provide a form for affidavits relating to a coronial investigation and sworn before a coroner's registrar or coroner's investigator pursuant to the Coroners Act.

PROPOSAL 76

[page 156]

Interruption of an inquest

That the penalty for breach of the offence of interrupting an inquest include a term of not more than 6 months' imprisonment or a fine of \$5,000.

PROPOSAL 77

[page 156]

Power to exclude from inquest

That the coroner's power to exclude a person or persons from an inquest also applies to pre-inquest hearings.

PROPOSAL 78

[page 157]

Restriction of publication

That the coroner's power to restrict publication of some or all of the evidence (currently s 49) be amended as follows:

- (1) A coroner must order that no report of a pre-inquest hearing or an inquest or of any part of the proceedings or of any evidence given at an inquest be published if the coroner reasonably believes that it would—
 - (a) be likely to prejudice the fair trial of a person; or
 - (b) be contrary to the public interest.
- (2) A coroner may order the restriction of publication of specified matters revealed at an inquest or a pre-inquest hearing that involve the disclosure of details of sensitive personal matters including, where the senior next of kin of the deceased have so requested, the name of the deceased.

That the penalty for contravening an order made under the above section be increased to \$10,000 for individuals and \$50,000 for corporations.

PROPOSAL 79

[page 158]

Publication of inquest findings, comments and recommendations

That, unless otherwise ordered by a coroner, the findings, comments and recommendations made following an inquest must be published on the Coroners Court website as soon as practicable.

PROPOSAL 80

[page 164]

Support for the coroner's prevention role

That a prevention team be established within the Office of the State Coroner employing sufficient research and systems information staff to:

- (a) update and maintain the Coroners Court website;
- (b) monitor and evaluate responses to and implementation of coronial recommendations;
- (c) undertake analysis of coronial data to identify incipient trends in deaths and opportunities for prevention activities;
- (d) conduct research to support the coroners' decision-making and recommendatory functions;
- (e) conduct consultations with stakeholders to inform the proposed formulation of coronial recommendations; and
- (f) liaise with and provide relevant coronial information to death prevention bodies, researchers and special interest advocacy groups approved by the Coronial Ethics Committee.

Coroners' power to make recommendations

1. That a coroner may make a recommendation on any matter connected with a death investigated at an inquest that relates to—
 - (a) public health or safety; or
 - (b) the administration of justice; or
 - (c) the prevention of future deaths in similar circumstances.
2. That recommendations may be addressed to any Minister, public statutory authority, public or private entity or individual.

PROPOSAL 82**Considerations relevant to the making of comments or recommendations**

That, in determining whether to make comments and recommendations in connection with a death investigated at an inquest, a coroner must consider:

- (a) the potential for comments or recommendations to play a constructive role in the prevention of future deaths in circumstances similar to the death of the deceased;
- (b) the extent to which the evidence presented at the inquest enables the making of comments or recommendations that have application to the particular circumstances of the death of the deceased; and
- (c) the advice, if any, of the specialist adviser or advisers appointed to assist the coroner at the inquest.

PROPOSAL 83**Notification of coroners' recommendations**

1. That any coroner who makes a recommendation following an inquest must ensure that a copy of a record of investigation that includes the recommendations is provided, as soon as is reasonably practicable, to:
 - (a) the State Coroner (unless the coroner is the State Coroner);
 - (b) any entity to which a recommendation included in the record is directed;
 - (c) the Attorney General;
 - (d) any other Minister (if any) that administers legislation, or who is responsible for the entity, to which a recommendation relates; and
 - (e) any other person or entity prescribed by regulation.
2. That a letter be included with the copy of a record of investigation drawing attention to the existence of the recommendations and to the obligation of the party or parties to whom they are directed to acknowledge receipt of the recommendations and provide a response to them within the time frame specified in Proposal 84.

Mandatory response to coronial recommendations

1. That a public statutory authority or public entity the subject of a coronial recommendation must, within 21 days of receiving the recommendation, acknowledge receipt of the recommendation in writing to the State Coroner.
2. That a public statutory authority or public entity the subject of a coronial recommendation must within three months of receiving the recommendation, provide a written response to the State Coroner specifying a statement of action (if any) that has, is or will be taken in relation to the recommendations made by the coroner.
3. That, as soon as reasonably practicable upon receipt of the written response from a public statutory authority or public entity, the State Coroner must publish the response on the internet and provide a copy of the response to any person who has advised the Principal Registrar that they have an interest in the subject of the recommendations.

QUESTION F

[page 173]

Mandatory responses to coronial recommendations – private entities and individuals

Should private entities and individuals be subject to the same mandatory reporting requirements in response to coronial recommendations as public entities? If not, should an exception be made for private entities that perform public functions pursuant to a contract with a public entity, government department or minister?

QUESTION G

[page 174]

Mandatory responses to coronial recommendations – penalty

Should there be an offence for failing to discharge reporting obligations under the Coroners Act? If so, what would be the appropriate penalty and should the penalty differ for public and private entities and individuals?

Proposal 85

[page 179]

Cultural competency training: police and coronial staff

1. That, in consultation with the Office of Multicultural Interests, the Office of the State Coroner establish cultural competency training for all staff who have dealings with the public. Such training should be tailored, as far as possible, to the organisational needs of the Office of the State Coroner.
2. That, in consultation with the Office of Multicultural Interests, the Coronial Investigation Unit (CIU) of the Western Australia Police establish cultural competency training for all staff and make information about dealing with different cultures during periods of grief available to police cadets and officers through CIU-run training.

Proposal 86

[page 182]

Coronial Liaison Unit

1. That the coronial counselling service be renamed the Coronial Liaison Unit to remove any stigma that may attach to seeking 'counselling' for users of the service and to better describe the services provided.
2. That the Coronial Liaison Unit be constituted by 'coronial liaison officers' who are qualified counsellors.
3. That consideration be given to providing the Coronial Liaison Unit with a dedicated administrative assistant.

Proposal 87

[page 184]

Provision of coronial counselling and liaison to Aboriginal people

1. That the Office of the State Coroner make arrangements with the Kimberley Aboriginal Medical Services Council and with Aboriginal Medical Services or relevant community agencies in other regions to enable Aboriginal health workers to provide coronial counselling and information liaison services to Aboriginal people. Aboriginal health workers should be provided with adequate training and resources to provide these services on behalf of the Office of the State Coroner.
2. That the staff of the Office of the State Coroner and of dedicated regional coroners undergo Aboriginal-specific cultural awareness training to assist in the organisation and delivery of culturally appropriate services to Aboriginal people in Western Australia.

Proposal 88

[page 186]

Community awareness education and training

1. That the Office of the State Coroner be sufficiently resourced to establish a comprehensive training and education strategy and to conduct targeted training and education for people involved in peripheral professions including aged and palliative care providers, funeral directors, community grief counselling services, Aboriginal health workers, coronial body transport contractors, and specialist investigators (such as mining inspectors and WorkSafe investigators) who have dealings with families of deceased.
2. That the Office of the State Coroner develop an information package that can be distributed to relevant industries and included, where possible, in industry training initiatives.

Proposal 89

[page 188]

Expand available translations of important coronial information

1. That the Coroners Court expand the range of languages in which key information (including, but not limited to, the brochure 'When a Person Dies Suddenly') is provided on its website.
2. That the Coroners Court provide links in the relevant language on the homepage of its website to translations of key coronial information.

Proposal 90

[page 190]

Use of interpreters

1. That, when delivering key information about the coronial process, including the rights of the senior next of kin under the Coroners Act, and when seeking information to assist the coronial investigation, police officers and Coroners Court staff should assess the need for a professional language interpreter and provide such an interpreter if required.
2. That family and friends should not be used to interpret and communicate key coronial information (including the right to object to a post mortem examination) to the senior next of kin, unless all reasonable avenues to obtain a professional language interpreter have been exhausted.
3. That Coroners Court staff should consider the need for provision of an interpreter to assist families to participate in inquest proceedings. The family or their representative should be consulted to ensure that an interpreter in the correct language and dialect is engaged.

Proposal 91

[page 192]

Coronial information service

That the Office of the State Coroner investigate ways to provide families with regular updates about the progress of the deceased's case through the coronial process and accessible information about each stage of the coronial process, including the provision of a secure online service that is able to be accessed by families.

Proposal 92

[page 193]

Release of post mortem examination report

1. That unless otherwise ordered by the coroner, the Office of the State Coroner must provide the senior next of kin of a deceased person with any reports given to a coroner as a result of a medical examination performed on the deceased.
2. That where a post mortem examination report is sent to a medical practitioner to assist the family of a deceased to interpret the findings, a second copy of the report is to be given to the medical practitioner along with instructions that the medical practitioner is to provide the copy of the report to the family after the contents of the report have been interpreted and explained.

Proposal 93

[page 194]

Coroners Court website

1. That the Office of the State Coroner review the content of Coroners Court websites in Queensland, South Australia and Victoria with a view to improving the Coroners Court website in Western Australia.
2. That the Coroners Court website provide, at a minimum, information sheets for families, healthcare professionals, witnesses, researchers and lawyers; copies of all State Coroner's guidelines and public forms; regularly updated inquest and pre-inquest hearing lists including, where practicable, information about the matters to be investigated at the inquest; copies of coronial findings, comments and recommendations following an inquest; responses to coronial recommendations; and links to community counselling and support organisations.

Proposal 94

[page 196]

State Coroner's guidelines: review, update and publish

1. That, in addition to issuing guidelines about the specific matters addressed in proposals throughout this Discussion Paper, the State Coroner review and update all existing guidelines and consider guidelines that should be made to discharge the obligation under s 58(1) of the Coroners Act.
2. That, at the earliest opportunity, all State Coroner's guidelines be publicly available for download from the Coroners Court website.

Proposal 95

[page 197]

Coronial forms

1. That forms to assist families and others to exercise their rights or discharge their obligations under the Coroners Act be developed and made available on the Coroners Court website.
2. That forms to assist professionals (including lawyers, medical practitioners and funeral directors) in their dealings with the coronial system be developed and made available on the Coroners Court website.

Proposal 96

[page 200]

Viewing and touching the deceased

1. That the Office of the State Coroner ensure that staff at the state mortuary are aware that all next of kin are permitted to view and touch the body of a deceased while the body is under the control of the coroner, unless the coroner determines that it is undesirable or dangerous to do so.
2. That the need for greater availability of coronial counsellors for families viewing or identifying coronial deceased be recognised and resourced.
3. That in cases where touching the deceased is not permitted consideration be given, where appropriate, to allowing families to decide whether they would prefer to view the deceased through glass or from behind a barrier.
4. That the Office of the State Coroner review the arrangements for viewing and touching of bodies while bodies are under the control of the coroner in regional area morgues including, the inclusion in contracts for body removal and transport of a separate fee for conducting a viewing and the provision of written authority to anyone requested or required to conduct a viewing.

Proposal 97

[pages 202–3]

Coroner may order external or preliminary post mortem examination

1. That a coroner may direct a forensic pathologist or doctor to perform an external post mortem examination for the purposes of determining, if possible, a medical cause of death.
2. That a coroner may direct a forensic pathologist or doctor to perform a preliminary post mortem examination to assist the coroner to determine whether or not to order a full internal post mortem examination or to perform any other function in respect of the death.
3. That an external post mortem examination and a preliminary post mortem examination be defined as:

- (a) a visual examination of the body (including a dental examination);
- (b) the collection and review of information, including personal and health information relating to the deceased person or the death of the person;
- (c) the taking of samples of bodily fluid including blood, urine, saliva and mucus samples from the body and the testing of those samples;
- (d) the imaging of the body including the use of computed tomography (CT scan), magnetic resonance imaging (MRI scan), x-rays, ultrasound and photography;
- (e) the taking of samples from the surface of the body including swabs from wounds and inner cheek, hair samples and samples from under fingernails and from the skin and the testing of those samples;
- (f) the fingerprinting of the body;
- (g) any other procedure that is not a dissection, the removal of tissue or prescribed by regulation to be an internal post mortem examination.

Proposal 98

[pages 203–4]

Conduct of post mortem examinations

1. That the following principles governing the conduct of a post mortem examination be inserted into the Coroners Act:
2. When a post mortem examination or other examination or test is conducted on the remains of a deceased person under this Part, regard is to be had to the dignity of the deceased person.
3. If more than one procedure is available to a person conducting a post mortem examination to establish the cause and manner of a deceased person's death, the person conducting the examination is to endeavour to use the least invasive procedures that are appropriate in the circumstances.
4. Without limiting subsection 2, examples of procedures that are less invasive than a full post mortem examination of the remains of a deceased person include (but are not limited to) the following:
 - (a) an external examination of the remains;
 - (b) a radiological examination of the remains;
 - (c) blood and tissue sampling; and
 - (d) a partial post mortem examination.

Proposal 99

[page 205]

Factors that coroners must consider in ordering an internal post mortem examination

That the Coroners Act provide that in making a decision whether or not to order an internal post mortem examination of a deceased a coroner must consider:

1. the extent to which an internal post mortem examination of the deceased will assist the coroner to make the relevant findings under the Coroners Act in the context of the information and evidence already available to the coroner or arising from investigations or examinations (such as an external post mortem examination) ordered by the coroner;
2. the potential for the death to have occurred in circumstances that suggest a serious criminal offence or a threat to public health or safety;

3. the potential healthcare benefits of an internal post mortem examination for the deceased's family or the community;
4. any known or communicated cultural, spiritual or customary beliefs of the deceased or the deceased's family;
5. any concerns raised by a family member, or another person with a sufficient interest, in relation to the type of post mortem examination to be conducted;
6. any advice provided by a medical adviser to the coroner following an analysis of medical records of the deceased; and
7. any advice provided by a pathologist or doctor who has undertaken an external or preliminary post mortem examination of the deceased at the direction of a coroner.

Proposal 100

[page 207]

Objection may only be made to internal post mortem examination

That the right of the senior next of kin to object to a post mortem examination of the deceased under the Coroners Act be limited to the undertaking of an internal post mortem examination.

Proposal 101

[page 208]

Time for objection to post-mortem examination

1. That the State Coroner's guidelines provide that in cases where a post-mortem examination does not have to be conducted immediately, a coroner should ensure that no post mortem examination is conducted until at least a period of 48 hours including one full working day has elapsed from the time when the coroner's brochure 'When a Person Dies Suddenly' is provided to a next of kin.
2. That the coroner's brochure 'When a Person Dies Suddenly' be amended to reflect the increase in time for objection to 48 hours.

Proposal 102

[page 209]

Supreme Court of Western Australia website

That the Supreme Court of Western Australia consider providing a link on its website page for 'self-represented persons' to basic application and process information including the relevant practice directions and links to forms required for applications under the Coroners Act.

Question H

[page 212]

Removal and retention of organs

Are there any issues the Commission should be aware of in relation to organ retention and return practices in Western Australia, particularly in the past five years?

Preparation of bodies for release from the State Mortuary

That technicians preparing bodies for release from the State Mortuary in Perth take care to ensure that bodies are released in good condition with due care and attention paid to the potential need for embalming and to measures to be taken to prevent seepage of bodily fluids during transport.

Need for urgent attention to State Mortuary

That the state government urgently consider PathWest's application for funding for the construction of a temporary facility to accommodate coronial viewings with a view to expediting construction.

Release of body by a coroner

1. That the provision for certifying disposal of a body in the Coroners Act (currently s 29) be repealed and replaced by a provision specifying that the coroner may order that a body under the control of the coroner be released if the coroner is satisfied that it is no longer necessary for the coroner to have control of the body in order to exercise his or her functions under the Coroners Act.
2. That an order for release made under the Coroners Act must specify a person to whom the body is to be released and may contain any terms and conditions that the coroner thinks necessary.
3. That an order for release may not be made until any application for a post mortem examination (currently s 36) is disposed of or the time for making such application, including any extension of time granted by the Supreme Court, has expired.
4. That consequential amendments be made to the Cremation Act 1929 (WA) and any other relevant Act to change references to coroner's certification permitting disposal of a body to an order of a coroner permitting release of the body.

Application for release of body by a coroner

That the Coroners Act provide that:

- (1) A person (the applicant) may apply to a coroner for a body to be released to the applicant.
- (2) If 2 or more applicants apply for release of the body, the coroner must determine the person to whom the body is to be released on the basis of who has the better claim.
- (3) In determining who has the better claim, the coroner must have regard to the following principles—
 - (a) if the person named in the will as an executor is an applicant, the body of the deceased should be released to the executor;
 - (b) if a person specified under paragraph (a) is not an applicant, the body should be released to the senior next of kin;

- (c) if there appear to be 2 or more applicants who are the senior next of kin of the deceased, the coroner should determine to whom the body is to be released having regard to any principles of common law relating to the release and disposal of a body of a deceased person;
- (d) if no person referred to in paragraph (a) or (b) is an applicant, the coroner should determine to whom the body is to be released having regard to the principles of common law relating to the release and disposal of a body of a deceased person.

Proposal 107

[page 219]

Supreme Court review of coroner's decision to release a body

That the Coroners Act provide that a person may apply to a single judge of the Supreme Court for review of a determination for release made pursuant to Proposal 106 on the basis of an error of law. That such application must be made within 48 hours of the determination being made by the coroner.

Proposal 108

[page 219]

Providing information about release to families

That the Office of the State Coroner advise the senior next of kin in writing of their responsibility to appoint a funeral director to obtain release of the body without delay and that this information be included in the 'When a Person Dies Suddenly' brochure and on the Coroners Court website.

Appendix B: Statistical tables

The data tables in this appendix, reproduced from Chapter Three of the Commission's Background Paper, provide a statistical overview of the coronial jurisdiction in Western Australia for the decade 2000–2009.

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Table 1: Coronial cases 2000–2009¹

	2000 ²	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 ³	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 ⁴	14%	14%	12%	12%	12%	13%	13%	14%	14%	14%

Table 3: Number of Inquests 2000–2009⁵

	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 ⁶	25%	20%	26%	19%	29%	24%	43%	38%	22%	39%

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

2. 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).

3. 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).

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

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

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

	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

	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 ⁷	35%	45%	42%	49%	43%	42%	37%	44%	51%	52%

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

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

Table 8: Inquests by Coroner 2000–2009

	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

Table 9: Number of Inquest Sitting Days per Coroner 2000–2009

	2000 ⁸	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

Table 10: Legal Representation in Western Australian Inquests 2000–2009⁹

	2000	2001	2002 ¹⁰	2003 ¹¹	2004 ¹²	2005 ¹³	2006 ¹⁴	2007	2008	2009 ¹⁵
Total Inquests	60	40	43	37	49	38	46	39	37	33
Inquests with counsel ¹⁶	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

Table 11: Coronial cases involving Indigenous deceased 2001–2009

	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 ¹⁷	159	134	131	134	136	171	178	195	130
Percentage of total coronial cases ¹⁸	11%	10%	9%	10%	9%	11%	10%	11%	7%

8. 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.

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

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

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

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

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

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

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

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

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

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

Table 12: Number of inquests involving one or more Indigenous deceased

	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 ¹⁹	5	6	7	8	13	5	4	10	6	5
Percentage of total inquests ²⁰	8%	15%	16%	21%	27%	13%	9%	26%	16%	15%

Table 13: Incidence of coronial recommendations in Western Australian Inquests

	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 ²¹	30%	33%	44%	46%	51%	37%	39%	56%	46%	42%

Table 14: Number of coronial recommendations in Western Australian Inquests

	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

Table 15: Completed cases timeliness – Western Australia 2006–2009²²

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

19. 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.

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

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

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

Table 16: Pending caseload timeliness – metropolitan and regional Western Australia 2006–2009²³

Months Pending ²⁴	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

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

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

Appendix C:

When a Person Dies Suddenly

This appendix contains a reproduction of the Coroners Court brochure 'When a Person Dies Suddenly'.

This brochure contains the information required under s 20 of the *Coroners Act 1996* (WA) to be provided to the next of kin, including reference to the right of the senior next of kin to object to a post mortem examination. The brochure is delivered to the next of kin by police when the next of kin is notified of the death.

For further discussion of the brochure and its place in the coronial process see Chapter Seven, 'Access to Coronial Information'.



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 W/A 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

Court and Tribunal Services Division

FCC-POK | JUL09 | JAN10/5000

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.

Appendix D: List of people consulted

The Commission thanks the following people for their input, advice or assistance during this reference.

Adrian Barrett, William Barrett and Sons, Bunbury
Alan Goodger, Detective, Western Australia Police, Kununurra
Alan Joyce, Acting Manager, Maternal and Child Health, Department of Health (WA)
Alana McCarthy, Senior Solicitor, Crown Solicitor (NSW)
Alison Flanagan
Ali M Barry, President, Guinean Community Association
Alistair Hope, State Coroner of Western Australia
Alka Jain, President, Hindi Samaj Western Australia Inc
Allan Anderson, Invocare
Amanda Banks, Journalist, The West Australian
Andrew Lewis, Librarian, Parliament of Western Australia
Angus Trewavas, Manager, Financial Ombudsman Service (Cth)
Anita Rudeforth, Senior Policy Officer, Strategic Development, Department of Mines and Petroleum
Ann O'Neill, Angelhands
Ben White, Solicitor, Aboriginal Legal Service, Broome
Bernadine Brierty, Bowra & O'Dea
Brett Burns, Registrar, Births Deaths & Marriages
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
Brigita White, Director, Office of the State Coroner (Qld)
Bronwyn Peters, Senior Legal Adviser, Department of Health (WA)
Casey Prins, Detective Inspector, Special Crime Squad, Western Australia Police
Caroline Thatcher, State Solicitor's Office (WA)
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, District Court of Western Australia
Claudia Chipper, Medical Scientist and Quality & Project Support Officer, PathWest QE11
Cleo Taylor, Senior Practice Development Officer, Department of Child Protection, Broome
Danie McNeil, Divisional Executive Officer, Australian Funeral Directors Association
Dave Dent, Registry Manager, Office of the State Coroner (WA)
Dave Taylor, Operations Manager, Pathwest QE11

David McCann, Perth Coroner and magistrate (ret.)
David Snell, Legislation and Policy Branch, Department of Justice and Community Safety (ACT)
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Dell Collins RN, Community Nurse, Kununurra
Denise Tilbee
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
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Dr Gavin Turbett, Director Forensic DNA, PathWest
Dr Ian Freckelton SC, Barrister, Owen Dixon Chambers, Melbourne
Dr Jacqueline Scurlock, consultant paediatrician, SIDS and Kids
Dr Jodi White, Forensic Pathologist, PathWest
Dr Judith McCreath, Forensic Pathologist, PathWest
Dr Karin Margolis, Forensic Pathologist, PathWest
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Dr Rebecca Scott-Bray, Lecturer, University of Sydney
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Dr Rowan Davidson, Chief Psychiatrist of Western Australia
Dr Steven Patchett, Director, Office of Mental Health (WA)
Dr Tim Rolfe, Clinical Consultant, Office of the Chief Psychiatrist (WA)
Dr Tom Hitchcock, Office of Safety and Quality, Health Department of Western Australia
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Evon Stewart
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Geoff Sorrell, Sergeant, Office of the State Coroner (WA)
Graeme Slattery, Snr Associate, Minter Ellison
Graham Sears, Senior Sergeant, Western Australia Police, Kununurra
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Greg Dick, Secretary, Thai-Australian Association of Western Australia (Inc)

Greg Swensen, Researcher
Habibul Ahmed, President, Bangladesh Australia Association of Western Australia
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Helen Soerink
James K Watmore
James Woodford, Associate to Justice Templeman, Supreme Court of Western Australia
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Janet Peacock, Manager, Office of Chief Psychiatrist (WA)
Janet Roy, Secretary, Office of the State Coroner (WA)
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Jennifer Searcy, Victim Advocate and Researcher, Murdoch University
Jennifer Whitton
Jenny Scott, Coroners Clerk, Coroners Court, Hobart (Tas)
Jessica Pearse, Manager, National Coroners Information System
Joanna Cotsonis, Access Liaison Officer, National Coroners Information System
Jodie Sieverts
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 of New Zealand
Judith Chambers
Julie Moll, Seasons Funeral Home
Karina Moore
Karoline Jamieson, Communicare
Katherine Hams, Manager, Kimberley Aboriginal Medical Services Council, Broome
Kathryn Dowling, Team Leader, Duty Intake, Department of Child Protection, Broome
Kathryn Keogh
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Leesa Ivey, Acting General Manager, PathWest
Leonard Sharp
Lois Henderson, Coroners Court, New Zealand
Lorraine Broun
Liz McDonald
Liz Prime
Lynette Gillam, The Compassionate Friends WA
M Evans
Magistrate Catherine Crawford, Kununurra/Perth Magistrates Court
Magistrate Colin Roberts, Broome Magistrates Court
Magistrate Elizabeth Hamilton, Albany Magistrates Court
Magistrate Felicity Zempilas, Kalgoorlie Magistrates Court (formerly counsel assisting)
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
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Margaret Bradley
Margaret Le Saux
Margaret Sandford
Marian Smith
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Michael Chambers
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Michelle Kosky, Executive Director, Health Consumers' Council (WA)
Miriam O'Donoghue
Naomi von Senff, Office of the State Coroner (NSW)
Nina Lyhne, Commissioner & Executive Director, WorkSafe Western Australia
Office of Multicultural Interests, Department of Local Government (WA)
Olive Siva, President, Australian Anglo Burmese Society
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Owen Starling, Regional Manager, Kimberley/Pilbara Courts, Broome Magistrates Court
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Paul Coombes, Detective Superintendent, Major Crime Division, Western Australia Police
Pauline Templeton
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Professor Richard Harding, former Inspector of Custodial Services (WA)
Professor Roger Byard, Chief Pathologist, Forensic Science Centre (SA)
Professor Sven Silburn, former Chair, Ministerial Council for Suicide Prevention (WA)
Rasa Subramaniam
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Sue Sansalone, Systems Information Manager, Office of the State Coroner (WA)
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Vicki Hall, Coronial Support officer, Coroner's Office (NT)
Vivienne Chinnery, Manager Customer Services, Registry of Births Deaths & Marriages (WA)

The Commission also thanks those members of the public who responded to its call for comments or completed the survey for family members and friends of deceased, but who wished to remain anonymous.

