Review of Coronial Practice in Western Australia

FINAL REPORT

Project No 100

January 2012

Law Reform Commission of Western Australia

The Law Reform Commission of Western Australia

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Foreword

IN 2008 the former Attorney General asked the Law Reform Commission of Western Australia to undertake the substantial and complex task of reviewing the coronial practices and procedures in Western Australia, including a comprehensive review of the operation of the *Coroners Act 1996* (WA) ('the Coroners Act'). The reference was timely in light of reforms in coronial law and systems internationally and across Australia. A complete review of the system was also important given the critical function that the coroner performs in making recommendations aimed at preventing deaths.

This Final Report contains the Commission's final recommendations for reform. The Commission engaged in extensive research and consultation throughout this reference culminating in a detailed Discussion Paper that was published in June 2011 putting forward a number of proposals. The Commission received overwhelming support for the proposals contained in the Discussion Paper. The Commission received 57 submissions from a broad cross-section of government agencies, community organisations, health professionals and members of the public. The Commission also undertook targeted consultations on specific proposals. The research, submissions and consultations have informed the recommendations in this Final Report.

The Final Report contains 113 recommendations for reform. While the majority of recommendations address much-needed legislative reform or clarification, there are a number of recommendations that invite reform to practices and policies, both of the Office of the State Coroner and of other agencies with peripheral involvement in the delivery of coronial services in Western Australia.

Western Australia has the second oldest Coroners Act in Australia. Reviews and recommendations for reform in the late 1980s to early 1990s resulted in the passing of the current Coroners Act in 1996. The Coroners Act has allowed for the development of a coronial system which has served Western Australia well. In particular, the State Corner, Alistair Hope, and the Deputy State Corner, Evelyn Vickers, have been instrumental in establishing a system to strengthen the prevention role of the coroner. However, in undertaking this reference it was clear that significant reforms were warranted. Significant delays to coronial findings in recent years have considerably added to the distress of families in a time of grief. This Report maps out a principled approach to reform of the coronial jurisdiction to address the concerns communicated by members of the public and by those closely involved in delivering coronial services in Western Australia. The Commission's recommendations will bring the Coroners Act into line with recent reforms in comparable jurisdictions in Australia while taking into account the special circumstances of Western Australia, in particular its geographic and demographic realities.

Although the number of deaths being dealt with by coroners has *not* radically risen (1526 in 2000 to 1827 in 2009), demands placed upon the coronial system have changed since the passage of the Coroners Act. Public expectations of coroners appear to be higher. People expect the coroner to play a greater role in the prevention of future deaths in similar circumstances and the recommended reforms in this report bring that role into greater focus in Western Australia.

People are also demanding greater transparency of the coronial process and greater accountability of the Coroners Court. There is an urgent need to promote public confidence in the coronial system. The Commission has made a number of recommendations to improve transparency of the coronial process. The Commission has also recommended that the next State Coroner be drawn from the District Court of Western Australia to increase accountability and to place the Coroners Court firmly within the judicial hierarchy of Western Australia.

The Commission found that the public as well as people involved in the delivery of coronial services lack knowledge of the system and this may add pressure to the system by placing unrealistic expectations upon it. There is a need for greater attention to public awareness and training for those involved either intimately or peripherally in the coronial system.

Significantly, the Commission found that regional Western Australians did not have equality of access to coronial services with problems including no coronial counselling services in the regions, uneven quality of coronial investigations, and significant concerns regarding the inadequate training of regional coroners and registrars. The Commission has recommended that coronial regions be established and serviced by dedicated regional coroners.

The Commission has also made recommendations to improve practices within the Office of the State Coroner. The Commission has recommended that a position of Principal Registrar be created. While there has been an increase in staff by over 50% since 2009 there has been no evaluation of inefficient internal administrative processes or any strategic plans made for the future. The Commission has recommended that there be an urgent independent strategic review of the Office of the State Coroner.

There have also been significant technological advances in the past 15 years in respect of the use of imaging technologies in post mortem examinations. Western Australia needs to be brought into the 21st century with legislative encouragement to utilise available technologies so that the least invasive procedures that are available and appropriate in the circumstances are used.

I would like to take this opportunity to acknowledge and thank all the Commissioners who have worked on this reference. It was begun when Judge Gillian Braddock was Chair of the Commission; she was instrumental in establishing the reference before ending her term at the Commission in November 2008. Joe McGrath SC assisted during the important consultation stage. Richard Douglas joined the Commission in May 2010 and has helped guide the Discussion Paper and Final Report. I would particularly like to acknowledge the input and hard work of Robert Mitchell SC who was a Commissioner for most of the reference before being appointed Acting Solicitor General in August 2011. Alan Sefton joined the Commission during the preparation for the Final Report, engaged quickly and constructively with the reference and provided the Commission with valuable input.

The Commission would like to acknowledge and thank all those who voluntarily provided their time and expertise during the consultations for this report. In particular the Commission wishes to thank those family members and friends of people whose death was the subject of a coronial investigation, who gave information to the Commission. The Commission recognises the value of this input and the emotional cost often involved in providing it. Special mention must be made of the State Coroner, the Deputy State Coroner, Counsel Assisting, the Office Manager and the administrative staff of the Office of the State Coroner. They have provided us with invaluable information to assist in the development of the recommendations we trust will improve the efficiency and effectiveness of the important work they provide to the Western Australian community into the future.

My fellow Commissioners and I would like to especially acknowledge the lead researcher and author of this Final Report, the Discussion Paper and the Background Paper, Dr Tatum Hands. As always, Dr Hands has provided excellent advice and has conducted extensive research and consultations (including in regional areas) on behalf of the Commission. She is to be particularly commended on managing the complex and often emotional strands of this reference with great care and understanding.

I have been part of this reference from the beginning and would not have been able to manage without the very important support from the Executive Officer Heather Kay and Project Manager Sharne Cranston. I thank them both for their loyalty and dedication to the Commission throughout this reference. Thank you also to our technical editor Cheryl MacFarlane for her assistance in the preparation of this Report.

The Commission believes that the recommend-ations in this Final Report will allow Western Australia to be recognised as a leading innovator in coronial law and practice into the future.

Mary Anne Kenny
Chair
2 January 2012

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Overview

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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.

In keeping with its terms of reference the Commission has engaged in 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 dealt with the structure of the Office of the State Coroner, its human resources, detailed budget and staffing allocations were considered to be beyond the scope of the reference.[1] As noted in its Background Paper,[2] resourcing issues were addressed in an operational review[3] of the Coroners Act conducted in 2008 by Queensland State Coroner Michael Barnes.[4]

CONSULTATIONS AND PUBLICATIONS

The Commission began work on this reference by consulting extensively with recognised experts in coronial law and practice both in Western Australia and elsewhere. It also consulted with those intimately involved with the delivery of coronial services in Western Australia.[5] In September 2010 the Commission published a Background Paper which provided a legislative history of coronial law in Western Australia, 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.[6]

The purpose of the Background Paper was to engage the public to ensure that proposed reforms to the coronial system acknowledged the views of those who ultimately are the 'users' of the system; that is, the family and friends of a 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, members of the public were invited to share their experiences of the coronial jurisdiction with the Commission. To assist people to focus their comments, the Commission also published an online survey to guide people through each step of the coronial process relevant to their experience.

1. The Commission has maintained throughout this reference that details such as the number of FTEs or the budget allocation the Coroners Court may require as a result of the Commission's recommended reforms 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. This was communicated to the Attorney General in letters dated 29 January 2009, 24 August 2009 and 15 June 2011.
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. This review was undertaken by State Coroner Barnes with the knowledge that the Commission had been given a contemporaneous reference to undertake a wider review of the coronial jurisdiction: Barnes M, *Review of the Coroners Act 1996 (WA)* (August 2008).
5. A list of people consulted for this reference may be found at Appendix B to this Report.
6. LRCWA, *Review of Coronial Practice in Western Australia,* Background Paper (September 2010).

Responses from members of the public, combined with the Commission's extensive research and consultation with experts, helped the Commission to formulate proposals for reform to the coronial system in Western Australia. These 108 proposals for reform were contained in the Commission's Discussion Paper, which was released for public comment in June 2011. The Commission received 57 submissions (including 14 supplementary submissions) from a range of public agencies, interest groups, professional organisations and members of the public. One submission was provided as a joint submission from eight separate agencies.[7] In response to a number of submissions discussing the appropriate definition of 'healthcare-related death', the Commission undertook further consultations with the Office of the State Coroner, the Department of Health, medical professional bodies and health consumer organisations. The submissions received by the Commission in response to its Discussion Paper and to the targeted consultations on specific proposals have informed the recommendations in this Final Report.

ABOUT THIS FINAL REPORT

This Final Report is intended to be read closely with the Commission's comprehensive Discussion Paper. The Discussion Paper examines in detail aspects of coronial practice, procedure and law identified by the Commission as requiring reform and provides justification for the Commission's proposals for reform. Where the Commission's proposals have been overwhelmingly supported and confirmed as recommendations, this Report simply refers the reader to the supporting material in the Discussion Paper rather than reproducing it.

This Report is divided into seven chapters following the structure of the Discussion Paper and discussing (with a small number of exceptions) the proposals in the order they appear in the Discussion Paper.

Chapter One provides a brief snapshot of the coronial process[8] and identifies the eight objectives of reform, which reflected concerns raised during the Commission's consultations and which, in turn, have informed the final recommendations in this Report. This chapter recommends that the role of the coroner and the objectives of the coronial process be defined more clearly in the Coroners Act by insertion of an objects clause.

Chapter Two sets out the current Coroners Court model in Western Australia and makes recommendations for institutional and structural reform. Such recommendations include that a system of coronial regions be established serviced by dedicated coroners and that the State Coroner be drawn from the bench of the District Court of Western Australia. Other recommendations include establishing an office of Principal Registrar in the Coroners Court; placing legislative limitations on the delegation of coronial power; training coroners and coronial registrars; and the need for a strategic review of the Office of the State Coroner.

Chapter Three examines issues with the system of reporting and registration of deaths in Western Australia, and recommends changes to the definition of reportable death in the Coroners Act. It also recommends that a coroner may, in certain circumstances, authorise a medical practitioner to issue a cause of death certificate in respect of a death that would otherwise be reportable. Other recommendations include legislative and administrative reforms to improve the processes of death certification and registration.

Chapter Four looks at the system of death investigation in Western Australia and examines concerns relating to specific types of investigation. It makes recommendations to augment coroners' investigations powers; for the establishment of a specialist healthcare death investigation team; for greater cooperation and collaboration between the Coroners Court, specialist investigators and other bodies; and for independent oversight of police investigations into police-related deaths.

Chapter Five discusses coronial findings and inquests including the powers of the coroner at the hearing and determination stage. Recommendations made in this chapter include recommendations to confine the coronial comment function; authorise the reopening of investigations or inquests in certain circumstances; and to

7. Australian Inquest Alliance, Submission No 39 (2 September 2011). Members of the Australian Inquest Alliance that contributed to the submission and endorsed the response were: Deaths in Custody Watch Committee (WA), Aboriginal Legal Service (WA); Federation of Community Legal Centres Inc (Vic), Aboriginal Legal Service Ltd (NSW/ACT); Aboriginal Legal Rights Movement Inc (SA), Aboriginal and Torres Strait Islander Legal Service Ltd (Qld), Victorian Aboriginal Legal Service Cooperative Ltd, and North Australian Aboriginal Justice Agency.

8. 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.

permit coroners to discontinue investigations or produce non-narrative administrative findings in certain circumstances. The Commission also recommends a new approach to deaths in respect of persons held in custody or care with a number of new categories of custody and care provided for. Other recommendations include provision for legislative and administrative guidance to coroners about when an inquest or joint should be held; the establishment of pre-inquest hearings; and a number of recommendations to improve inquest processes.

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. It makes recommendations to enhance the prevention role of the coroner, to guide coroners in the making of informed recommendations and to legislate for a mandatory response to coronial recommendations from public entities.

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. Recommendations in this chapter include improvements to training, education and information provided within the coronial system, to related service providers and to the public at large. Recommendations are also made about improving the access of families to information about progress of a deceased's case and about their rights in the coronial process. Finally, the Commission makes a number of recommendations about post mortem examinations including recommendations to enable external post mortem examinations in all cases; to legislate factors that coroners must consider when ordering an internal post mortem examination; to govern objections to post mortem examination; and to govern the release of a body by a coroner.

A NEW CORONERS ACT?

While the recommendations for reform in this Final Report are substantial, it should be noted that there are a number of miscellaneous provisions in the current Coroners Act that were not subject to specific scrutiny by the Commission but which remain useful and necessary. As noted in its Discussion Paper, 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.[9] The recommendations for reform throughout this Report 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).

9. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 5.

Coronial process in brief

Both the Commission's Background Paper and Discussion Paper describe in detail the operation of the coronial system in Western Australia. While it is not intended to revisit that level of detail in this Report, it is useful to provide a brief description of the coronial process in Western Australia so that recommendations in the following chapters can be more easily understood.

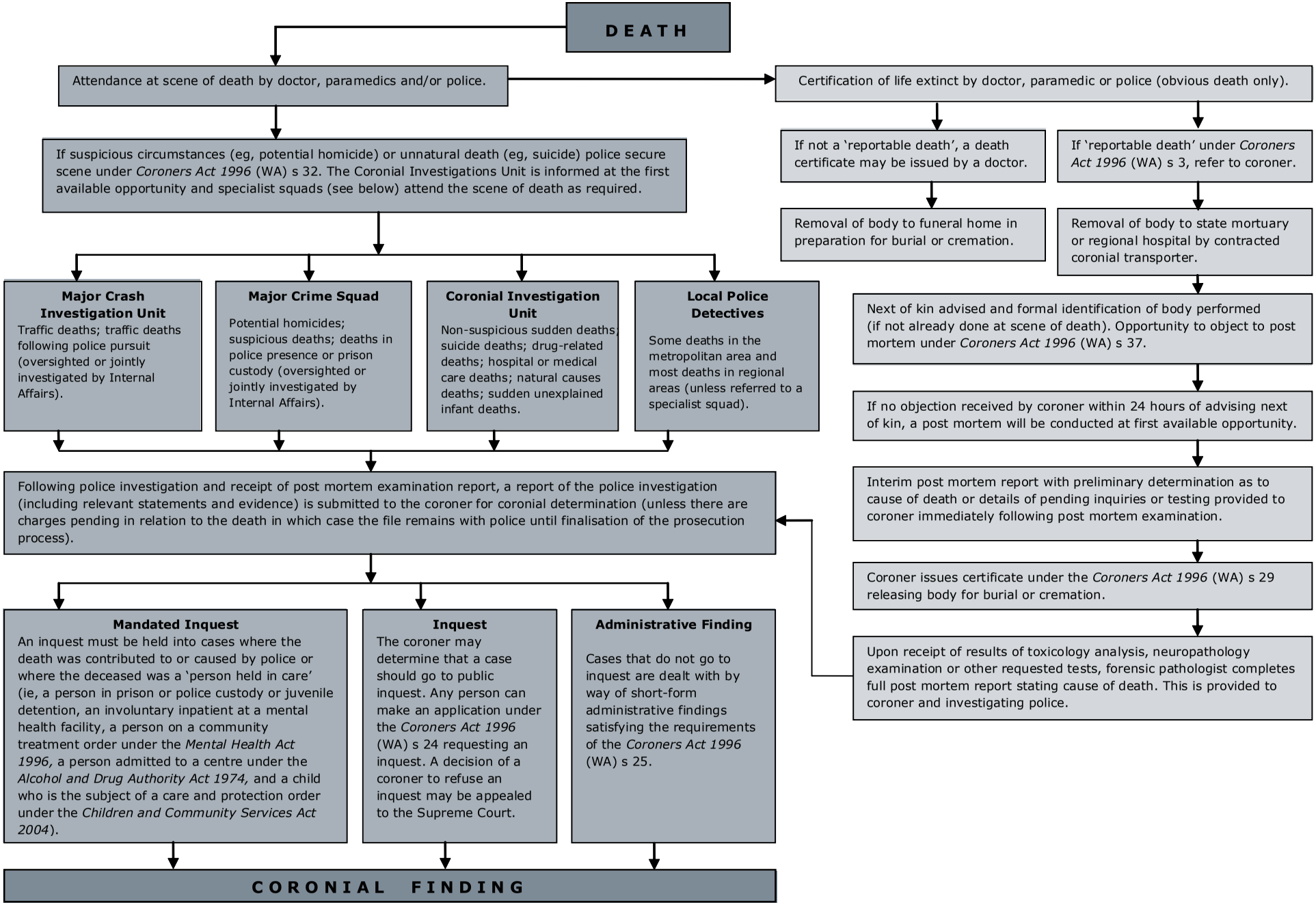
Approximately 2,300 deaths are reported to the coroner each year[1] pursuant to s 17 of the *Coroners Act 1996* (WA) ('the Coroners Act'), of which around 1,800 become accepted as coronial cases.[2] This means approximately 14% of total deaths each year in Western Australia are investigated by a coroner.[3] 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.[4] 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 or EnergySafety), mining deaths (investigated by the Department of Mines and Petroleum) and aviation deaths (investigated by the Australian Transport Safety Bureau).[5]

Reports produced by forensic pathologists, police and (on request) specialist investigators are provided to the coroner who then undertakes an internal review of reports[6] 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.[7]

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.[8] 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.[9] A characteristic 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.

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,[10] while the total number of coronial cases has increased by almost 20% over the same period.[11] In 2009 a total of 33 inquests were undertaken in Western Australia with 17 of those being inquests

1. For the financial year 2006–2007 a total of 2,341 cases were referred to the coroner with 717 death certificates issued after the case was reported to the coroner: Office of the State Coroner (WA), *Annual Report 2006–2007* (2007) 34.
2. 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.
3. There are approximately 12,500 deaths in Western Australia each year. 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 LRCWA, *Review of Coronial Practice in Western Australia*, Discussion Paper (June 2011) Appendix B, tables 1 & 2.
4. For detail of the post mortem examination and police investigation process, see ibid, Chapter Four.
5. For a detailed discussion, see 'Specialist Investigators', ibid, 80–83.
6. The internal review may include a review of reports by the coroner's in-house medical adviser and requests for further specialist reports.
7. This list is not exhaustive. For a full discussion, see 'Mandated Inquests', ibid 122–30.
8. *Coroners Act 1996* (WA) s 22(2).
9. For examples, see LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 137–38.
10. 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,* Discussion Paper (June 2011) Appendix B, table 3.
11. Ibid, table 1.


DEATH
Attendance at scene of death by doctor, paramedics and/or police.
Certification of life extinct by doctor, paramedic or police (obvious death only).
If suspicious circumstances (eg, potential homicide) or unnatural death (eg, suicide) police secure scene under Coroners Act 1996 (WA) s 32. The Coronial Investigations Unit is informed at the first available opportunity and specialist squads (see below) attend the scene of death as required.
If not a 'reportable death', a death certificate may be issued by a doctor.
If 'reportable death' under Coroners Act 1996 (WA) s 3, refer to coroner.
Removal of body to funeral home in preparation for burial or cremation.
Removal of body to state mortuary or regional hospital by contracted coronial transporter.
Major Crash Investigation Unit
Traffic deaths; traffic deaths following police pursuit (oversighted or jointly investigated by Internal Affairs).
Major Crime Squad
Potential homicides; suspicious deaths; deaths in police presence or prison custody (oversighted or jointly investigated by Internal Affairs).
Coronial Investigation Unit
Non-suspicious sudden deaths; suicide deaths; drug-related deaths; hospital or medical care deaths; natural causes deaths; sudden unexplained infant deaths.
Local Police Detectives
Some deaths in the metropolitan area and most deaths in regional areas (unless referred to a specialist squad).
Next of kin advised and formal identification of body performed (if not already done at scene of death). Opportunity to object to post mortem under Coroners Act 1996 (WA) s 37.
If no objection received by coroner within 24 hours of advising next of kin, a post mortem will be conducted at first available opportunity.
Interim post mortem report with preliminary determination as to cause of death or details of pending inquiries or testing provided to coroner immediately following post mortem examination.
Coroner issues certificate under the Coroners Act 1996 (WA) s 29 releasing body for burial or cremation.
Upon receipt of results of toxicology analysis, neuropathology examination or other requested tests, forensic pathologist completes full post mortem report stating cause of death. This is provided to coroner and investigating police.
Following police investigation and receipt of post mortem examination report, a report of the police investigation (including relevant statements and evidence) is submitted to the coroner for coronial determination (unless there are charges pending in relation to the death in which case the file remains with police until finalisation of the prosecution process).
Mandated Inquest
An inquest must be held into cases where the death was contributed to or caused by police or where the deceased was a 'person held in care' (ie, a person in prison or police custody or juvenile detention, an involuntary inpatient at a mental health facility, a person on a community treatment order under the Mental Health Act 1996, a person admitted to a centre under the Alcohol and Drug Authority Act 1974, and a child who is the subject of a care and protection order under the Children and Community Services Act 2004).
Inquest
The coroner may determine that a case should go to public inquest. Any person can make an application under the Coroners Act 1996 (WA) s 24 requesting an inquest. A decision of a coroner to refuse an inquest may be appealed to the Supreme Court.
Administrative Finding
Cases that do not go to inquest are dealt with by way of short-form administrative findings satisfying the requirements of the Coroners Act 1996 (WA) s 25.
CORONIAL FINDING

that were mandated under the Coroners Act.[12] Thirteen of the 33 inquests held in 2009 were held in regional areas.[13] These figures are reasonably representative of the past five years.[14]

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 checked 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).[15]

The above chart serves to illustrate the coronial investigation and determination process from death to coronial conclusion.

12. Ibid, tables 4 & 6. Inquests which are mandated by the *Coroners Act 1996* (WA) include deaths in custody or care. For further discussion, see ibid 122–30.
13. Ibid, table 4.
14. 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.
15. For a full discussion of administrative findings see ibid, 118–21.

Objectives of reform

As noted in the Introduction, the Commission has undertaken extensive consultations with recognised experts in coronial law and practice, 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 ideas for potential reforms to the coronial system. The results of these consultations were summarised in the Commission's Background Paper where a number of apparently systemic problems with the current coronial process were also identified.[1] The Commission's consultations and research informed the following (interrelated) objectives of reform, which were explained in detail in its Discussion Paper.[2]

1. Strengthen and support the prevention role of the coroner.
2. Improve communication and cooperation between individuals and entities involved in the coronial process.
3. Reduce delay in the coronial process.
4. Promote public confidence in the coronial system.
5. Improve reporting of deaths, recording of coronial data and identification of trends.
6. Facilitate informed recommendations and encourage meaningful responses.
7. Enhance the role and support of families in the coronial process.
8. Promote equality of access to coronial services for regional Western Australians.

These eight objectives serve to explain the Commission's approach to this reference and underpinned the proposals for reform presented in the Commission's Discussion Paper. These objectives have also remained at the forefront of the Commission's deliberations in formulating the recommendations that appear in this Final Report.

OBJECTS OF THE CORONERS ACT

As noted in the Discussion Paper, almost all Australian and New Zealand coronial legislation enacted during the past decade contain an objects clause and 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.[3] Proposal 1 of the Commission's Discussion Paper set out a proposed objects clause with the prevention role of the coroner clearly stated. Submissions were overwhelmingly supportive of this proposal and, therefore, the inclusion of an objects clause in the Coroners Act is recommended below.

A small number of submissions raised minor issues in relation to the wording of the proposed objects clause. In response to a submission from the Australian Inquest Alliance the Commission has added the word 'comments' to clause (d), which sets out the ways in which a coroner may contribute to a reduction in the incidence of preventable deaths.[4] The submission of the Department of the Attorney General noted the usefulness of objects clauses in providing 'guidance in the interpretation of provisions' and 'by articulating the principle policy objectives intended to be achieved by the legislation'.[5] However, the department expressed reservations about the wording of clause (f) (which articulates the provision of a counselling service attached to the Coroners Court as an object of the Act), suggesting that it 'may be too broad'.[6] Although under the current *Coroners Act 1996* (WA) ('the Coroners Act') a counselling service must be attached to the court and the service must be made available as far as practicable 'to

1. LRCWA, *Review of Coronial Practice in Western Australia,* Background Paper (September 2010) ch 4.
2. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 9–12.
3. LRCWA, Review of Coronial Practice in Western Australia, Discussion Paper (June 2011) 12. 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: Barnes M, *Review of the Coroners Act 1996 (WA)* (August 2008) recommendation 1.
4. Australian Inquest Alliance, Submission No 39 (2 September 2011).
5. Department of the Attorney General, Submission No 40 (31 August 2011).
6. Ibid.

any person coming into contact with the coronial system',[7] it could be argued that provision of the service to family members, friends and others as set out in Proposal 1 is wider than the provision in the current Act. The Commission has therefore amended the wording of clause (f) to 'offer' rather than 'provide'.

Both the State Coroner and the Department of the Attorney General submitted that consideration should be given to inserting a provision into the objects section dealing with the role of the coroner in educating the public and the health and legal professions about the coronial system.[8] The Commission has considered such an addition; however, it is of the view that this is a policy matter that is not likely to be dealt with by legislative reform. As such, the Commission does not believe that it is appropriate to make specific reference to education in the objects section of the Coroners Act.

RECOMMENDATION 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, comments 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 offer a counselling service to family members, friends and others associated with a death the subject of a coronial investigation.

It should be noted that two submissions[9] disagreed with clause (c) above regarding the Commission's proposal to establish coronial regions in Western Australia. These submissions are dealt with in the following chapter which sets out the recommended structure of the coronial jurisdiction in Western Australia.

7. *Coroners Act 1996* (WA) s 16.
8. Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Department of the Attorney General, Submission No 40 (31 August 2011), noted in response to Proposal 72 dealing with enhancing the education about the coronial system available to the legal profession.
9. Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011); Department of the Attorney General, Submission No 40 (31 August 2011).

Chapter Two

Restructuring the Coronial Jurisdiction

Contents

Structure of the Coroners Court

The Commission's Discussion Paper described in some detail the current semi-centralised coronial system operating under the *Coroners Act 1996* (WA) ('the Coroners Act').[1] This system is constituted by a full-time State Coroner and Deputy State Coroner based in Perth and magistrates acting ex officio as coroners in regional areas.[2] The Coroners Court is a court of record[3] and the State Coroner is head of jurisdiction with responsibility for overseeing and coordinating coronial services throughout Western Australia.[4] In this section, the Commission discusses the problems with the current structure of the Coroners Court and makes recommendations for reform to address these issues and to generally improve the effectiveness of the coronial system throughout the state.

THE CURRENT MODEL

Perth

Coronial deaths in the metropolitan area are reported to the Office of the State Coroner in Perth and bodies of the deceased are immediately transported to the State Mortuary for post mortem examination.[5] Metropolitan coronial deaths are (generally) investigated by a specialist unit within the Western Australia Police – the Coronial Investigations Unit – with specialist investigators undertaking investigations where necessary or relevant.[6] Currently there are three coroners based in Perth: the State Coroner, the Deputy State Coroner and a 'temporary' coroner appointed for a specified period (six months) under s 11 of the Coroners Act. These coroners are responsible for all administrative findings and inquests for coronial deaths in the metropolitan area. In addition, the State Coroner and Deputy State Coroner perform most inquests in regional areas.

Coroners in Perth are assisted by a range of support staff within the Office of the State Coroner including four registry staff, three legal counsel (to prepare inquest briefs and assist coroners at inquests), two police sergeants, two part-time medical advisers, a court manager, a findings clerk (to draft administrative findings), two administrative assistants, a systems information officer (responsible for maintaining the court's entries onto the national coronial database), a data entry officer and a receptionist.[7] In addition, the Office of the State Coroner has a dedicated counselling service staffed by three qualified counsellors who act as liaison between the Coroners Court and the family and friends of a deceased.

Regional Western Australia

Under s 11 of the Coroners Act each magistrate is contemporaneously a coroner; however, in practice only regional magistrates exercise functions under the Coroners Act. Coronial deaths outside the metropolitan area (approximately 30% of all coronial deaths) are reported to the relevant regional court whose registrar 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).[8] Bodies of deceased are transported to the State Mortuary in Perth for post mortem examination,[9]

1. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 17–20.
2. *Coroners Act 1996* (WA) ss 6, 7 & 11.
3. *Coroners Act 1996* (WA) s 5.
4. *Coroners Act 1996* (WA) s 8.
5. A body may be released from the State Mortuary without having undergone a post mortem examination if an objection against a post mortem examination is upheld by a coroner: see LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 198–209.
6. For example, traffic deaths, deaths in custody and suspected homicides are investigated by other squads within the Western Australia Police. Workplace, energy-related, aviation and mining deaths anywhere in Western Australia are investigated by specialist bodies in addition to police. For a full discussion of death investigation processes, see LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) ch 4.
7. The level of human and financial resources provided to the Office of the State Coroner has been a subject of concern for the State Coroner for at least the past five years and the present government has responded to these concerns by approving substantial temporary budget increases since August 2009: see LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 18–19.
8. 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.
9. 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.

and regional police in the relevant area investigate the death[10] 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. 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.[11] Because regional magistrates rarely undertake inquests, they have no need for in-house legal counsel assisting or other inquest management services.[12] 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

The Commission's consultations and research identified a number of problems plaguing the coronial system in Western Australia.[13] Some of the key 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. Principal among these were lengthy delays in completion of coronial cases; lack of communication and cooperation between the Office of the State Coroner in Perth and regional magistrates, registrars, contractors and investigators; and limited guidance, information, training and oversight being provided to those responsible for the delivery of coronial services in the regions. Over the past decade only a handful of regional inquests have been undertaken by a regional magistrate and this (in combination with a notable absence of training and guidance) has led to magistrates becoming deskilled in coronial matters. Over the same period the coronial jurisdiction has become increasingly specialised, particularly in respect of the research and prevention function being embraced by dedicated coroners in Australian jurisdictions.[14] The Commission noted in its Discussion Paper that regional magistrates in Western Australia lacked access to the tools necessary to perform this prevention role.[15]

Most regional magistrates with whom the Commission consulted also explained 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 prepare and hold inquests or direct police investigations of coronial cases. Indeed, the quality and timeliness of coronial police investigations in some regional areas had been subject to criticism by the State Coroner with a number of police briefs found to be substantially deficient.[16] The Commission's consultations revealed that there was some uncertainty among regional police as to what the coroner's requirements were and how a coronial investigation might differ from a criminal investigation: an issue which certainly would impact upon the quality of coronial investigations in regional areas.[17]

A particularly concerning issue across the whole of the coronial system (regional and metropolitan) is the extent to which important coronial functions (such as directions to conduct a post mortem examination and the drafting of coronial findings) are delegated to court registrars or clerks. In regional areas this is significant because new magistrates (who are given no specific coronial training) must rely upon the experience of their registrars to understand their role and responsibilities in the coronial system. The Commission was told that each regional court relied upon its own templates and precedents for coronial findings and that they were often reliant upon the experience of their registrar.[18] In consequence, the lack of uniformity in the approach to investigations and coronial findings across the state, which the passage of the Coroners Act was intended to address, continues unabated.[19]

10. In some circumstances, a specialist metropolitan police team may be deployed to investigate a regional death.
11. Consultation with Regional Magistrates (9 November 2009).
12. 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,* Discussion Paper (June 2011) Appendix B, table 5.
13. Ibid 9–12. See also, LRCWA, *Review of Coronial Practice in Western Australia,* Background Paper (September 2010) ch 4.
14. For a full discussion of the prevention function, see ibid, ch 6.
15. Ibid 20. For example, neither magistrates nor their regional registrars are trained in the identification or investigation of cluster cases (such as suicides, baby deaths, etc) or the making of coronial recommendations. In addition, the Commission found that few regional magistrates had any knowledge of the existence of the National Coroners Information System (NCIS) database or had been trained in its use. Further, they had no direct access to the findings or recommendations of the State Coroner and Deputy State Coroner and thus had no understanding of what areas had been the subject of previous recommendations by a dedicated coroner in Western Australia or any precedent from which to work to guide the making of their own findings, comments and recommendations in a particular case.
16. Ibid 24–5.
17. This appeared to be due to both the lack of direction and guidance from regional coroners at the initial stages of an investigation and the lack of training of regional police officers in respect of the coroner's requirements: ibid 24–5, 69.
18. Regional Magistrates, consultation (9 November 2009).
19. Ibid 19–23. Many of these issues were raised by previous reviews of the coronial jurisdiction in Western Australia: see

A NEW MODEL FOR WESTERN AUSTRALIA

Although a number of concerns with the current coronial model (eg, delay, lack of communication and training) apparently impact across the entire coronial system, it is apparent from the above that regional Western Australians do not have the same access to coronial services as their metropolitan counterparts. In its Discussion Paper, the Commission examined alternative models for the delivery of coronial services in Western Australia to overcome the problems identified across the system and to enhance the quality and availability of coronial services for regional Western Australians. A model favoured by Queensland State Coroner Barnes in his 2008 operational review[20] of the Coroners Act was centralisation of all coronial services to Perth.[21] The Commission examined the two jurisdictions (South Australia and the Northern Territory) where a centralised model has been adopted and found that the geographic and demographic differences between those jurisdictions and Western Australia were significant.[22] While the Commission acknowledged that the current semi-centralised model was not working effectively, it was not persuaded that a fully centralised model would deliver an improved service to regional Western Australians. In particular, the Commission noted that, although centralisation may have certain advantages in terms of potential economies of scale, it came 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.[23]

Ultimately, the Commission proposed a system where the coronial role would be removed from regional magistrates but coronial regions in the north and south of the state would be established and serviced by dedicated coroners.[24] A version of this model is currently operating in Queensland and, to a greater extent, in New Zealand and received significant support during the Commission's consultations, including in regional areas. While Proposal 2 (that magistrates should no longer hold automatic contemporaneous ex officio appointments as coroners) was overwhelmingly supported by submissions,[25] Proposal 3 (the establishment of north, south and metropolitan coronial regions) and Proposal 4 (the assignment of dedicated regional coroners to the north and south regions) received some opposition. Of the 14 submissions that commented on this issue, eight supported the proposals for establishing coronial regions with dedicated coroners;[26] three favoured a fully centralised model;[27] one suggested an alternative model;[28] and two wished to maintain the status quo.[29]

As can be seen, the majority of submissions supported the idea of established coronial regions in the north and south of the state serviced by dedicated regional coroners and support staff. In its submission, the Department of Health noted that the 'creation of appropriately funded and staffed coronial regions would facilitate improvements in the quality and timeliness of coronial investigations in rural areas'.[30] Likewise, the Western Australia Police noted that the creation of coronial regions would improve investigations as well as address current deficiencies 'in respect to culture, training and monitoring of coronial cases'.[31] The

Barnes M, *Review of the Coroners Act 1996 (WA)* (August 2008); and *Report of an Ad Hoc Committee for the Review of the Coroners Act* (August 1989).

20. Barnes, ibid.
21. As noted in the Discussion Paper, the arguments raised by Barnes in support of his recommendation to centralise the coronial function in Western Australia related almost exclusively to the use of regional magistrates as ex officio coroners. The Commission accepted the force of these arguments and under the Commission's proposed model (with which Barnes' submission agreed) coronial jurisdiction would no longer be automatically vested in magistrates.
22. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 22–3.
23. Significantly, trends in regional deaths to date have usually 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.
24. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) proposals 2, 3 & 4.
25. Only two submissions did not support the removal of the coronial function from magistrates generally. Chief Magistrate Heath maintained his argument (discussed in the Commission's Discussion Paper) that the Coroners Court should be subsumed into the Magistrates Court, while the Department of the Attorney General expressed concern about the cost of the proposed model: Steven Heath, Chief Magistrate, Magistrates Court of Western Australia, Submission No 1 (18 July 2011); Department of the Attorney General, Submission No 40 (31 August 2011).
26. Registry of Births, Deaths, and Marriages, Submission No 9A (24 August 2011); Department of Health, Submission No 11 (17 August 2011); Commissioner for Children and Young People, Submission No 15 (22 August 2011); Jennifer Searcy, Adjunct Professor, Murdoch University, Submission No 19 (23 August 2011); Baha'i Council of WA, Submission No 31 (26 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Western Australia Police, Submission No 35 (1 September 2011); Australian Inquest Alliance, Submission No 39 (2 September 2011).
27. Dominic Mulligan, Coroner, Office of the State Coroner WA, Submission No 14 (20 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011).
28. David McCann, Former Perth Coroner, Submission No 16 (19 August 2011).
29. Steven Heath, Chief Magistrate, Magistrates Court of Western Australia, Submission No 1 (18 July 2011); Department of the Attorney General, Submission No 40 (31 August 2011).
30. Department of Health, Submission No 11 (17 August 2011).
31. Western Australia Police, Submission No 35 (1 September 2011).

Commissioner for Children and Young People highlighted that 'the lack of adequate services is consistently raised (in regional areas) across all areas of service delivery' and submitted that the Commission's proposed regional model 'would be a significant improvement' in this area.[32]

Those submissions that favoured centralisation (or the status quo), generally cited resourcing issues as militating against the Commission's proposed model. This was something that the Commission addressed in its Discussion Paper, stating that although the dedicated regional coroner model would require further and necessary resourcing of the coronial jurisdiction, there would be a positive impact on the resources of the Magistrates Court because regional magistrates and regional court clerks would no longer be required to perform coronial functions.[33] But practical concerns were also an issue for some respondents. The State Coroner acknowledged the need to improve coronial service delivery to regional areas but suggested that there might be difficulties in recruiting appropriately skilled staff in regional areas and accommodating both the regional office and the regional coroner. The Deputy State Coroner expressed concern that a coroner might be placed into a regional office without sufficient experience or training in coronial work and may therefore struggle to effectively perform their coronial functions. Interestingly the submission from Queensland State Coroner Michael Barnes (who had previously recommended centralisation of the coronial system in Western Australia) supported the Commission's proposed coronial region model with dedicated regional coroners – a system that is currently operating well in Queensland.

The Commission has carefully considered the arguments in all submissions; however, it maintains that its proposed coronial region model with dedicated regional coroners will deliver the best coronial service for Western Australia and overcome the current inequality of service in regional areas. Having said that, the Commission recognises that there may be resourcing and other practical issues that may, for the time being, make the establishment of dedicated regional coroners within their regions difficult. The Commission was attracted to a variation on the proposed model suggested by former Perth Coroner David McCann whereby dedicated coroners with responsibility for particular regions are based centrally.[34] It has therefore amended its recommendation to allow for dedicated regional coroners to be based in Perth for the time being with the ultimate goal of moving them to the regions that they service. The Commission views this as a workable and sensible compromise; however, it warns that this should not be seen as supporting centralisation of the coronial jurisdiction in Western Australia. It is merely recognition that there may not, at this time, be enough work to sustain a permanent coroner based in the north of the state. There is arguably already sufficient work to sustain a southern-based coroner and, based on the population projection research set out in its Discussion Paper, the Commission believes that within the next 5–10 years there will be sufficient population to staff and sustain a northern-based coroner.[35] By that time, dedicated regional coroners based in Perth will have sufficient experience and training to overcome the concerns expressed by the Deputy State Coroner.

Finally, the Commission highlights that dedicated regional coroners (whether based in Perth or within their regions) should be tasked with creating strong relations with their regions, in particular with police officers investigating coronial matters. Under the Commission's model, the dedicated regional coroners will be responsible for all administrative findings in their regions as well as the holding of inquests (with the exception of certain high profile inquests that may demand the presence of the State Coroner). As well, regional coroners may be tasked by the State Coroner to perform work in the metropolitan area when required (eg, when the State or Deputy State Coroner is on leave or when caseloads require it).

RECOMMENDATION 2

No ex officio coroners

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

32. Commissioner for Children and Young People, Submission No 15 (22 August 2011).
33. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 26. Under the Commission's recommendations, the only involvement that regional Magistrates Courts will have in coronial matters is the conduct of file viewings when requested by family. All other matters will be referred to the dedicated coroner for that region.
34. A similar suggestion was also made by the Western Australia Police, although it supported the Commission's proposals.
35. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 24.

RECOMMENDATION 3

Establish coronial regions

That three coronial regions be established in Western Australia 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).

RECOMMENDATION 4

Dedicated regional coroners

That dedicated coroners be assigned to service the northern region and the southern region (as defined in Recommendation 3), with the objective that those coroners ultimately be based in these regions.

STRATEGIC REVIEW OF THE OFFICE OF THE STATE CORONER

The Office of the State Coroner has suffered problems of delay and lack of communication with implications that impact across the system (described above), as well as unsupervised coronial power being routinely delegated to coroners' registrars (addressed below). These were contributed to by many years without sufficient human and financial resources.

Although in recent years the Coroners Court has received an increase in funding, this has been channelled into the task of reducing the very substantial backlog of coronial cases and inquests and no action had been taken to address the underlying processes and practices that may be contributing to problems experienced by the system. The Commission therefore proposed that a strategic review of the Office of the State Coroner be undertaken at the earliest opportunity to ensure that any sustained increase in human and financial resources is used to maximum effect, and that systems and administrative processes are rigorously evaluated.[36] This proposal received complete support from submissions[37] and is therefore confirmed as a recommendation.

RECOMMENDATION 5

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 at the earliest opportunity. 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.

Consultations with relevant stakeholders including the Registry of Births Deaths and Marriages, PathWest, Western Australia Police, 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.

36. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) Proposal 11.

37. Department of Health, Submission No 11 (17 August 2011); David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Western Australia Police, Submission No 35 (1 September 2011); Department of the Attorney General, Submission No 40 (31 August 2011).

Status of the Coroners Court

From the outset of the Commission's consultations questions were raised about the position of the Coroners Court in the judicial hierarchy. Currently the Office of the State Coroner and the Coroners Court of Western Australia fall within the Specialist Courts and Tribunals Division of the Department of the Attorney General. Concerns were expressed about the independence and status of the court and the coroners, the lack of control the State Coroner had over items falling within the office's dedicated budget, the need for the court's interests to be better represented, and the need to ensure accountability of the court for its output. The 2008 Barnes review recommended that the Commission consider a 'repositioning' of the Coroners Court.[1]

In its Discussion Paper the Commission considered a number of options for repositioning the court or otherwise addressing the concerns referred to above.[2] On balance, it determined that the Coroners Court should be moved within the umbrella of the District Court with a State Coroner being appointed from the District Court bench and with a Deputy State Coroner and other coroners being drawn from the magistracy. The Commission felt that this would appropriately elevate the status and authority of the jurisdiction and include it more overtly within the judicial hierarchy of the state. It also had 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. The Commission noted that this was an option previously recommended by the Ad Hoc Committee which reviewed the Coroners Act in 1989 as well as suggested by the Royal Commission into Aboriginal Deaths in Custody in 1991 and the Barnes review in 2008.[3] It was further noted that the most recent coronial law reform process (undertaken in Victoria) made a similar recommendation and that a judge of the County Court (equivalent to the District Court in Western Australia) is now State Coroner in that jurisdiction.[4] The Commission had received very encouraging support for this suggested course during its extensive consultations and this support was also reflected in submissions to proposals 5, 6 and 7 of its Discussion Paper.

STATUS AND TENURE OF CORONERS

As noted in the Discussion Paper, many respondents to the Commission's consultations suggested that all coronial positions, including that of the State Coroner, should be of limited tenure.[5] 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. Currently the role of State Coroner in Western Australia is an appointment for life.[6] In all other Australian jurisdictions with unified coronial systems the appointment of State Coroner is for a finite term of between five and seven years with eligibility for reappointment.[7] The Commission proposed that all coroners (including the State and Deputy State Coroners) should be appointed for an initial term of not more than five years, which may be renewed for one further term of five years (making a total maximum term of 10 years).[8] There was some opposition in submissions to limiting tenure in this way. The State Coroner argued that this might result in a 'great loss of corporate knowledge and experience',[9] while the Chief Magistrate expressed concern that magistrates appointed as coroners may return to the bench after 10 years with no relevant experience. On the other hand, the Department of Health expressed strong support

1. Barnes M, *Review of the Coroners Act 1996 (WA)* (August 2008) 14–6, recommendation 4.
2. See LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 26–28.
3. Ibid 27.
4. *Coroners Act 2008* (Vic) s 91.
5. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 27.
6. The Deputy State Coroner is drawn from the magistracy and appointed for a finite renewable term.
7. 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.
8. Proposals 5.2, 6.2 & 7.3.
9. Alistair Hope, State Coroner, Submission No 18 (23 August 2011).

for limited tenure saying that it 'recognises that the coronial jurisdiction is a demanding and challenging [one]'.[10]

> Over time there is the potential for decisions to be made based on previous experience of similar investigations, rather than on the basis of the evidence available in the specific matter. Strong opinions and frustrations may also develop overtime. The coronial jurisdiction would benefit from the appointment of a new State Coroner every 5 to 10 years.[11]

Considering all submissions, the Commission has determined that there should be a base appointment for a term not exceeding five years, with coroners being eligible for reappointment, but not specifying the number of renewals that may be made.[12] This solution would appear to satisfy all respondents. It would permit periodic renewals of terms of up to five years, more than once if circumstances require it. This has the benefit of enabling appointees to be 'tested' in the role on shorter initial contracts without jeopardising a potentially long career as a coroner. It also allows coroners to move back to their relevant court should they experience 'burnout' and permits the appointment of temporary coroners from the magistracy for shorter periods (eg, on renewable yearly contracts).

RECOMMENDATION 6

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 State Coroner be appointed for a term not exceeding five years and is eligible for reappointment.
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.

RECOMMENDATION 7

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 Deputy State Coroner be appointed for a term not exceeding five years and is eligible for reappointment.
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.

RECOMMENDATION 8

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 a term not exceeding five years, eligible for reappointment.
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.

10. Department of Health, Submission No 11 (17 August 2011).
11. Ibid.
12. The Commission notes that this is the position in Victoria with its State Coroner being drawn from the equivalent of the District Court of Western Australia appointed for a term not exceeding five years and eligible for reappointment: *Coroners Act 2008* (Vic) s 91.

ACTING CORONERS

The above recommendation permits the appointment of temporary coroners from the magistracy; however, the current Coroners Act goes further to permit the appointment of coroners for limited periods from the legal profession, providing the person is eligible for appointment as a magistrate. Such appointment may be made by the Attorney General on recommendation of the State Coroner. A number of short-term appointments have been made under this section to date, including that of a former judicial officer and of a member of the independent bar with significant experience as counsel assisting the coroner. The State Coroner submitted to the Commission that the flexibility to appoint a temporary coroner with experience in coronial work from the bar was important and should be retained. The State Coroner also referred to a number of occasions in the United Kingdom where 'senior judicial officers have been appointed as coroners to complete particularly high profile or lengthy inquests with considerable success'.[13]

The Commission agrees that this flexibility should be retained in any new or amended Act to be drafted in response to this Report. In light of the fact that coroners (as judicial officers) should be attached to a substantive court,[14] the Commission believes it is appropriate to name such temporary appointments 'acting coroners'.[15] In keeping with its recommendations above in respect of tenure, the Commission recommends that any appointment of an acting coroner shall be for a term not exceeding two years, eligible for reappointment.

RECOMMENDATION 9

Acting coroners

1. That a person who is eligible to be appointed as a magistrate may be appointed as an acting coroner by the Attorney General on recommendation of the State Coroner.
2. That an appointment of an acting coroner shall be for a term not exceeding two years, eligible for reappointment.

13. Alistair Hope, State Coroner, Submission No 18 (23 August 2011).
14. The Commission was advised that it was the usual practice of government that judicial appointments to courts and tribunals in Western Australia require a base appointment to the Magistrates, District or Supreme Court of Western Australia. This has been a factor in its decision to recommend that the State Coroner be drawn from the District Court and that the Deputy State Coroner and other coroners be drawn from or simultaneously appointed to the magistracy.
15. It is noted that provision for similar appointments of acting coroners is made in s 94 of the *Coroners Act 2008* (Vic).

OATH OF OFFICE

In its Discussion Paper the Commission proposed that there be a prescribed oath or affirmation of office for all coroners, not just for the State Coroner as is currently the case. All submissions that commented on this issue agreed with the proposal[16] except for the Deputy State Coroner who did not agree that the oath should be sworn before a Supreme Court judge when oaths of judicial office are generally sworn before the Governor.[17] However, under the Commission's recommendations all coroners (with the exception of acting coroners) will already be, or will simultaneously be, appointed a judicial officer and therefore will have already taken an oath of judicial office before the Governor of Western Australia. This was pointed out in the Commission's Discussion Paper, which highlighted that a further coroner-specific oath should be developed in consultation with the State Coroner and sworn or affirmed by all coroners.[18] In these circumstances, the Commission believes it is appropriate the oath of office as coroner continues to be sworn before a Supreme Court judge and that it should be extended to apply also to acting coroners appointed pursuant to Recommendation 9.

RECOMMENDATION 10

Oath of Office

1. That a person appointed as coroner or acting 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.

16. Department of Health, Submission No 11 (17 August 2011); David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011).
17. Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011).
18. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 29.

Exercise of coronial power

DELEGATION OF CORONIAL POWER

As noted earlier in this chapter, concerns were expressed during consultations about the extent of coronial power being delegated to coroners' registrars (or clerks), which may include inexperienced staff (particularly in some regional courthouses). In his 2008 review of the *Coroners Act 1996* (WA) ('the Coroners Act'), Queensland State Coroner Michael Barnes stated that he was 'alarmed by the demands placed on staff and the level of responsibility unavoidably born [sic] by very junior officers'.[1] He also expressed concern about the fact that staff were not being properly supervised because their supervisors (eg, the Office Manager) are 'themselves heavily involved in casework' such as drafting findings on behalf of coroners or undertaking registry duties.[2] The Commission's Discussion Paper envisaged the professionalisation of the coronial jurisdiction in Western Australia with the removal of coronial power from regional magistrates and the creation of coronial regions with dedicated regional coroners. Part of this professionalisation involved placing limits on the inappropriate delegation of coronial power and the creation of the quasi-judicial supervisory position of Principal Registrar.

Principal Registrar

The Commission proposed that a position of Principal Registrar should be established (similar to a Registrar of the District Court) and filled by a suitably qualified person who is eligible for appointment to the Magistrates Court.[3] It was argued that such a position would alleviate the pressures upon the Office Manager and coroners in Perth, and provide a clear supervisory hierarchy for metropolitan and regional registrars. The Commission suggested 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,[4] might include the following functions:

- checking the daily list of reportable deaths, critically evaluating facts of initial police reports (P98 mortuary admission forms) and making such directions to police as seem appropriate in respect of initial coronial investigation;
- making 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;
- overseeing the management of the Perth registry and coordinating operations between the Perth registry and regional registries (when such registries are established);
- approving applications for file viewings by families and making determinations as to what can and cannot be viewed on the file;
- determining whether a natural causes death[5] requires coronial investigation (pursuant to Recommendation 56);[6]
- authorising restriction of access to premises and sign off on first extension to time for access (with further extensions to be approved by a coroner);[7]
- authorising 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;[8]
- notifying 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;[9] and
- ensuring that notification of particulars required to register and finalise death are provided by coroners without delay to the Registrar of Births, Deaths and Marriages.[10]

1. Barnes M, *Review of the Coroners Act 1996 (WA)* (August 2008) 11.
2. Ibid.
3. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) Proposal 10.
4. See ibid 30.
5. That is, a death in respect of which an external post mortem examination has concluded was consistent with natural causes.
6. 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'.
7. *Coroners Act 1996* (WA) s 32.
8. *Coroners Act 1996* (WA) s 33.
9. *Coroners Act 1996* (WA) s 27(4).
10. *Coroners Act 1996* (WA) s 28.

In addition to the functions identified above, the State Coroner submitted that the Principal Registrar could have a role in 'liaising with other agencies in respect of the sharing of information and confidentiality and privacy issues'.[11] The Commission received overwhelming support for its proposal[12] and makes the following recommendation.

RECOMMENDATION 11

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.

Coroners' registrars

In its Discussion Paper the Commission argued that the current s 10 of the Coroners Act, which 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' is too wide. It noted that standing delegations of important coronial powers and functions were being made to coroners' registrars. This observation was confirmed during consultations and in submissions to the Discussion Paper. For example, the Department of Health submitted that:

> From time to time there have been concerns that important functions and powers were being delegated to non-judicial (and non-legal) employees of the Coroners Court.[13]

The Commission believed the jurisdiction would benefit from specification of the functions and powers of a coroner that are capable of delegation to coroners' registrars in the Coroners Act. Having regard to delegation provisions in other Australian jurisdictions, the Commission proposed a provision, modelled on s 99 of the *Coroners Act 2008* (Vic), which provided that certain specified powers could not be delegated, except to the Principal Registrar.[14]

While the majority of submissions supported the Commission's proposal in every respect, there was resistance from the State Coroner and the Department of the Attorney General to the prohibition of delegation of two powers: the power to order the release of a body and the power to direct an internal post mortem examination.[15] These powers are currently the subject of a standing delegation to coroners' registrars (both metropolitan and regional), which has led to certain requirements of the Coroners Act being neglected. For example, the Commission found that, despite a legislative requirement that a direction to perform a post mortem examination be based on whether such examination is reasonably believed by the coroner to be necessary for the investigation of a death, in practice there is no consideration given to whether the cause of death can be determined without an internal examination.[16] No doubt many families would be troubled upon learning that no consideration was given to the need for an internal post mortem examination on their deceased loved one before a direction was made. In the Commission's opinion, the presumption of an internal post mortem examination in every case would probably not exist were it not for the standing delegation made to coroners' registrars, possibly as a result of human resource pressures experienced by the coronial system.

The State Coroner submitted that 'experienced registrars' should be able to direct a post mortem examination and certify a body for release,[17] while the Department of the Attorney General submitted that any concerns with the way registrars exercise this power may be 'addressed by an increased

11. Alistair Hope, State Coroner, Submission No 18 (23 August 2011).
12. Department of Health, Submission No 11 (17 August 2011); David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Department of the Attorney General, Submission No 40 (31 August 2011).
13. Department of Health, Submission No 11A (10 September 2011).
14. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) Proposal 9.
15. Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Department of the Attorney General, Submission No 40 (31 August 2011). A similar comment was made by former Perth coroner David McCann: David McCann, Former Perth Coroner, Submission No 16 (19 August 2011).
16. Unless there is an objection to post mortem examination under the *Coroners Act 1996* (WA) s 37. For a full discussion of this matter see LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 200–9.
17. Alistair Hope, State Coroner, Submission No 18 (23 August 2011).

emphasis on training'.[18] With respect, the issue is not one of how experienced or well trained the registrar is, but whether it is appropriate that a registrar should be exercising such important coronial powers. The proposals in Chapter Seven of the Commission's Discussion Paper require that coroners take an active role in considering whether an internal post mortem examination is required[19] and to whom the body is released.[20] These proposals were supported by the State Coroner and the Commission believes that it would be inappropriate for persons of a status less than a coroner or the Principal Registrar (being a person who is eligible to be appointed a magistrate) to make such decisions.[21] This is particularly the case in respect of the factors (set out in Recommendation 103) that a coroner must consider in ordering an internal post mortem examination. The Commission also notes that the decision whether or not to order a post mortem examination and to whom a body is to be released are decisions that may be reviewed by a higher court and should ideally therefore be made by a coroner.[22] The Commission reiterates its proposal in the following recommendation.

RECOMMENDATION 12

Delegation from the State Coroner to coroners' registrars

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 (other than 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) performing such other functions as are prescribed by regulation.

TRAINING OF CORONERS AND CORONERS' REGISTRARS

The Commission's Discussion Paper highlights that the coronial jurisdiction is, unlike other Western Australian courts, inquisitorial in nature. This means that there are no litigants (parties),[23] 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,[24] and his or her findings are not binding and are without legal force: the coroner's function is therefore primarily one of fact-finding.[25]

Training of those required to exercise functions under the Coroners Act has long been neglected in Western Australia. Significantly, as noted in the Commission's 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.[26] 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 coroners' decisions are so rarely appealed.[27] The Commission proposed that comprehensive

18. Department of the Attorney General, Submission No 40 (31 August 2011).
19. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) Proposals 97 and 99 (now Recommendations 101 and 103).
20. Ibid, Proposals 105 and 106 (now Recommendations 110 and 111).
21. The Department of the Attorney General made no comment on these proposals.
22. This is particularly the case with the release of a body, which under the Commission's proposed scheme may be reviewed by the Supreme Court: see LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 215–20, specifically Proposal 107.
23. 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).
24. *Coroners Act 1996* (WA) s 25(5).
25. Indeed, in *Perre v Chivell* [2000] SASC 279 Nyland J states that the 'jurisdiction of the coroner is limited to making findings of fact' (at [54]).
26. 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).
27. Barnes M, *Review of the Coroners Act 1996 (WA)* (August 2008) 16.

training be provided for new coroners and coroners' registrars.[28] The Commission received complete support from submissions in respect of its proposal.[29] In his submission, the State Coroner suggested that training for coroners should include instruction in the medical aspects of the position, including the purpose and conduct of a post mortem examination.[30] The Commission agrees and notes that this is particularly important in light of the discussion above and the proposal (also supported by the State Coroner) that coroners must consider and balance certain factors when deciding whether to direct an internal post mortem examination.[31] The Commission has therefore added training in medical aspects to its recommendation below.

RECOMMENDATION 13

Training of coroners, acting coroners and coroners' registrars

1. That the State Coroner provide for persons appointed as coroners or acting 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; training in medical aspects of the role of coroner, including the purpose and conduct of a post mortem examination; 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.

28. 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.
29. Registry of Births, Deaths, and Marriages, Submission No 9 (15 August 2011);Department of Health, Submission No 11 (17 August 2011); David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Western Australia Police, Submission No 35 (1 September 2011); Department of Corrective Services, Submission No 38 (1 September 2011); Australian Inquest Alliance, Submission No 39 (2 September 2011); Department of the Attorney General, Submission No 40 (31 August 2011).
30. Alistair Hope, State Coroner, Submission No 18 (23 August 2011).
31. LRCWA, *Review of Coronial Practice in Western Australia,* Background Paper (September 2010) Proposal 99 (now Recommendation 103).

Chapter Three

Reporting, Certification and Registration of Deaths

Contents

Coroner's jurisdiction

The Commission's Discussion Paper describes in detail the processes of reporting, certification and registration of coronial deaths.[1] This chapter discusses the responses to the Commission's proposals in these areas and makes recommendations addressed to definitional matters, including defining the types of death that fall within the coroner's jurisdiction, and to ways in which the efficiency and effectiveness of the coronial process in Western Australia may be improved.

CORONIAL DEATHS

Section 19 of the *Coroners Act 1996* (WA) ('the Coroners Act') gives jurisdiction to Western Australian coroners to investigate deaths[2] 'if it appears to the coroner that the death is or may be a reportable death' as defined in s 3 of the Coroners Act.[3] Hence, the 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:

> **13C. 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.[4]

The Coroners Act does not refer to the death of 'a person' in s 19: it merely refers to 'a death'. 'Death' is not independently defined in the *Interpretation Act*, which refers, as noted above, to 'death of a person'. The only relevant Act that defines the term 'death' without reference to the word 'person' is the *Births, Deaths and Marriages Registration Act 1998* (WA) ('the BDMR Act'), which includes a stillborn child in its definition of death for registration purposes.[5] Under that section a stillborn child 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]

Historically stillborn children have not fallen within the coroner's jurisdiction because where there has been no independent life, there can be no death.[7] While it is clear that the BDMR Act definition is confined to registration of the death of a stillborn under that Act, the lack of reference to 'a person' in the jurisdictional sections of the Coroners Act might arguably be thought enough to evoke uncertainty about whether the death of a stillborn is technically within the coroner's jurisdiction in this state. During consultations the Commission was advised that the Office of the State Coroner in Western Australia had never considered stillborns to be within the coronial jurisdiction.[8] As explained in the Discussion Paper, it is uniformly accepted that stillborns are outside the coroner's jurisdiction and no Australian jurisdiction gives the coroner power to investigate their deaths.[9] Most jurisdictions make no mention of stillbirths in their Coroners Acts,[10] but following the recent law

1. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) ch 3.
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.
3. See 'Reportable Deaths', below.
4. Until August 2008 Western Australia did not have a legislative definition of death. The current definition was enacted in response to recommendation 3 in the Commission's *Review of the Law of Homicide* (September 2007).
5. *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.
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. *Levine on Coroner's Courts* (London: Sweet & Maxwell, 1999) 142.
8. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 40.
9. Ibid 41.
10. The New South Wales and Queensland Coroners Acts provide for a coroner to order a post mortem examination for the purposes of establishing whether a child is stillborn; however, 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: *Coroners Act 2009* (NSW) s 89(2); *Coroners Act 2003* (Qld) s 19. There is nothing in the *Coroners Act 1996* (WA) to prevent a coroner from directing a post mortem examination for the purpose of establishing whether the child was born alive and therefore falls within the coroner's jurisdiction. See discussion ibid 39–42.

reform process in Victoria the *Coroners Act 2008* (Vic) expressly excludes application to stillbirths.[11] The Commission therefore considered whether the Coroners Act required clarification in respect of the coroner's jurisdiction over a stillborn child.

The Commission considered that the position of the coroner in respect of lack of jurisdiction over stillborn children should be made clear in the Coroners Act. It proposed 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 its conclusion, the Commission noted that there was little utility in the coroner assuming jurisdiction over stillbirths in Western Australia because of the existence of a dedicated statutory body – the Perinatal and Infant Mortality Committee – assigned with the function of investigating and researching perinatal deaths.[12] The Commission highlighted that this body (comprised of a panel of experts) performs a specialist medical investigation into each stillborn death – including 'homebirth' deaths where no medical practitioner or midwife was present – to establish circumstances and cause of death, possible preventable factors and other issues of public health significance.[13] In addition, the Perinatal and Infant Mortality Committee has a significant prevention role and is tasked with proposing recommendations to effect system-wide reforms aimed at reducing perinatal and infant mortality rates.[14] The Committee therefore performs all relevant functions of a coroner except for the holding of public hearings.

The proposal that the section of the Coroners Act governing the jurisdiction of a coroner to investigate a death should specifically refer to 'death of a person' received complete support from submissions. In regard to clarifying the jurisdictional position of the coroner in respect of stillbirths the Commission's proposal received significant support.[15] A perinatal pathologist with significant experience in and knowledge of the coronial systems of Western Australia and the United Kingdom expressed strong support for the Commission's proposal, noting that:

> The investigation into stillbirths requires a particular skill set which is not available within the coronial system involving a multidisciplined team of obstetricians, perinatal pathology, midwives and other investigators as identified by national guidelines and international guidelines (eg, the Australian guidelines PSANZ, the American college recommendations and the CEMACH process in the UK).[16]

He submitted that to 'duplicate the hospital and statewide processes would be unnecessary', stating that the feedback to parents in the hospital system (in relation to infant deaths) is much more than they currently receive in the coronial system.[17] The Department of Health and the Australian Medical Association commented that because of its significant expertise and record of 'excellent work'[18] the Perinatal and Infant Mortality Committee remains the appropriate forum for the investigation of deaths of stillborns.[19]

Although the State Coroner supported 'the stipulation that a stillbirth should not constitute a death for the purposes of the Coroners Act', he suggested that a coroner should nonetheless 'have jurisdiction to investigate the death of a child who was alive within 24 hours preceding birth'.[20] In support of this suggestion, the State Coroner submitted that:

> The Coroner's Court receives a number of letters from concerned family members relating to cases where deaths have occurred during home births where it is unclear whether the baby was born alive in the absence of medical professionals being present. The Coroner's Court also receives a number of letters expressing concern where deaths appear to have occurred during the process of childbirth, particularly in cases where those involved

11. *Coroners Act 2003* (Vic) s 3.
12. 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: 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. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 41.
14. Ibid 41–2.
15. Perinatal Loss Service – King Edward Memorial Hospital, Submission No 7 (1 August 2011); Department of Health, Submission No 11 (17 August 2011); David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Dr Adrian Charles, Perinatal/Paediatric Pathologist, Submission No 22 (23 August 2011); Australian Medical Association, Submission No 29 (25 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Western Australia Police, Submission No 35 (1 September 2011).
16. Dr Adrian Charles, Perinatal/Paediatric Pathologist, Submission No 22 (23 August 2011).
17. Ibid.
18. Australian Medical Association, Submission No 29 (25 August 2011).
19. However, the Department noted that the Committee's reports were unfortunately delayed by the failure of the Coroners Court to release information in a timely manner regarding infant deaths and suggested that 'any efforts to finalise coronial investigations of infants more quickly would enable the Committee to release its reports … and recommendations more quickly [with] considerable benefit to the health system': Department of Health, Submission No 11 (17 August 2011).
20. Alistair Hope, State Coroner, Submission No 18 (23 August 2011).

> in the birth do not have relevant training or problems have occurred during childbirth which, in the opinion of family, should have been recognised in advance.
>
> In a number of these cases it appears the baby would have been born alive but for actions or inactions on the part of various individuals. If the definition of a 'death' included deaths of all children alive within 24 hours preceding birth, that would enable proper investigation to take place in some of these difficult cases.[21]

The Commission has given careful consideration to this suggestion, but does not see any benefit in pursuing such a course. It notes that where there is any question whether the baby was born alive, the coroner may, under the present system, assume jurisdiction over the body to determine that issue by the conduct of a post mortem examination.[22] Including deaths of children alive within 24 hours of birth within the definition of death could create unnecessary jurisdictional complications for coroners. For example, what would happen in cases where there is no independent proof that the foetus was alive 24 hours before the birth? And further, what would happen if the test that establishes that the foetus was alive was performed 25 hours prior to the birth? Presumably, families would still have the same concerns about the birth, but it would be more difficult for the coroner to explain his or her lack of jurisdiction. Further, it is important to note that the definition of death in the *Interpretation Act* applies for all laws and purposes within the state, not just the Coroners Act. Any change to the definition might have significant impacts in respect of other areas of law, including criminal law and the law of succession. In the Commission's considered view, it would not be appropriate to extend the definition of death in this way or create a different definition for coronial purposes alone without extensive and targeted consultation in regard to the impact on other areas of law.

In these circumstances and in light of the very detailed and expert investigations that already take place in Western Australia into stillbirths (including homebirths), the clear historical position that stillbirths fall firmly outside of the coroner's jurisdiction and the overwhelming support for its proposal, the Commission makes the following recommendation.

21. Ibid.
22. This was confirmed in submissions by the Department of Health which stated, 'On occasion the coroner does undertake preliminary investigations into stillbirths, however it is our experience that these investigations (appropriately) cease once confirmation is received that the child was in fact stillborn': Department of Health, Submission No 11 (17 August 2011).

RECOMMENDATION 14

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

As noted above, the coroner's jurisdiction to investigate a death is confined to deaths that appear to a coroner to be 'reportable'. Section 3 of the Coroners Act defines 'reportable death' as 'a Western Australian death':[23]

> (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;[24]
>
> (e) of a person who immediately before death was a person held in care;[25]
>
> (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;

23. A Western Australian death is one that occurred or the cause of which occurred in Western Australia, where the body is in Western Australia or where the deceased ordinarily resided in Western Australia: *Coroners Act 1996* (WA) s 3.
24. To the Commission's knowledge, no circumstances have ever been prescribed under this section.
25. The definition of 'person held in care' is discussed in detail in the Commission's Discussion Paper but 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 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: see LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 122.

(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.

Under s 17 of 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.[26] Failure to do so is an offence carrying a fine of $1,000.

The inadequacy of the current penalty for this offence was highlighted in the Barnes review of the Coroners Act.[27] In its Discussion Paper the Commission examined similar offences in the Coroners Acts of other Australian jurisdictions and found that Western Australia has the lowest penalty for failure to report a death. It proposed that the penalty be increased to $10,000 or 12 months' imprisonment. The Commission received complete support from submissions for its proposal;[28] however, to bring the penalties in the Coroners Act into line with the relationship between fines and terms of imprisonment under s 41 of the *Sentencing Act 1995* (WA)[29] and some of the more common penalty provisions under the *Criminal Code,* the Commission has decided to amend its recommendation to increase the penalty to a fine of $12,000 or 12 months' imprisonment. Other penalty provisions recommended throughout this Report are similarly amended.

RECOMMENDATION 15

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 $12,000 or 12 months' imprisonment.

26. Unless 'the person has reasonable grounds to believe that the death has already been reported': *Coroners Act 1996* (WA) s 17.
27. Barnes M, *Review of the Coroners Act 1996 (WA)* (August 2008) 24.
28. Registry of Births, Deaths, and Marriages, Submission No 9A (24 August 2011); Department of Health, Submission No 11 (17 August 2011); David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Australian Medical Association, Submission No 29 (25 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Western Australia Police, Submission No 35 (1 September 2011); Australian Inquest Alliance, Submission No 39 (2 September 2011).
29. That is, one month's imprisonment equates to a fine of $1,000: *Sentencing Act 1995* (WA) s 41(6)(a).

SUSPECTED DEATHS

Under the Coroners Act 'death' is defined to include a suspected death[30] and thus all provisions of the Act applying to deaths apply equally to suspected deaths. In his 2008 review of the Coroners Act, Michael Barnes noted that there was no obligation in the Act to report a suspected death to the coroner.[31] 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.[32] The Commission saw merit in specifying this obligation in the Act and made a proposal to this effect in its Discussion Paper. The proposal received full support from submissions.[33]

RECOMMENDATION 16

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 a reportable death, the police officer must report the suspected death to the coroner.

30. *Coroners Act 1996* (WA) s 3.
31. Barnes M, *Review of the Coroners Act 1996 (WA)* (August 2008) 24.
32. Ibid.
33. Registry of Births, Deaths, and Marriages, Submission No 9A (24 August 2011); David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Western Australia Police, Submission No 35 (1 September 2011); Australian Inquest Alliance, Submission No 39 (2 September 2011).

Changes to reportable death categories

ANAESTHESIA-RELATED DEATHS

The current definition of reportable death in s 3 of the *Coroners Act 1996* (WA) ('the Coroners Act') includes two categories of anaesthesia-related deaths, being a death:

> (b) that occurs during an anaesthetic;
>
> (c) that occurs as a result of an anaesthetic and is not due to natural causes.

In its Discussion Paper the Commission noted that the categories were no longer considered appropriate and highlighted that recent reforms in New South Wales, Victoria and Queensland had replaced reference to anaesthesia-related deaths with categories that related more specifically to medical procedure or healthcare-related deaths.[1] The Commission therefore proposed that the anaesthesia death categories be removed. Submissions received in respect of this proposal showed full support,[2] with the Australian Medical Association commenting that the Commission's proposal 'recognises that the existing provision is a legacy of history and does not necessarily catch the types of medical adverse events that should be investigated by Coroners'.[3] The Commission therefore confirms its proposal as a recommendation.

RECOMMENDATION 17

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.

1. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 46.
2. Department of Health, Submission No 11 (17 August 2011); David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011); Australian Medical Association, Submission No 29 (25 August 2011); MDA National, Submission No 30 (24 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Australian Inquest Alliance, Submission No 39 (2 September 2011).
3. Australian Medical Association, Submission No 29 (25 August 2011).

HEALTHCARE-RELATED DEATHS

As noted above, a number of Australian jurisdictions have inserted a category of healthcare-related death into their Coroners Acts to replace specific anaesthesia death categories and to recognise a wider range of unexpected medical deaths that should be referred for coronial investigation. In its Discussion Paper the Commission analysed the current provisions existing in other jurisdictions and determined that the Queensland provision[4] (inserted in 2009) represented the best and most comprehensive formulation.[5] In particular, the Commission noted that the provision covered matters, such as deaths resulting from failure to treat or from alternative therapies that purported to be of benefit, which remained unaddressed by the provisions in other states. The Commission therefore proposed 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).[6] 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—

4. *Coroners Act 2003* (Qld) s 10AA.
5. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 46–48.
6. Ibid, Proposal 17.

(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.

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;[7] or

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

7. 'Health procedure' is defined to mean 'a dental, medical, surgical or other health related procedure, including for example the administration of an anaesthetic, analgesic, sedative or other drug': *Coroners Act 2003* (Qld) sch 2.

While all submissions agreed with the concept of including a category of healthcare-related death (the majority of which agreed with the Commission's proposal),[8] three submissions suggested that the Queensland model was too complex and may not be sufficiently understood by medical practitioners.[9] In its submission, the Department of Health further stated that the test proposed by the Commission was too 'broad' and because of its complexity medical practitioners would adopt 'defensive practices'; that is, they would 'necessarily err on the side of caution and report all deaths to the Coroners Court'.[10] The Department requested to be consulted further on the proposal.[11] Responding to this request, the Commission invited the Department to offer an appropriate alternative that captured the elements of the Queensland provision but which could, in its opinion, be more easily applied by medical practitioners. The Commission asked that 'in canvassing appropriate alternatives, the Department should keep in mind the need to capture relevant coronial cases in *all* healthcare settings'.[12]

The Department's legal branch consulted with a number of medical practitioners in considering an appropriate formulation of the definition of healthcare-related death and offered the following alternative.

> *Health-care related death* means the death of a person after receiving or seeking health care in circumstances where:
>
> (a) the person's death was not the reasonably expected outcome of health care; or
>
> (b) the person might not have died at the time of the person's death if the person had received the health-care which could reasonably have been provided to them.
>
> *Health-care* means assessment, examination, a diagnostic test, treatment or a procedure performed or provided by a person registered under the *Health Practitioner Regulation Law (WA) Act 2010;*

8. Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011); Health Consumers' Council, Submission No 27 (24 August 2011); Australian Medical Association, Submission No 29 (25 August 2011); MDA National, Submission No 30 (24 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Western Australia Police, Submission No 35 (1 September 2011); Australian Inquest Alliance, Submission No 39 (2 September 2011).
9. Dr Tom Hitchcock, Clinical Director of the Directorate of Critical Care, Fremantle Hospital, Submission No 3 (20 July 2011); Department of Health, Submission No 11 (17 August 2011); David McCann, Former Perth Coroner, Submission No 16 (19 August 2011).
10. Department of Health, Submission No 11 (17 August 2011).
11. Ibid.
12. LRCWA, letter to Dr D Russell-Weisz, A/Director General, Department of Health (24 August 2011).

Reasonably expected means expected by an objective person appropriately qualified in the relevant area of health-care.[13]

The Department of Health noted that its alternative definition was modelled on s 6(3) of the *Coroners Act 2009* (NSW)[14] with the addition of an inserted paragraph to cover cases of a failure to provide healthcare. The Department conceded that its proposed alternative was 'very broad' but that it considered it to be 'simpler than the Queensland model, and thereby more capable of application by medical practitioners'.[15] While the Department stated that it had considered extending the definition to cover purported healthcare (eg, alternative therapies or the administration of treatment by a person other than a registered health practitioner) it ultimately decided that this would be confusing for practitioners and could, if necessary, be dealt with by a separate category.[16]

The Commission forwarded the Department's proposed alternative definition to the State Coroner, medical professional bodies, health consumer bodies and the medical members of its advisory panel for their expert comment. Supplementary submissions on this issue were received from the Australian Medical Association, MDA National (a medical defence and insurance organisation), the Health Consumers' Council and the State Coroner. All submissions raised concerns with the Department's alternative definition; in particular, that it failed to cover purported healthcare, that it did not apply to non-registered health practitioners and that the wording of the failure to treat provision (subsection (b)) was obtuse and so did not meet the Department's own criteria that the definition be clear and simple to apply. Submissions on these matters, and on the efficacy of the current Queensland definition, are discussed below.

Purported healthcare

In its submission, MDA National expressed concern that the Department's definition of healthcare was too narrow because it did not cover the area of purported healthcare and alternative therapies which, it noted, was the subject of 'recent WA coronial matters of great significance'.[17] The Australian Medical Association made similar observations in its submission stating that the Coroners Court must have jurisdiction to scrutinise healthcare cases involving non-registered practitioners.[18] The same view was expressed by the Health Consumers' Council.[19] All three organisations preferred the Queensland definition of healthcare which covers the provision of 'care, treatment, advice, service or goods provided for or purportedly for the benefit of human health'.[20]

The State Coroner made strong representations to the Commission about the importance of including purported healthcare in the definition of healthcare-related death. In his opinion, what was required was a provision that would cover the entire range of possibilities including:

(i) registered medical practitioners providing 'alternative', unscientific treatment;

(ii) unregistered or de-registered medical practitioners purporting to provide medical treatment;

(iii) persons with various types of 'alternative' training providing treatment; and

(iv) persons with no relevant training purporting to provide treatment with or without scientific efficacy.[21]

The State Coroner provided a variant of the Department's proposed definition to accommodate these possibilities, drawing on the Queensland definitions of healthcare and health procedure found in s 10AA and schedule 2 respectively of the *Coroners Act 2003* (Qld). This definition is discussed further below.

Failure to provide healthcare

The submissions of MDA National and the Health Consumers' Council drew attention to a problem with the Department of Health's proposed definition in paragraph (b) covering failure to provide healthcare. That paragraph provided that a healthcare-related death included where a person had received or sought healthcare in circumstances where 'the person might not have died at the time of the person's death if the person had received the healthcare which could reasonably have been provided to them'.[22]

13. Dr D Russell-Weisz, A/Director General, Department of Health, letter to LRCWA (30 September 2011).
14. As noted in the Discussion Paper, while this is the most recently enacted provision in Australia, it was modelled on the former Queensland provision which was amended to 'clarify the circumstances in which medical deaths are reportable and make it clear that a failure to provide health care is captured': LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 47.
15. Dr D Russell-Weisz, A/Director General, Department of Health, letter to LRCWA (30 September 2011).
16. Ibid.
17. MDA National, Submission No 30A (3 November 2011).
18. Australian Medical Association, Submission No 29A (1 November 2011).
19. Health Consumers' Council, Submission No 27A (2 November 2011).
20. *Coroners Act 2003* (Qld) s 10AA(5)(b).
21. Alistair Hope, State Coroner, Submission No 18B (11 October 2011).
22. Dr D Russell-Weisz, A/Director General, Department of Health, letter to LRCWA (30 September 2011).

Submissions noted that the Department's proposed definition did not provide clearly for situations where there was a failure to provide healthcare.[23] In particular, the term 'reasonably' was singled out as requiring further clarification for medical practitioners. The Health Consumers' Council submitted that the reference to 'reasonably' rather than 'reasonably expected' (which is defined in the Department's proposed alternative as being reasonably expected by 'an objective person appropriately qualified in the relevant area of health-care') raised the question who would determine the issue of reasonableness in respect of a failure to treat.[24]

The Commission's conclusion

As noted earlier, one reason the Department of Health felt the Commission's proposed definition (modelled on the Queensland provision) was unsatisfactory was because of the potential of medical practitioners adopting 'defensive practices' and over-reporting healthcare deaths. The Department doubted that the Coroners Court would have the capacity to deal with any rise in reporting of healthcare-related deaths.[25] The Commission consulted on this issue with Queensland State Coroner Michael Barnes to see whether there had been any problems with the provision as it operated in practice in Queensland. Barnes stated that the medical profession in Queensland was accepting of the reporting criteria and that similar concerns of potential over-reporting of healthcare deaths expressed at the time of the amendment had not been borne out in that state.[26] In addition, Coroner Barnes stated that he had 'certainly not observed anything I would describe as "defensive practices"'.[27] In its submission, MDA stated that its members had not expressed any concerns with the Queensland provision since its amendment, though MDA's solicitors had reported difficulties with the previous Queensland definition on which the New South Wales definition (and the Department's proposed definition) was modelled.[28]

Despite the evidence that the Queensland provision is working well, the Commission does accept that it is somewhat complex. Recognising this, the State Coroner offered an alternative provision modelled on that proposed by the Department but which, in his opinion, addressed all the concerns with the Department's version. The State Coroner's proposal reads as follows:

> *Healthcare or purported healthcare related death* means the death of a person after receiving or seeking healthcare or purported healthcare in circumstances where –
>
> (a) immediately before receiving the healthcare or purported healthcare the person's death was not the reasonably expected outcome;[29] or
>
> (b) the person might not have died at the time of the person's death if the person had received the healthcare which could reasonably have been provided to them.
>
> *Healthcare* means assessment, examination, diagnostic test, treatment or a medical, surgical, dental or other health related procedure (including the administration of an anaesthetic, sedative or other drug or substance).
>
> *Purported healthcare* includes all cases of purported "healthcare" whether or not the assessment, examination, diagnostic test, treatment or a medical, surgical, dental or other health related procedure has scientific efficacy.
>
> *Reasonably expected* means expected by an objective person appropriately qualified in the relevant area of healthcare.[30]

It is noted that the above definition does not address the issue highlighted by the submissions of MDA National and the Health Consumers' Council in relation to the word 'reasonably' in paragraph (b). However, the Commission suggests that that is easily remedied by rephrasing the paragraph to read 'the person might not have died at the time of the person's death if the person had received the healthcare which could be *reasonably expected* to have been provided to them'. In this way, the definition of reasonably expected applies to circumstances in which there has been a failure to provide healthcare. Assuming the above amendment, the Commission is attracted to the State Coroner's modified variant of the Department's proposed definition, because it offers a definition that is inclusive of purported healthcare, captures non-registered health practitioners, and provides a reasonably

23. Health Consumers' Council, Submission No 27A (2 November 2011); MDA National, Submission No 30A (3 November 2011).
24. Health Consumers' Council, Submission No 27A (2 November 2011).
25. Department of Health, Submission No 11 (17 August 2011).
26. Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34A (2 November 2011).
27. Ibid.
28. MDA National, Submission No 30A (3 November 2011).
29. The addition of the words 'immediately before receiving the healthcare or purported healthcare' were added by the State Coroner to overcome the problem of *when* the death was not the reasonably expected outcome. The State Coroner noted that this was 'a real issue and has caused problems in interpretation of the existing legislation': Alistair Hope, State Coroner, Submission No 18B (11 October 2011).
30. Ibid.

simple and objective test. The Commission also notes that because it maintains the basic formula offered by the Department of Health after its own consultations, it may be more likely to gain acceptance within the Department than the Queensland model originally proposed by the Commission. The Commission therefore makes the following recommendation.

RECOMMENDATION 18

Reportability of healthcare-related deaths

Healthcare or purported healthcare-related death means the death of a person after receiving or seeking healthcare or purported healthcare in circumstances where –

(a) immediately before receiving the healthcare or purported healthcare the person's death was not the reasonably expected outcome; or

(b) the person might not have died at the time of the person's death if the person had received the healthcare which could be reasonably expected to have been provided to them.

"Healthcare" means assessment, examination, diagnostic test, treatment or a medical, surgical, dental or other health related procedure (including the administration of an anaesthetic, sedative or other drug or substance).

"Purported healthcare" includes all cases of purported *"healthcare"* whether or not the assessment, examination, diagnostic test, treatment or a medical, surgical, dental or other health related procedure has scientific efficacy.

"Reasonably expected" means expected by an objective person appropriately qualified in the relevant area of healthcare.

REPORTING OF DEATHS IN PRACTICE

The Commission's Discussion Paper set out how, in practice, deaths were reported to the coroner. It also discussed a number of studies and reviews in Australia and elsewhere that have highlighted the possible underreporting or non-reporting of coronial deaths by medical practitioners and hospitals.[31] Submissions to the Commission's Background Paper had identified that medical practitioners demonstrated some uncertainty as to what deaths should be reported under the current regime and 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.[32]

In view of the proposed changes to reportability of deaths set out in the Discussion Paper, and in particular in light of the proposal to introduce a category of healthcare-related death, the Commission proposed that the State Coroner publish detailed guidelines to assist persons who may be required to report a death to comply with their reporting obligations under the Coroners Act.[33] It was noted that for the new category of healthcare-related deaths, it would be necessary for the guidelines to step the reader through the process of determining whether a particular death is reportable.[34] It was noted that legislative formulations should be interpreted and explained and examples should be provided. The Commission drew attention to the detailed guidelines provided online by the State Coroner of Queensland and commended these to the Western Australian State Coroner as a useful model for the creation of similar guidelines in Western Australia.

The Commission's proposal received complete support from submissions[35] with the Department of Health commenting that the 'guidelines would be a valuable and helpful resource for medical practitioners and may reduce or limit the need for medical practitioners to seek clarification or guidance from the Coroners Court in relation to

31. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 50–2.
32. Ibid 51.
33. Ibid, Proposal 19.
34. 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.
35. Registry of Births, Deaths, and Marriages, Submission No 9A (24 August 2011); Department of Health, Submission No 11 (17 August 2011); David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011); Australian Medical Association, Submission No 29 (25 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Western Australia Police, Submission No 35 (1 September 2011); Australian Inquest Alliance, Submission No 39 (2 September 2011); Department of the Attorney General, Submission No 40 (31 August 2011).

specific deaths'.[36] Therefore, the Commission makes a recommendation reflecting its original proposal. Similarly, the Commission confirms as a recommendation its proposal that the State Coroner work together with relevant agencies and bodies to deliver information to medical practitioners about any changes to their reporting obligations under the Coroners Act, which also received full support from submissions.[37]

RECOMMENDATION 19

State Coroner's Guidelines: Reportable deaths

That the State Coroner, in consultation with medical advisers, relevant agencies and professional bodies, produce 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 the types of deaths that may fall into each of the categories of reportable death under the Coroners Act.

RECOMMENDATION 20

Informing medical practitioners of relevant changes to the Coroners Act

That the Office of the State Coroner work together with relevant agencies and professional bodies (including the Australian Medical Association 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.

36. Department of Health, Submission No 11 (17 August 2011).
37. Registry of Births, Deaths, and Marriages, Submission No 9A (24 August 2011); Department of Health, Submission No 11 (17 August 2011); David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011); Australian Medical Association, Submission No 29 (25 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Australian Inquest Alliance, Submission No 39 (2 September 2011); Department of the Attorney General, Submission No 40 (31 August 2011).

Death certification

AUTHORISATION TO ISSUE A DEATH CERTIFICATE

The Commission's Discussion Paper set out the requirements of the *Births, Deaths and Marriages Registration Act 1998* (WA) in respect of certification of a death. It noted that failure to issue a death certificate within a certain time period is an offence,[1] unless the death has been reported to a coroner.[2] The Discussion Paper noted that in some cases, deaths which do not warrant a coronial investigation and where the cause of death is known are reported to the coroner because they technically fall within the definition of reportable death under the *Coroners Act 1996* (WA) ('the Coroners Act'). It discussed the recommendation of the 2008 Barnes review that the Act should be amended to provide for a coroner to issue a cause of death certificate without undertaking an autopsy where the cause of death is 'sufficiently certain'.[3] In Barnes' view, the typical case that would come within such a provision was where an elderly person died from hospital-acquired pneumonia as a result of immobility after a fall.[4]

The Discussion Paper examined the existing provisions permitting the issue of cause of death certificates in the Queensland and New South Wales Coroners Acts, preferring the operation of the Queensland provision because it retained such cases within the coroner's jurisdiction by recording initial reporting of the deaths. The Commission noted the positive effect the Queensland provision had on coronial resources in that jurisdiction and discussed the effect a similar provision would have on the delays in the Western Australian system.[5] The Commission proposed that a provision be added to the Coroners Act to permit the issue of a death certificate upon authorisation by a coroner in circumstances where the cause of death was sufficiently certain.[6] The Commission received overwhelming support from submissions for this proposal.[7] Two issues were raised in respect of the Commission's proposal. The first, raised by the Health Consumers' Council, was that the proposal required clarification in respect of who determines whether the cause of death is 'sufficiently certain'.[8] The Commission has amended its recommendation to make clear that such a determination is made by the coroner on the evidence before him or her. The second issue related to notification of coroner-authorised cause of death certificates to the Registry of Births, Deaths and Marriages. The Registrar requested that such cases be separately notified, presumably to provide independent verification from the coroner that he or she had authorised the certificate.[9] The Commission agrees that this is a sensible precaution and makes the following recommendation.

RECOMMENDATION 21

Authorisation to issue a cause of death certificate

1. 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 –

1. *Births, Deaths and Marriages Registration Act 1998* (WA) s44.
2. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 53.
3. Barnes M, *Review of the Coroners Act 1996 (WA)* (August 2008); ibid 53–55.
4. Ibid.
5. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 55.
6. Ibid, Proposal 21.
7. Registry of Births, Deaths, and Marriages, Submission No 9 (15 August 2011); Department of Health, Submission No 11 (17 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011); Australian Medical Association, Submission No 29 (25 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Western Australia Police, Submission No 35 (1 September 2011); Australian Inquest Alliance, Submission No 39 (2 September 2011). The Commission received only one submission that did not support the proposal on the basis that if all the information is available to the coroner he or she should make a finding: David McCann, Former Perth Coroner, Submission No 16 (19 August 2011). However, in the Commission's opinion the proposed mechanism will save the coroner some time and positively impact on delays.
8. Health Consumers' Council, Submission No 27 (24 August 2011).
9. Registry of Births, Deaths, and Marriages, Submission No 9 (15 August 2011).

(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, in the coroner's opinion, sufficiently certain; and

(c) the coroner is satisfied that no further investigation of the death is warranted.

2. That the coroner report to the Registry of Births, Deaths and Marriages any cause of death certificates approved for issue under this section.

REVIEW OF GUIDELINES AND FORMS

The Commission also proposed 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,[10] and that the 'Death in Hospital' and 'Medical Certificate of Cause of Death' forms be reviewed.[11] The guidelines proposal received full support from submissions.[12] The review of forms proposal received overwhelming support,[13] but three submissions objected to the suggestion that the 'Death in Hospital' form contain 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.[14] A further two submissions thought this requirement would be practically difficult[15] while two others strongly endorsed the requirement.[16] In light of the mixed submissions about the family input requirement, the Commission has determined that this should not feature in the review recommendation, but instead has recommended that consideration be given to this requirement in the consultative process of developing guidelines. The Commission therefore makes the following recommendations.

RECOMMENDATION 22

State Coroner's Guidelines: Authorisation to issue a cause of death certificate

1. That the State Coroner, in consultation with medical advisers, relevant agencies and professional bodies, 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.

2. That, in the development of such guidelines the State Coroner give consideration to the process in Queensland which requires medical practitioners to obtain input from family about concerns and provide to the coroner copies of the deceased's discharge summary, recent hospital admission notes and the draft cause of death certificate.

RECOMMENDATION 23

Review of 'Death in Hospital' form

That the State Coroner and the Department of Health jointly review the current 'Death in Hospital' form to incorporate changes to reporting requirements under the Coroners Act, and to ensure that information relevant to a coroner's decision to authorise the issue of a death certificate is adequately recorded.

10. The Commission commended the Queensland Form 1A and accompanying guidelines to the State Coroner and suggested that a similarly comprehensive procedure be established in Western Australia.
11. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) proposals 22 and 23.
12. Registry of Births, Deaths, and Marriages, Submission No 9 (15 August 2011); Department of Health, Submission No 11 (17 August 2011); Dr Derek Pocock, Former State Forensic Pathologist, Submission No 12 (17 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011); Australian Medical Association, Submission No 29 (25 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Western Australia Police, Submission No 35 (1 September 2011); Australian Inquest Alliance, Submission No 39 (2 September 2011).
13. Registry of Births, Deaths, and Marriages, Submission No 9 (15 August 2011); Department of Health, Submission No 11 (17 August 2011); David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011); Health Consumers' Council, Submission No 27 (24 August 2011); Australian Medical Association, Submission No 29 (25 August 2011); MDA National, Submission No 30 (24 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Western Australia Police, Submission No 35 (1 September 2011); Australian Inquest Alliance, Submission No 39 (2 September 2011)
14. Department of Health, Submission No 11 (17 August 2011); Australian Medical Association, Submission No 29 (25 August 2011); MDA National, Submission No 30 (24 August 2011).
15. David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011).
16. Health Consumers' Council, Submission No 27 (24 August 2011); Western Australia Police, Submission No 35 (1 September 2011).

Requirements of Medical Certificate of Cause of Death

A Medical Certificate of Cause of Death is completed by a medical practitioner to enable registration of a death where the death is not a reportable death under the Coroners Act. If Recommendation 21 of this Report is implemented, a Medical Certificate of Cause of Death will also be issued by a medical practitioner where a death is reportable but the coroner has authorised certification. The Commission's Discussion Paper featured a discussion of the Harold Shipman case in England, where a medical practitioner had intentionally killed a number of his elderly patients and avoided coronial scrutiny by issuing death certificates.[17] Two substantive reviews of the Shipman case had found a number of systemic failings in relation to the medical certification of cause of death and certification for cremation.[18]

The Commission noted that the 2008 Barnes review of the Coroners Act in Western Australia had suggested that there was a need for 'more rigour around the circumstances in which a certificate may issue'.[19] Barnes believed consideration should be given to placing additional requirements on certifying doctors, including that doctors should:

(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; and

(d) acknowledge that he or she is aware that it is an offence to fail to report a reportable death under the Coroners Act.

The Commission noted that, while these requirements were sensible, it had no evidence as to whether they would be practical in the Western Australian context. The Commission therefore invited submissions as to whether these or other additional requirements should be placed on medical practitioners certifying a death.

Submissions on this question showed resistance to the requirements listed at (b) and (c) above.[20] In relation to paragraph (b) the Department of Health stated that:

> Medical practitioners would be extremely reluctant to provide a response other than confirmation that the care was reasonable and had no bearing on the death. It is unclear how this certification would work in the context of a team environment, where a junior medical practitioner is certifying with respect to more senior colleagues… The imposition of this requirement would be a further deterrence for the completion of death certificates and be likely to result in increased (and unnecessary) reporting to the Coroners Court.[21]

A similar submission was made by MDA National which stated that it was a 'potentially unworkable requirement', particularly in cases where a junior doctor is asked to comment on the care provided by their supervising consultant.[22] Dr Tom Hitchcock noted that whether the death is reportable (requirement (c)) is not a matter of opinion and should be clearly defined in the Coroners Act.[23] The Commission found the arguments presented in submissions in relation to requirements (b) and (c) to be sound and does not propose to recommend that course. However, the Commission received sufficient supportive submissions in respect of paragraphs (a) and (d) to make a recommendation for change.[24] In regard to external examination of a body, the Commission highlights that its recommendation is that such an examination take place only where practicable. This avoids the situation, raised by the State Coroner, where the certifying doctor is away at the time of death and is not in a position to undertake an examination of the body.[25] In such situations the body will have been transported to the State

17. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 56–58.
18. United Kingdom, *Death Certification and the Investigation of Deaths by Coroners* ('the Shipman Inquiry'), Third Report (Cmd 5854, July 2003); 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').
19. Barnes M, *Review of the Coroners Act 1996 (WA)* (August 2008) 21.
20. Dr Tom Hitchcock, Clinical Director of the Directorate of Critical Care, Fremantle Hospital, Submission No 3 (20 July 2011); Registry of Births, Deaths, and Marriages, Submission No 9 (15 August 2011); Department of Health, Submission No 11 (17 August 2011); Health Consumers' Council, Submission No 27 (24 August 2011); MDA National, Submission No 30 (24 August 2011).
21. Department of Health, Submission No 11 (17 August 2011).
22. MDA National, Submission No 30 (24 August 2011).
23. Dr Tom Hitchcock, Clinical Director of the Directorate of Critical Care, Fremantle Hospital, Submission No 3 (20 July 2011).
24. Dr Tom Hitchcock, Clinical Director of the Directorate of Critical Care, Fremantle Hospital, Submission No 3 (20 July 2011); David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Health Consumers' Council, Submission No 27 (24 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Western Australia Police, Submission No 35 (1 September 2011).
25. Alistair Hope, State Coroner, Submission No 18 (23 August 2011).

Mortuary in lieu of certification and the fact of death and the identity of the deceased will have already been established to the satisfaction of the coroner.[26] The Commission makes the following recommendation combining its recommendation for review of the Medical Certificate of Cause of Death found in Proposal 23 of the Discussion Paper (for which full support was received from submissions) with the additional requirements established as a result of its invitation to submit.

RECOMMENDATION 24

Review of 'Medical Certificate of Cause of Death' form

That the State Coroner and the Registry of Births, Deaths and Marriages jointly review the current 'Medical Certificate of Cause of Death' (Form BDM 202) with specific consideration to providing for the following requirements:

1. That, in the case of a reportable death, the certifying doctor must note on whose authority the cause of death certificate was issued.
2. That the certifying doctor must undertake an external examination of the deceased's body, where practicable, and note any observations on the death certificate.
3. That the certifying doctor must acknowledge that he or she is aware that it is a requirement of the Coroners Act to report a reportable death.

26. Former Perth Coroner David McCann observed in his submission that in the absence of an external examination the certifying practitioner should be required to state how he or she is satisfied of the identity of the deceased, the fact of death and the information upon which he or she relies to complete the certificate: David McCann, Former Perth Coroner, Submission No 16 (19 August 2011).

Death registration

NOTIFICATION OF A DEATH

The Discussion Paper highlighted a concern that the Registry of Births, Deaths and Marriages was not always being notified of deaths by funeral directors as required under s 42 of the *Births, Deaths and Marriages Registration Act 1998* (WA). The Registrar of Births, Deaths and Marriages had stated to the Commission that it would be useful if the coroner could (in addition to the identifying information it routinely submitted) advise to whom the deceased's body was released in all coronial cases to enable it to follow up on death notifications in a timely manner.[1] The Commission made a proposal to this effect which attracted complete support from submissions.[2] The Registrar of Births, Deaths and Marriages submitted that in addition to the name of the person to whom the body is released it would be helpful to know the contact details of the funeral director engaged to dispose of the deceased's remains.[3] The Commission has made that amendment and makes the following recommendation.

RECOMMENDATION 25

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 and, if known, the name and contact details of the Funeral Director who has been engaged to dispose of the deceased's remains.

1. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 59, Proposal 24.
2. Registry of Births, Deaths, and Marriages, Submission No 9 (15 August 2011); David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011); Australian Medical Association, Submission No 29 (25 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Australian Inquest Alliance, Submission No 39 (2 September 2011); Department of the Attorney General, Submission No 40 (31 August 2011).
3. Registry of Births, Deaths, and Marriages, Submission No 9 (15 August 2011).

NOTIFICATION OF CORONER'S DETERMINATION

In its Discussion Paper the Commission noted that 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, which may be some years after the death.[4] It was noted that while this delay will not usually affect the granting of probate, it may affect the payout of insurances which often require formal certification of cause of death. The Commission discussed some examples of hardship as a consequence of delays in the registration process which were communicated by family members of a deceased. It also drew attention to a prior practice where the Coroners Court would provide an interim coronial determination[5] under s 28(2) of the Coroners Act to the Registrar in every case for the purposes of enabling registration. It was noted that the interim determination was in the past enough to satisfy the needs of families, insurance companies and others, though the Commission did hear some comments suggesting that insurance companies and superannuation funds may now be less inclined to pay out on a claim on the basis of an interim determination.[6]

In light of the significant backlog in coronial cases in Western Australia and the delays in finalising even the most simple of cases, the Commission proposed that the Office of the State Coroner consider reviving the practice of providing interim determinations to enable the issuing of a death certificate at the earliest opportunity.[7] The

4. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 60–62.
5. An interim determination would include the name of the person, age, date of death, place of death and interim cause of death. The latter was sometimes non-specific (eg, 'multiple injuries sustained in a motor vehicle accident').
6. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 61. In her submission the Deputy State Coroner questioned 'the motives' of insurers and superannuation companies in this respect. She stated that the 'alleged need for some of this information is entirely spurious and appears to be a mechanism by which the settlement of these claims is avoided': Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011).
7. LRCWA, ibid, Proposal 25.

proposal received overwhelming support.[8] In his submission former Perth Coroner David McCann admitted to being 'puzzled and concerned' as to why the practice of providing interim determinations had ceased.[9] In its submission the Western Australia Police noted that there is enough information captured on initial police forms (eg, formal identification, mortuary admission form, certificate of life extinct, initial report of death etc) to enable an interim determination to be made.[10] The State Coroner supported the proposal stating that a new computer system to be implemented in his office should enable the identification of cases where delays are expected and where an interim determination could be provided.[11] The Commission therefore makes the following recommendation.

RECOMMENDATION 26

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

That, where after a period of three months from the date of death has elapsed no coronial determination has been made and further delay is expected, the Office of the State Coroner provide the Registry of Births, Deaths and Marriages with an interim determination under s 28(2) of the Coroners Act. Such interim determination should have 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 any insurance, superannuation or other claims.

8. Registry of Births, Deaths, and Marriages, Submission No 9A (24 August 2011); David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011); Australian Medical Association, Submission No 29 (25 August 2011); Western Australia Police, Submission No 35 (1 September 2011); Australian Inquest Alliance, Submission No 39 (2 September 2011); Department of the Attorney General, Submission No 40 (31 August 2011). Michael Barnes' submission indicated that provision of an interim determination may be unduly burdensome on coroners: Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011).
9. David McCann, Former Perth Coroner, Submission No 16 (19 August 2011).
10. Western Australia Police, Submission No 35 (1 September 2011). The Commission observes that if the National Police Form is adopted, as recommended in this Report, the process of making such a determination should be further improved.
11. Alistair Hope, State Coroner, Submission No 18 (23 August 2011).

Chapter Four

Death Investigation

Contents

Coronial investigation

The Commission's Discussion Paper described in detail the current coronial investigation process in Western Australia and discussed a number of concerns and issues that had been identified during the research and consultation phase of the reference. As shown in the chart in Chapter One of this Report, investigations on behalf of the coroner are undertaken by police (whether specialist units or local police). In some cases there may be a simultaneous investigation by a specialist body such as WorkSafe or the Australian Transport Safety Bureau. This chapter makes recommendations for practical, procedural, policy and legislative reform to overcome identified concerns in the area of death investigation.

CORONER'S INVESTIGATORS

Although s 14(1) of the *Coroners Act 1996* (WA) ('the Coroners Act') provides for the appointment of independent 'coroner's investigators',[1] in practice all coronial investigation is undertaken by the Western Australia Police who, by virtue of s 14(2), are contemporaneously coroner's investigators for the purpose of the Act. The Western Australia Police has established a designated unit for coronial investigations in the Perth metropolitan area: the Coronial Investigation Unit (CIU). However, in some cases other specialist units of the Western Australia Police undertake investigations on behalf of the coroner. These include the Major Crime Squad (for homicides, deaths in custody and deaths in police presence), the Major Crash Investigation Unit (for traffic deaths) and the Water Police (for maritime deaths). In regional areas (and for some metropolitan deaths) investigations are conducted by local police.[2]

The Commission's Discussion Paper discussed the police investigation process in considerable detail and made proposals about the need for guidance from the Coroners Court, the need for adoption of the National Police Form and powers of coroner's investigators. The response to these proposals is discussed below.

Guidance from coroners

In its Discussion Paper the Commission noted that since raising the issue as one of concern in its Background Paper, some improvements had been made in the metropolitan area to enhance communication, guidance and direction from coroners to coronial investigators within the Western Australia Police. However, it was noted that the Guidelines for Police issued by the State Coroner in 1997 were outdated, limited and in need of review.[3] The Commission proposed that these be updated[4] and this proposal received complete support from submissions.[5]

RECOMMENDATION 27

State Coroner's Guidelines: Police

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

Adoption of the National Police Form

The National Police Form was developed by the National Coroners' Information Service to improve standardised data collection across Australia and to provide consistent and improved information for coroners, pathologists and toxicologists about the circumstances of death to assist in the coronial investigation. The Commission's Discussion Paper set out the benefits of the national police form and noted that the form (or versions of it) is now used in several Australian states and

1. As noted in the Discussion Paper, it is apparent that Parliament intended s 14(1) to 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: Western Australia, *Parliamentary Debates*, Legislative Assembly, 22 June 1995, 5705 (Ms C Edwardes, Attorney General).
2. See discussion LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 67–8.
3. Ibid 70.
4. Ibid, Proposal 26.
5. Registry of Births, Deaths, and Marriages, Submission No 9A (24 August 2011); Department of Health, Submission No 11 (17 August 2011); David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Western Australia Police, Submission No 35 (1 September 2011); Australian Inquest Alliance, Submission No 39 (2 September 2011); Department of the Attorney General, Submission No 40 (31 August 2011).

territories.[6] The Commission proposed that it be adopted for use in Western Australia[7] and received complete support from submissions.[8] The Western Australia Police submission was enthusiastic in its support of the form noting that its use would enhance development of prevention strategies by permitting the electronic tracking of trends.[9] The State Coroner highlighted that the form should not be seen as a substitute for a final police report (containing a review of evidence), but noted that it would nonetheless provide much of the substance that feeds into such a report and should be adopted.[10] The Department of the Attorney General referred to successful use of the form in other jurisdictions and underlined that it considered its adoption 'would contribute to efficiency improvements'.[11]

RECOMMENDATION 28

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 CORONER'S INVESTIGATORS

Restriction of access to area

Section 32 of the Coroners Act empowers coroner's investigators to control the scene where a death occurred by restricting access to premises. Pursuant to that section police (as coroner's investigators) may immediately impose a restriction on access to an area, but the restriction must be confirmed in writing by a coroner as soon as is practicable after the restriction is imposed.[12] If the order is not confirmed after the elapse of six hours, it ceases to have effect.[13] Although s 32 does not place a time limit on a restriction order, the Commission was told by police that in practice coroners often only approved continuance of restriction orders for a period of six hours (making a maximum of 12 hours depending on the time at which approval is sought). The Commission's Discussion Paper examined the use of this power in practice and whether there was a need to increase the time limit before which approval from a coroner must be sought. The Commission proposed 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.[14] 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.

The Commission received full support for this proposal.[15] In its submission the Western Australia Police suggested a minor change in wording of the proposal (from 'may' to 'must' in paragraph 4) with which the Commission agrees.[16] The Department of Health noted that the utilisation of power to restrict access to an area may have a significant impact in a hospital context. It suggested that the coroner's investigator (or police) actively advise any person aggrieved by the operation of the section of their right under s 32(7) to apply to the coroner to vary or remove the restriction.[17] The Commission believes this is appropriate and suggests that the State Coroner should place such a direction in his or her guidelines for police.[18]

At the request of the State Coroner the Commission also examined the penalty attaching to this offence which was set extraordinarily low at only a fine of $2,000. The Commission analysed comparable

6. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 70–71.
7. Ibid, Proposal 27.
8. Registry of Births, Deaths, and Marriages, Submission No 9A (24 August 2011); David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Western Australia Police, Submission No 35 (1 September 2011); Australian Inquest Alliance, Submission No 39 (2 September 2011); Department of the Attorney General, Submission No 40 (31 August 2011).
9. Western Australia Police, Submission No 35 (1 September 2011).
10. Alistair Hope, State Coroner, Submission No 18 (23 August 2011).
11. Department of the Attorney General, Submission No 40 (31 August 2011).
12. *Coroners Act 1996* (WA) s 36(2).
13. *Coroners Act 1996* (WA) s 36(3).
14. It was noted that a broadly similar process exists in relation to the creation of protected forensic areas under the *Criminal Investigation Act 2006* (WA).
15. Department of Health, Submission No 11 (17 August 2011); David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Western Australia Police, Submission No 35 (1 September 2011); Australian Inquest Alliance, Submission No 39 (2 September 2011).
16. Western Australia Police, Submission No 35 (1 September 2011).
17. Department of Health, Submission No 11 (17 August 2011).
18. See above Recommendation 27.

penalty provisions in other jurisdictions and proposed that a fine of $10,000 or 6 months' imprisonment was appropriate. Submissions agreed; however, given s 86 of the *Sentencing Act 1995* (WA) which prohibits the imposition of a term of six months or less, the Commission has adjusted its penalty to a term of imprisonment of 12 months. To reflect the relationship between fines and terms of imprisonment in the *Sentencing Act*,[19] the Commission has further determined to amend its recommendation to increase the penalty to a fine of $12,000. As noted earlier, other penalty provisions recommended throughout this Report are similarly amended.

RECOMMENDATION 29

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 must 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: $12,000 or 12 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.

19. That is, one month's imprisonment equates to a fine of $1,000: *Sentencing Act 1995* (WA) s 41(6)(a).

Powers of entry, inspection and possession

Coroner's investigators have wide search and seizure powers under s 33 of the Coroners Act. The Commission's Discussion Paper set out the provision and discussed amendments made in 2003 to enable investigators to enter, search and seize without a warrant.[20] The Commission noted that the primary concern of interested parties in regard to s 33 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 examined the penalties attaching to similar offences in other jurisdictions and found that the current penalty of a $2,000 fine was too low. The Commission proposed that the same penalty as that applying to a breach of restriction of access to an area should apply.[21] Submissions showed complete support for such an increase in penalty.[22] Although the proposed penalty was $10,000 or 6 months' imprisonment, as noted above,[23] the Commission has been persuaded by the provisions of the *Sentencing Act 1996* (WA)[24] to adjust the penalty to a fine of $12,000 or 12 months' imprisonment and makes the following recommendation.

RECOMMENDATION 30

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 $12,000 or 12 months' imprisonment.

In its Discussion Paper the Commission noted 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

20. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 73–74.
21. In making its proposal that this offence should carry a term of imprisonment, the Commission noted that the offence of Obstructing a Public Officer under the *Criminal Code* (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.
22. David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Western Australia Police, Submission No 35 (1 September 2011); Australian Inquest Alliance, Submission No 39 (2 September 2011).
23. See 'Restriction of access to area', above.
24. Specifically *Sentencing Act 1995* (WA) s 41(6)(a) and s 86.

the regulations', there are no provisions in the *Coroners Regulations 1997* (WA) dealing with this matter.[25] The Commission noted that this seemed to be an oversight that should be rectified at the earliest opportunity, though it made no proposal in that regard. A submission to the Commission's Discussion Paper related an instance where documents taken by police were apparently never given to the coroner and allegedly were surrendered to a third person.[26] Another submission urged the need to make a formal recommendation about the need for regulations,[27] while the submission of the Western Australia Police suggested that guidance was required as to how things seized should be 'retained and disposed of'.[28] The Commission therefore makes the following recommendation.

RECOMMENDATION 31

Regulations for dealing with items seized by coroner's investigators

That the State Coroner and the Department of the Attorney General produce regulations to deal with how things seized pursuant to the power under s 33 of Coroners Act are kept and dealt with during the period of investigation, and how they are returned or disposed of after the investigation into the death is finished or if it is determined that there is no jurisdiction under the Coroners Act to investigate the death.

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 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)[29] 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. As noted in the Discussion Paper the three most recently enacted Coroners Acts (Victoria, New South Wales and New Zealand) do make such provision.[30] A provision to compel medical practitioners to report was urged upon the Commission as a means of protecting them against any breach of doctor–patient confidentiality when assisting the coroner in his or her investigation.[31] The Commission made a proposal to the effect that a coroner's investigator may serve written notice requiring a medical practitioner to give a report to the coroner relating to the deceased within a specified reasonable time.[32] The proposal set a penalty of $2,000 for failure to comply with such a notice without lawful excuse and made provision for the Coroners Regulations to be amended.

The Commission received strong support for its proposal;[33] however, submissions from the Department of Health and the Western Australia Police raised concern in relation to what might be considered a 'reasonable' time for compliance with the written notice.[34] The Commission explored three options to overcome potential problems in this respect. Firstly, as suggested by the Police submission, specifying a time for compliance in the legislation; secondly, providing for consultation regarding a reasonable time; and thirdly, providing for the consultative development of protocols to govern the time for compliance with a request made under the power. The Commission felt that the first option lacked flexibility and that the second could prove difficult to apply in practice as it required the medical practitioner and the coroner (or his or her investigator) to agree on a time. Ultimately the Commission favoured option three and this is set out in paragraph 8 of Recommendation 32 below.

The Department of Health did not support the proposal requiring a medical practitioner to produce a report for the coroner on the basis that it was time consuming and that 'the utility of these reports is questionable given that at the time of preparing the report, the medical practitioner will not ordinarily have access to the post mortem report or information as to cause of death'.[35] The

25. Ibid 74.
26. Jennifer Searcy, Adjunct Professor, Murdoch University, Submission No 19B (29 August 2011).
27. David McCann, Former Perth Coroner, Submission No 16 (19 August 2011).
28. Western Australia Police, Submission No 35 (1 September 2011).
29. *Coroners Act 1996* (WA) s 46A.
30. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 75–76.
31. Ibid 75.
32. Ibid, Proposal 30.
33. Registry of Births, Deaths, and Marriages, Submission No 9A (24 August 2011); David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011); MDA National, Submission No 30 (24 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Western Australia Police, Submission No 35 (1 September 2011); Australian Inquest Alliance, Submission No 39 (2 September 2011).
34. Department of Health, Submission No 11 (17 August 2011); Western Australia Police, Submission No 35 (1 September 2011).
35. Department of Health, Submission No 11 (17 August 2011).

Department suggested that if this proposal went ahead consideration should be given to provision of the post mortem examination report and that the notice specify the information sought by the coroner.[36] While the Commission's proposal did require specification as to the information sought by the coroner, it did not cover provision of the post mortem examination report and this became the subject of lengthy deliberations within the Commission. In order to assist it to make its decision on this matter the Commission asked the State Coroner whether there was anything that might militate against the provision of post mortem examination information to a doctor for the purpose of preparing such a report. The State Coroner replied that 'the majority of reports to which [the proposal] was likely to apply would be reports from a deceased person's general practitioner' rather than from a hospital for which the Department has responsibility.[37] In respect of the latter it was observed that hospitals 'already have access to post mortem reports … immediately upon completion'.[38] The State Coroner noted that most requests for such reports will be made prior to the post mortem results being available and 'very often the reports will assist in providing the medical history on which the forensic pathologist will rely in ultimately determining a cause of death'.[39] The Commission found the arguments of the State Coroner compelling and has therefore not included provision of post mortem information within its final recommendation. However, for reasons raised by the Department of Health and discussed in the next section in respect of prepared statements by medical practitioners, the Commission has recommended that provision of post mortem information be provided upon request for those purposes in Recommendation 33.

Submissions received from the State Coroner and from the State Coroner of Queensland caused the Commission to consider the potential that a doctor might raise an objection to producing a report for the coroner in cases where he or she was concerned that the information provided would criminate or tend to criminate them.[40] The Commission was urged to consider means of acknowledging such objection but maintaining the requirement to provide a report to assist the coronial investigation process. The Commission has done so and recommends (Recommendation 34) that the provisions permitting a coroner to grant a certificate under the Coroners Act (currently s 47) be extended to apply where a medical practitioner objects, on the ground of self-incrimination, to preparing and providing a written report required by the coroner. The Commission has added paragraphs 4, 5 and 6 to Recommendation 32 to provide for this.

36. Ibid.
37. Alistair Hope, State Coroner, Submission No 18C (11 October 2011).
38. Ibid.
39. Ibid.
40. Ibid; Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011).

RECOMMENDATION 32

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 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 a lawful excuse for failure to comply with a requirement to provide the coroner a written report does not include that the provision of the written report will criminate or tend to criminate the medical practitioner.

5. That a medical practitioner may, within the time specified for providing the written report, notify the coroner that the medical practitioner objects to the provision of the report on the ground that it will criminate or tend to criminate the medical practitioner.

6. That, subject to s 47 of the Coroners Act (or its equivalent in future legislation), the coroner may require the medical practitioner to provide the report within such further period of time as is specified by the coroner.
7. That the Coroners Regulations be amended to provide for a fee for medical practitioners who are not in receipt of a salary from the state for the provision of a medical report requested by the coroner pursuant to this power.
8. That the State Coroner, in consultation with relevant agencies and professional bodies, develop protocols to govern what is a reasonable time for compliance with a request made under this power and that such protocols may include different times for the provision of reports depending upon the level of detail required.

Power to request documents and prepared statements

As noted in the Commission's Discussion Paper, it is rare in Western Australia that police investigating a hospital death will question the relevant health professionals and take statements. Information about the death is usually provided by way of a requested medical report from the doctor (dealt with above) or a statement that is generally provided through their legal representative.[41] There is no power (in the absence of an inquest) to compel a person to comply with such a request and no offence is committed if the person fails to comply. The Commission proposed that a power to request documents and prepared statements be inserted in the Coroners Act following the model provided by s 42 of the *Coroners Act 2008* (Vic).[42] While such a provision will greatly assist the investigation of medical deaths, it was noted that it is a provision of broader application and as such may apply to any person, including specialist investigators whose statements addressing specified matters may assist in a coronial investigation.

The Commission received excellent support for this proposal in submissions to its Discussion Paper.[43] In expressing his strong support for the proposal the State Coroner observed that:

> On occasions it has been necessary to commence an inquest solely because statements have not been provided within a reasonable period of time. In at least one case the inquest need not have been held if the witness had provided a statement or report… It is not uncommon for lengthy new witness statements, drafted with the assistance of lawyers, to first be provided after an inquest has commenced.[44]

Obviously such practices would be eliminated if statements were compellable pursuant to the Commission's proposal.

The Department of Health did not support the proposal.[45] Its submission noted that requests for statements were regularly made by coroner's investigators some significant time after the death and that often health professionals had 'moved on and independent recollections of events [had] faded'.[46] In addition, it observed that:

> Typically correspondence does little more than indicate that witness statements should be provided by 'all relevant' staff members, and effectively it is then left up to the health service to progress the investigation on behalf of the coronial investigator.
>
> This is particularly troubling given that there is frequently no information provided as to cause of death or any concerns regarding the treatment provided by the hospital or health service. As such, witness statements tend to be provided in a vacuum without taking into account other relevant information, and may fail to address the coronial investigator's concerns.[47]

The Commission made similar observations in its Discussion Paper in support of the need for a specialist healthcare-related death investigation team.[48] It also noted that a consequence of the failure of requests to specify the issues that the coroner seeks to explore at inquest 'can create the false perception that the witness is avoiding issues

41. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 77.
42. Ibid, Proposal 31.
43. David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Western Australia Police, Submission No 35 (1 September 2011); Department of Corrective Services, Submission No 38 (1 September 2011); Australian Inquest Alliance, Submission No 39 (2 September 2011).
44. Alistair Hope, State Coroner, Submission No 18 (23 August 2011).
45. Department of Health, Submission No 11 (17 August 2011).
46. Ibid.
47. Ibid.
48. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 97–98.

that are of concern to the court'.[49] The Department submitted that in light of these concerns, compulsion to provide a witness statement as proposed by the Commission should only be considered where the healthcare professional has access to the post mortem examination report or information about cause of death. It was also submitted that 'if specific concerns exist with respect to the treatment provided, these should be brought to the attention of the health professional so that they can be considered and addressed in the witness statement'.[50]

The Commission viewed these submissions as reasonable and asked the State Coroner whether he contemplated any problem with releasing the post mortem examination report and the results of tests ordered by the forensic pathologist in respect of a deceased to assist the preparation of statements by healthcare professionals. In his response the State Coroner conceded there were some cases where the knowledge provided by a post mortem examination report may be helpful to a healthcare professional who has been asked to prepare a statement.[51] The State Coroner stated that it was his preference (and that of his medical advisers) 'that post mortem reports only be provided when there are aspects of the reports which it would be helpful for the witness to address or where the witness seeks a copy'.[52] The Commission has incorporated this qualification into its recommendation in paragraph 3 of Recommendation 33. The State Coroner also noted that it was important that medical practitioners not be induced to make 'guesses as to the focus of the investigations based on post mortem reports'.[53] With this in mind the Commission recommends that healthcare professionals be advised of any concerns relating to the treatment of the deceased that the statement should address. This would not only overcome the potential identified by the State Coroner but also the problems discussed in the Commission's Discussion Paper and in the Department of Health's submission.

Finally, as with the previous recommendation, the Commission has added paragraphs 5, 6 and 7 to the following recommendation to deal with submissions received from the State Coroner and from the State Coroner of Queensland about the potential for objection to preparing a statement at the request of a coroner on the ground of self-incrimination.[54]

RECOMMENDATION 33

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, where a prepared statement is requested of a healthcare professional, the healthcare professional be provided, where directed by the coroner or where requested by the healthcare professional, with a copy of any post mortem examination report and results of tests ordered by forensic pathologists in respect of the deceased and that the healthcare professional be advised of any concerns relating to the treatment of the deceased that the statement should address.
4. 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.
5. That a lawful excuse for failure to comply with a requirement to provide a document to the coroner or to prepare and provide a statement to the coroner does not include that the provision of the document or preparation and provision of the statement to the coroner will criminate or tend to criminate the person.

49. Ibid 98.
50. Department of Health, Submission No 11 (17 August 2011).
51. Alistair Hope, State Coroner, Submission No 18C (11 October 2011).
52. Ibid. The State Coroner stated that it was important to note that the cause of death given by the forensic pathologist was not always that which was ultimately adopted by the court and that in rare cases, following receipt of additional information, a forensic pathologist might change his or her opinion.
53. Ibid.
54. Ibid; Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011).

6. That a person may, within the time specified for preparing and providing a statement to the coroner, notify the coroner that the person objects to the preparation and provision of the statement on the ground that it will criminate or tend to criminate the person.
7. That, subject to s 47 of the Coroners Act (or its equivalent in future legislation), the coroner may require the person to prepare and provide the statement within such further period of time as is specified by the coroner.

OTHER MATTERS

Protection against self-incrimination

In view of its impact on the above two recommendations, the Commission has moved its consideration of the issue of self-incrimination from Chapter Five to Chapter Four.[55] As noted above, as a result of submissions received from the State Coroner and from the State Coroner of Queensland,[56] the Commission has determined that the provisions permitting a coroner to grant a certificate under the Coroners Act (currently s 47) should be extended to apply outside of the context of an inquest. The following recommendation therefore extends the protection to circumstances where a person objects to preparing and providing a written report or statement required to be provided to the coroner on the ground that it will criminate or tend to criminate the person.

The Commission's original Proposal 74 concerned extending the protection provided by s 47 of the Coroners Act to civil and disciplinary proceedings with a formula based on s 38 of the *Coroners Act* (NT). That proposal read:

> 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.[57]

In support of its proposal the Commission argued 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.[58] The proposal received complete support from submissions.[59] However, a submission from the North Australian Aboriginal Justice Agency (NAAJA) advised the Commission of a recent death in custody case concerning the application of s 38 of the *Coroners Act* (NT) on which the Commission's proposal was modelled.[60] The NAAJA stated that the wording 'in proceedings before a tribunal or person exercising powers and functions in a judicial manner against the person' had been interpreted to exclude administrative disciplinary processes such as the potential for dismissal from employment under the *Public Sector Employment and Management Act* (NT).[61] In consequence, the coroner did not require that the prison officer witnesses give evidence under the protection of a certificate on the basis that a certificate would not protect them from exposure to penalty in the form of administrative disciplinary action.[62] The NAAJA stated that a number of parties to the inquest made submissions that the coroner should recommend an amendment to s 38 of the *Coroners Act* (NT) to close the gap and it submitted that the Commission should seek an alternative model.[63]

The Commission is grateful to the NAAJA for drawing this case to its attention and recognises that potentially important evidence could be lost to the coroner if the amendment as proposed was implemented. The Commission has therefore amended its recommendation to make clear that its intentions are that evidence given under a s 47 certificate (including a written report or prepared statement requested by the coroner) should not be admissible in any disciplinary proceedings.

55. See LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 153–154.
56. Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011).
57. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011), Proposal 74.
58. Ibid 154.
59. Dominic Burke, Consultant, Clayton Utz, Submission No 10 (16 August 2011); Department of Health, Submission No 11 (17 August 2011); David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Australian Inquest Alliance, Submission No 39 (2 September 2011); North Australian Aboriginal Justice Agency, Submission No 42 (13 September 2011).
60. North Australian Aboriginal Justice Agency, Submission No 42 (13 September 2011).
61. Ibid.
62. Ibid.
63. Ibid.

RECOMMENDATION 34

Extend protection against self-incrimination

1. That the provisions permitting a coroner to grant a certificate under the Coroners Act (currently s 47) be extended to apply where a person objects to preparing and providing a written report or statement required to be provided to the coroner on the ground that it will criminate or tend to criminate the person.
2. That the protection provided for a person by a certificate given under the Coroners Act (currently s 47) extend to protection against the use of the statement, report or evidence in subsequent criminal, civil or disciplinary proceedings against the person other than for an offence under the Coroners Act or arising from giving false or incomplete information or evidence.

Provision of information to the coroner

The Discussion Paper drew attention to the low penalty provision for failure to provide information to a coroner under s 18 of the Coroners Act. Section 18 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.

Following a comparative analysis of penalty ranges for similar offences in other jurisdictions the Commission proposed that the penalty be increased to a fine of $5,000. Submissions showed complete support for this proposal.[64] The Commission considered a submission from Western Australia Police that the penalty for police officers in s 18(2) should be further increased, but ultimately it was persuaded that the proposed fine was appropriate.[65] This conclusion was supported both by its comparative analysis which showed that a fine of $5,000 is among the highest penalties for this offence in Australia and by the observation that, even following the reforms in other jurisdictions, Western Australia remains the only jurisdiction to have a specific offence applying to police for failure to provide information to a coroner.[66]

RECOMMENDATION 35

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.

64. David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Western Australia Police, Submission No 35 (1 September 2011); Australian Inquest Alliance, Submission No 39 (2 September 2011).
65. Western Australia Police, Submission No 35 (1 September 2011).
66. Although, 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: *Coroners Act 2003* (Qld) s 16.

Specialist investigators

As noted at the beginning of this chapter, there are some 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. The Commission's Discussion Paper identifies a number of specialist investigative bodies which prepare reports into certain types of deaths.[1] In some cases, specialist investigations are completely independent and undertaken by statutory bodies established specifically for the purpose of investigating certain deaths (eg, work-related, mining and aviation deaths). In other cases, concurrent investigations are undertaken internally by the institution in which the death occurred (eg, hospitals, prisons, mental health facilities).

COOPERATION WITH CORONIAL INVESTIGATION

In consultations the Commission heard that there was a need for better cooperation between workplace safety authorities and coronial police to aid the investigations of both parties, and to avoid unnecessary duplication of investigations and consequent waste of resources. In its Discussion Paper the Commission noted a number of ways that this could be practically achieved 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);
- provision of statements or reports of specialist investigators prepared pursuant to the power contained in Recommendation 34; 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.[2]

To encourage such cooperation the Commission proposed that the police Coronial Investigation Unit and workplace safety agencies consider the development of protocols to facilitate communication between parties investigating workplace fatalities in the interests of avoiding unnecessary duplication during investigations of workplace deaths.[3]

This proposal was strongly supported by submissions.[4] In its submission WorkSafe noted that it already had a number of measures in place to enhance cooperation with coronial police during an investigation.[5] It submitted that while material that might be subject to legal professional privilege could not be released, statements taken by WorkSafe inspectors could be provided to police in circumstances where the witness agreed to its release. To ease this process, WorkSafe had placed a standard release clause on the statement template and inspectors were instructed to ask witnesses whether they agreed to the release of the statement to the coroner.[6] It also noted that witnesses were given two copies of their statement and coronial police were advised that they may approach witnesses to obtain a copy of their statement. The Commission is satisfied by WorkSafe's submission (and by the provision of relevant protocols and materials by WorkSafe)[7] that it has made significant efforts to accommodate coronial matters and that it will continue to work with the Coroners Court and coronial police to ensure a cooperative approach. However, the Commission's proposal extends to all workplace safety agencies and, in light of support

1. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 80.
2. Ibid 80-81.
3. Ibid Proposal 33.
4. David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011); Western Australia Police, Submission No 35 (1 September 2011); WorkSafe, Submission No 36 (29 August 2011); Australian Inquest Alliance, Submission No 39 (2 September 2011).
5. WorkSafe, Submission No 36 (29 August 2011).
6. Ibid.
7. Ibid.

from submissions, the Commission confirms the following recommendation.

RECOMMENDATION 36

Cooperation between workplace safety inspectors and coronial police

That the Coronial Investigation Unit and workplace safety agencies (ie, the Department of Mines and Petroleum, EnergySafety and WorkSafe) 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.

Information sharing and confidentiality

As highlighted in the Commission's Discussion Paper WorkSafe, EnergySafety and the Department of Mines and Petroleum 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 are concluded.

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. Because coronial police and the Coroners Court appear to rely on the WorkSafe investigation report (which is privileged until any prosecution is completed), 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.[8] 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.

In its Discussion Paper the Commission noted that there is nothing in the Coroners Act to prevent a coroner from making an early administrative finding or interim determination in relation to a workplace death in cases where an inquest is unlikely to be held, thereby eliminating unnecessary delay.[9] However, to do so coronial police will require as much information as possible to enable them to undertake an effective investigation. The Commission therefore proposed legislative reform to encourage cooperation and authorise information sharing between investigative agencies. The Commission's proposal took the following form:

> 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.

The Commission received 10 submissions in response to this proposal, with all supporting the need for legislative reform to authorise the sharing of information between agencies to reduce delays in the coronial process and to avoid unnecessary duplication in investigations.[10] Two submissions expressed qualified support.[11] The Department of Health suggested that it would support a provision similar to s 23 of the *Children and Community Services Act 2004* (WA), which enables the discretionary disclosure or exchange of information to relevant public authorities and interested persons, but not a provision which compelled the production of information. However, the Commission notes that there is already an existing power in the Coroners Act empowering a coroner to summon a person to produce any document or other material where he or she reasonably believes it is necessary for the

8. See LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 82–83.

9. Ibid 82.

10. Department of Health, Submission No 11 (17 August 2011); Commissioner for Children and Young People, Submission No 15 (22 August 2011); David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Western Australia Police, Submission No 35 (1 September 2011); WorkSafe, Submission No 36 (29 August 2011); Australian Inquest Alliance, Submission No 39 (2 September 2011); Department of the Attorney General, Submission No 40 (31 August 2011).

11. Department of Health, Submission No 11 (17 August 2011); Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011).

purpose of an inquest.[12] Further, the Commission's recommendations for the provision of documents and prepared statements and reports (discussed earlier) will, if implemented, empower a coroner to require the provision, subject to lawful excuse, of such information.[13] The Deputy State Coroner supported the proposal subject to adequate protection being in place for material provided in confidence to the coroner for the purposes of investigation.[14] The Commission agrees that such provision should be made and, based on the approach in s 17(4) of the *Coroners Act 2003* (Qld), it has added to its recommendation to make clear that a coroner may only disclose information received pursuant to the recommendation for a purpose connected with the investigation being conducted by the coroner. In addition, the Commission believes it is appropriate that, like the Queensland provision, disclosure (whether direct or indirect) of confidential information by a person who has been given access to that information by a coroner should be an offence. In conformity with other penalty provisions recommended in this Report, the Commission proposes a maximum fine of $12,000 or a period of 12 months' imprisonment.

In its submission WorkSafe advised that the *Occupational Health and Safety Act* will shortly be replaced by the Model Work Health and Safety legislation mirrored by WorkSafe agencies throughout Australia.[15] The Bill (which is currently being debated in federal Parliament) contains provisions which impact upon the ability of WorkSafe to share information and evidence. In particular, proposed s 271 provides WorkSafe with the discretion to disclose information that is currently unable to be released.[16] The discretion only applies to legislation prescribed in the Regulations that will accompany the Act and WorkSafe submitted that the Coroners Act should be so prescribed to effect information sharing.[17] Currently only other Work Health and Safety laws are listed as prescribed legislation for the purposes of proposed s 271;[18] the Commission therefore adds to its recommendation that the Coroners Act be included in the Western Australian version of the Model Work Health and Safety legislation currently being drafted.

12. *Coroners Act 1996* (WA) s 46.
13. See Recommendations 32 and 33.
14. Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011).
15. WorkSafe, Submission No 36 (29 August 2011).
16. Model Work Health and Safety Bill 2011 (Cth) cl 271. According to WorkSafe's website, approval has been given by Cabinet for drafting of a Western Australian version of the Model Work Health and Safety Bill <h ttp://www.commerce.wa.gov.au/worksafe/Content/About_Us/Legislation/National_model_act_FAQs.htm>.
17. WorkSafe, Submission No 36 (29 August 2011).
18. Model Work Health and Safety Regulations 2011 (Cth) reg 702 'Confidentiality of information—exception relating administration or enforcement of other laws'.

RECOMMENDATION 37

Information sharing and confidentiality

1. 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.
2. That a coroner may only disclose information obtained pursuant to paragraph 1 for a purpose connected with the investigation being conducted by the coroner.
3. That a person who has been given access to confidential information by a coroner, must not directly or indirectly disclose the information other than for the purposes of the investigation or unless the disclosure is permitted or required under the Coroners Act or another Act and that breach of such provision be an offence punishable by a fine of $12,000 or 12 months' imprisonment.
4. That the Coroners Act be prescribed in the Regulations for the purposes of disclosure of information under proposed s 271 'Confidentiality of Information' of the Western Australian Model Health and Safety legislation.

OMBUDSMAN REVIEW OF CERTAIN DEATHS

In its Discussion Paper the Commission noted that the Western Australian Ombudsman now has the legislative conduct of reviews into the unexpected deaths of children known to the Department for Child Protection.[19] Reviews are undertaken for the purposes of ascertaining the circumstances of the death, identifying any patterns or trends

19. Division 3A of the *Parliamentary Commissioner Act 1971* (WA).

in child deaths, and making recommendations to improve policies and practices for the prevention of deaths of children in similar circumstances. The Commission noted that it had 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.[20] After discussion of the similar function undertaken by the New South Wales Ombudsman and the potential merits of such review the Commission posed a question seeking submissions as to whether a similar function should be bestowed upon the ombudsman in Western Australia.[21]

The Commission received only six submissions in response to this question.[22] Former Perth Coroner David McCann and Queensland State Coroner Michael Barnes noted that this was properly the function of the coroner and expressed concern that the coroner might resile from investigation of such deaths because another body is also investigating.[23] The Western Australia Police submission argued that such a proposal would be too 'resource intensive' and unnecessary in the absence of a complaint from a family member or interested person.[24] The Disability Services Commission supported such review but noted that there is currently a review mechanism (following complaint) undertaken by the Health and Disability Services Complaints Office (HADSCO).[25]

While HADSCO does not investigate cause of death, it advised the Commission that there is 'potential [in its processes] for identifying and making recommendations about systemic issues for strong interagency coordination'.[26] The Department of the Attorney General submitted that further analysis would be required to assess whether such an additional review mechanism is necessary.[27] In his submission, the Western Australian Ombudsman noted that his office 'does not express views about proposals that ultimately are, or will be, matters of government policy, including proposals for new functions for the office of the Ombudsman'.[28] However, he stated that the experience developed by his child death review team would equip it for successfully undertaking the function of reviewing deaths of persons with a disability living in a residential facility.[29]

The Commission observes that its Recommendation 59 has highlighted the coroner's role in relation to this vulnerable group by specifically designating persons living in residential care facilities for the disabled as persons 'held in care', the consequence of which makes all such deaths reportable and subject to the presumption of inquest.[30] In light of this and the fact that there is already a body to investigate and report on systemic issues in cases where complaints have been made and the submissions noted above, the Commission has determined not to make any recommendation in this regard.

20. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 83.
21. Ibid Question B.
22. David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Disability Services Commission, Submission No 20 (23 August 2011); Ombudsman Western Australia, Submission No 28 (24 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Western Australia Police, Submission No 35 (1 September 2011); Department of the Attorney General, Submission No 40 (31 August 2011).
23. David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011).
24. Western Australia Police, Submission No 35 (1 September 2011).
25. Disability Services Commission, Submission No 20 (23 August 2011).
26. Health and Disabilities Service Complaints Office, Submission No 2 (18 July 2011). HADSCO did not specifically comment on this question, but provided a general submission to the Commission.
27. Department of the Attorney General, Submission No 40 (31 August 2011).
28. Ombudsman Western Australia, Submission No 28 (24 August 2011).
29. Ibid.
30. See Chapter Five, 'Person Held in Care'.

Deaths in custody or police presence

The definition of 'reportable death' in the *Coroners Act 1996* (WA) ('the Coroners Act') 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] The Commission's Discussion Paper examined the current investigation models for these types of deaths and made a number of proposals to improve or assist investigation practices.

DEATHS IN PRISON CUSTODY

In Western Australia, death in custody[3] 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 illnesses[5] to suicides or homicides and under s 22 of the Coroners Act all such deaths must be inquested.

Notification of the coroner

Section 17(5) of the Coroners Act deals with the obligation to report deaths in custody to a coroner. It provides:

> 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.

The Discussion Paper set out the terms of the Department of Corrective Services' Policy Directive 30, which governs how prison officers deal with a death in custody upon discovery. The Commission noted that the documented practice in Policy Directive 30 was to notify the coroner 'within one working day',[6] rather than immediately upon discovery as required by s 17(5). The Commission observed that departmental policy did not adequately reflect its obligation under the Coroners Act and proposed 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 it also proposed should be appropriately prioritised.[7]

The Commission received six submissions in respect of this proposal, five of which (including the Western Australia Police and Deputy State Coroner) expressed support.[8] The sixth submission – from the Department of Corrective Services – merely submitted that the Commission's proposal was 'noted'.[9] In support of this proposal Queensland State Coroner Michael Barnes observed that officers of the Department of Corrective Services who failed to immediately report a death in custody to the coroner would 'be committing a criminal offence'.[10] Indeed, as the Commission's Discussion Paper notes, a breach of this requirement currently attracts a fine of $1,000.[11] In this Report, the Commission recommends that the penalty for this offence be

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 below: see 'Deaths Involving Police'.
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. Department of Corrective Services, Policy Directive 30 [4.7].
7. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) Proposal 36.
8. Registry of Births, Deaths, and Marriages, Submission No 9A (24 August 2011); David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Western Australia Police, Submission No 35 (1 September 2011).
9. Department of Corrective Services, Submission No 38 (1 September 2011).
10. Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011).
11. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 89, fn 8.

increased to a maximum fine of $12,000 or a term of up to 12 months' imprisonment.[12]

RECOMMENDATION 38

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,[13] the State Coroner has developed guidelines for the investigation of deaths of 'Prisoners in the Custody of the Ministry of Justice' (now the Department of Corrective Services).[14] However, like the Guidelines for Police these have not been updated since they were drafted in 1997. The Commission proposed that the State Coroner review and update the guidelines, placing particular emphasis on the obligations of custodial officers under the Coroners Act.[15] This proposal received the full support of submissions and is confirmed below.[16]

RECOMMENDATION 39

State Coroner's Guidelines: Deaths in custody

That the State Coroner review and update the guidelines for the investigation of deaths in custody.

12. Recommendation 15.
13. Royal Commission into Aboriginal Deaths in Custody, *National Report* (1991) vol 5, recommendation 8.
14. State Coroner, 'Guidelines – Persons Held in Care – Prisoners in the Custody of the Ministry of Justice' (undated).
15. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) Proposal 37.
16. David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Western Australia Police, Submission No 35 (1 September 2011); Department of the Attorney General, Submission No 40 (31 August 2011).

Adequacy of death in custody investigations

The Commission's Discussion Paper addressed matters raised during consultations about delays between investigation and inquest of deaths in custody that had been attributed in a 2004 review to the police investigation stage.[17] The Commission noted that the time between death and inquest had increased such that the average time for a death in custody to reach inquest was 31 months with many cases being natural causes deaths and some being the expected outcome of terminal illnesses.[18] The Discussion Paper also discussed issues raised by the Aboriginal Legal Service which observed that deaths in custody investigations by police often tended to have a narrow focus on criminality rather than addressing all the issues that a coronial investigation should address, including policy and procedure issues raised by the circumstances surrounding the death.[19] The Commission noted that the Coronial Investigation Unit (CIU) had redesigned its officer training to refocus its officers' investigations (once criminality is discounted) to the questions the coroner needs answered; however, the same training had not been undertaken by investigators in Major Crime who are responsible for death in custody investigations. The Commission proposed that the CIU 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.[20] In addition, the Commission proposed that Major Crime Squad and CIU jointly attend the scene of a death in prison custody to ensure that the coronial aspects of the investigation are adequately addressed.[21]

Both proposals gained the full support of submissions[22] and are repeated below. In respect of the proposal for training the State Coroner requested that any training be developed in consultation with his office.[23] The Commission

17. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 91 citing Office of the Inspector of Custodial Services, *The Diminishing Quality of Prison Life: Deaths at Hakea Prison 2001–2003*, Report No 22 (2004) 81.
18. LRCWA, ibid.
19. Ibid.
20. Ibid Proposal 38.
21. Ibid Proposal 39.
22. Registry of Births, Deaths, and Marriages, Submission No 9A (24 August 2011); David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Western Australia Police, Submission No 35 (1 September 2011).
23. Alistair Hope, State Coroner, Submission No 18 (23 August 2011).

has made that amendment to Recommendation 40 below. The Western Australia Police gave its full support to the training proposal, submitting that it

> can easily be designed and incorporated in the Major Crime Squad training. The additional key areas required during the assessment and reporting phases (covering public health and safety, administration of justice and ways to prevent deaths of a similar nature) would be incorporated.[24]

With regard to the proposal for joint attendance, the Western Australia Police submitted that it supported the proposal but that, in its opinion, it need only be implemented for a period adequate to ensure that Major Crime Squad investigators were sufficiently trained in the practical application of coronial investigation skills imparted in the proposed training module.[25] While the Commission's view (and its recommendation) remains unchanged, it accepts that the period of implementation is properly a decision for the Western Australia Police.

RECOMMENDATION 40

Coronial training for Major Crime Squad

That, in consultation with the State Coroner, 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.

RECOMMENDATION 41

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.

24. Western Australia Police, Submission No 35 (1 September 2011).
25. Ibid.

Collaboration with the Office of the Inspector of Custodial Services

In its Discussion Paper the Commission noted that there was significant scope and opportunity for the Coroners Court to improve its identification of systemic concerns and to better fulfil its prevention role in respect of deaths in custody.[26] The Commission considered 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. It noted that the Office of the Inspector of Custodial Services was well placed to offer such assistance having completed four inspection rounds of all Western Australian custodial facilities since 2000, giving its officers a thorough understanding of the practices of each prison and the issues that impact across the system. It was observed that the Inspector of Custodial Services and the State Coroner should be more aware of each others' recommendations and a collaborative information sharing relationship was proposed between the parties.[27]

The Commission's proposal received the complete support of submissions.[28] In his submission, the State Coroner agreed 'that there could be more interaction' between the two offices and suggested that this be achieved by 'counsel assisting who is preparing the matter for inquest writing to the Office of the Inspector of Custodial Services seeking any relevant advice or information'.[29] The Inspector of Custodial Services strongly supported the proposal. He stated that his office paid close attention to coronial findings in its inspections activities[30] and observed that there was a need for the Coroners Court to more actively seek the assistance of his office in preparation for inquest.[31] As noted above, the State Coroner's submission indicated that such an approach would be made in the future.

26. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 92–93.
27. Ibid Proposal 40.
28. Registry of Births, Deaths, and Marriages, Submission No 9A (24 August 2011); David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Office of the Inspector of Custodial Services, Submission No 37 (31 August 2011).
29. Alistair Hope, State Coroner, Submission No 18 (23 August 2011).
30. Examples were provided in support of this submission.
31. Office of the Inspector of Custodial Services, Submission No 37 (31 August 2011).

RECOMMENDATION 42

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

The Commission's Discussion Paper explored concerns expressed in consultations about potential for an actual or perceived conflict of interest where police officers investigate deaths that may have been caused or contributed to by police.[32] 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.

The Commission observed that the current arrangement in Western Australia meets the requirements set down by the Royal Commission into Aboriginal Deaths in Custody.[33] The Commission acknowledged that there are advantages to police investigating such deaths including that they have the appropriate skills and expertise in death investigation and knowledge of police practices. However, it noted that questions remain about the independence of police investigators in police-related deaths. 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 considered that examination of other models of investigation was warranted.

The Commission's Discussion Paper examined a number of alternative models.[34] On the basis of this examination and consultations with police it formed the preliminary view that a model currently operating in Los Angeles and Canada involving a civilian employed to oversee and assess the impartiality of police investigations into a police death was appropriate for Western Australia.[35] The Commission observed that the Corruption and Crime Commission (CCC) was well placed to supply experienced 'civilian' investigators for the purpose of oversighting 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. The support for this model expressed by police in consultations, its relatively limited resource burden and its ease of implementation were noted by the Commission.[36] Rather than making a proposal to this effect the Commission invited submissions on the following question:

> 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.[37]

The Commission was widely congratulated in submissions for paying attention to this area and the idea of having a CCC investigator overseeing (but not involved in) the police investigation was overwhelmingly supported.[38] In support of the idea, the State Coroner suggested that the independent

32. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 93–96.
33. That is, that investigating officers should be the highest qualified investigators, independent of the officers allegedly or apparently involved in the death and also preferably from an internal affairs unit: Royal Commission into Aboriginal Deaths in Custody, *National Report* (1991) vol 5, recommendations 33 & 34.
34. Ibid 94–95.
35. Ibid 95–96.
36. Ibid.
37. Ibid, Question C.
38. David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Public Interest Advocacy Centre, Submission No 26 (24 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Western Australia Police, Submission

CCC investigator could provide a separate report which 'addresses the level of cooperation provided by police and any perceived deficiencies in the quality of scene preservation in particular and the investigation generally'.[39] Queensland State Coroner Michael Barnes agreed.[40]

The Public Interest Advocacy Centre and the Australian Inquest Alliance supported the approach in preference to the status quo, but preferred that an independent body be established and funded to carry out investigations into deaths in custody and police-related deaths.[41] This was one model examined in the Commission's Discussion Paper, but it was ultimately discounted because of the very small number of deaths involved and the very large resource burden such an initiative would entail.[42]

In its submission the CCC noted that, while all police-related deaths are not currently subject to its oversight, police internal investigations into deaths in police custody are 'actively monitored and reviewed' by the CCC.[43] It submitted that it had 'specific regard to the role of the coroner' in these cases.[44] In respect of other police-related deaths (eg, deaths resulting from high-speed pursuits or police shootings) the CCC stated that it does not actively monitor them. However, the CCC is notified of internal investigations upon commencement and the *Corruption and Crime Commission Act 2003* (WA)[45] empowers it to 'monitor the progress of police internal investigations as they proceed and review their adequacy once they have been completed'.[46]

The CCC expressed reservations about having an officer 'embedded' with a police investigation from the outset, stating that it 'could lead to allegations or perceptions of tacit approval of actions taken' by investigators.[47] It also raised the issue of possible impact on the agency's independence 'if called upon to investigate the conduct of an investigation in which one of its officers has been involved'.[48] The Commission acknowledges that the word 'embedded' which appeared in Question C in its Discussion Paper may have different connotations for the CCC to that intended by the Commission. The Commission's question suggested the introduction of an element of independent oversight (not investigation) by the CCC 'to ensure the integrity of the [police] investigation is monitored and that the requirements of the coroner are properly addressed'.[49] As it appears from the CCC's submission that they already 'actively monitor and review all police internal investigations into deaths in police custody' without impacting their independence the Commission sees no reason why this role should not extend to all police-related deaths.[50] In the Commission's opinion, this active monitoring may include placement of a CCC officer to observe the way in which a police investigation into a police-related death is handled. For example, a CCC officer may be deployed to review police witness statements or to independently observe interviews of police officers who were involved in or witness to the death. As part of this independent oversight role, the CCC may provide a report to the coroner on the adequacy of the questioning or investigation.

The CCC submission stated that in its view the 'Western Australia Police are best placed to investigate [police-related deaths] having regard to their experience, expertise and resources, such as extensive forensic capabilities'.[51] The Commission highlights that its question did not propose that any agency other than the Western Australia Police *investigate* police-related deaths. As noted above its question focussed on independent observation or oversight to maintain public confidence in the police investigation process. Having considered all submissions on this subject the Commission makes the following recommendation.

RECOMMENDATION 43

Oversight of police-related deaths by Corruption and Crime Commission

That the Corruption and Crime Commission actively monitor and review police investigations into all police-related deaths and provide a report to the coroner about the integrity, depth and nature of the investigation.

No 35 (1 September 2011); Australian Inquest Alliance, Submission No 39 (2 September 2011).
39. Alistair Hope, State Coroner, Submission No 18 (23 August 2011).
40. Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011).
41. Public Interest Advocacy Centre (PIAC), Submission No 26 (24 August 2011); Australian Inquest Alliance, Submission No 39 (2 September 2011). The latter body adopted the submission of PIAC.
42. See LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 92–93 (in respect of deaths in prison custody) and 94–95 (in respect of police-related deaths).
43. Corruption and Crime Commission, Submission No 41 (5 September 2011).
44. Ibid.
45. *Corruption and Crime Commission Act 2003* (WA) ss 40 & 41.
46. Corruption and Crime Commission, Submission No 41 (5 September 2011).
47. Ibid.
48. Ibid.
49. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) Question C.
50. Corruption and Crime Commission, Submission No 41 (5 September 2011).
51. Ibid.

Deaths in healthcare facilities

DEATHS IN HOSPITALS

The Discussion Paper highlighted concerns raised by police and others during consultations that police were not effective investigators of deaths in medical settings.[1] 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'.[2]

The Discussion Paper set out the current police investigation practice for hospital deaths in Western Australia. It noted that rather than interviewing doctors and witnesses to a hospital death, it was the practice of police to request statements from doctors and nurses, often some time after the death. As discussed earlier, these requests are often general and rely upon the hospital to identify relevant witnesses.[3] Current practice therefore tends to internalise investigations to the hospital and may give an appearance of bias. In addition, the generality of requests may result in a statement that does not address the issues of concern 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. Other problems with current investigative practice included that hospital notes were not always immediately seized (particularly in regional areas) which may impact upon the forensic pathologist's capacity to properly investigate the death; and that delays in requesting statements and information about hospital deaths complicated investigations causing issues with the recollection by medical staff of the event and problems of locating staff who may have moved interstate or overseas. [4]

In its Discussion Paper the Commission identified the clinical liaison service attached to the Coroners Court of Victoria as a useful model for reform of the current investigative system for hospital deaths in Western Australia. The service consists of doctors and nurses working onsite with police investigators to clinically enhance the coroner's death investigation process and create collaborative partnerships between the coroner and the healthcare sector.[5] As part of a series of proposals to address concerns about the efficacy and efficiency of coronial investigation of healthcare-related deaths (including those relating to provision of medical reports and prepared statements), the Commission proposed that a specialist healthcare-related death investigation team be established in Western Australia.[6] The Discussion Paper examined options for location and constitution of such a unit and concluded that 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.[7] Noting criticisms about the treatment of hospital witnesses in inquests and concerns about relations between the Coroners Court and the healthcare sector, the Commission proposed that a significant function of the specialist healthcare-related death investigation team should be the development 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.[8]

Submissions strongly supported the Commission's proposal.[9] The Public Interest Advocacy Centre

1. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 97–98.
2. Ranson D, 'How Effective, How Efficient' (1998) 23 *Alternative Law Journal* 284.
3. See 'Power to request documents and prepared statements', above.
4. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 97–98.
5. Ibid 98.
6. Ibid Proposal 41.
7. Ibid 98–101.
8. Ibid, Proposal 41.
9. Perinatal Loss Service – King Edward Memorial Hospital, Submission No 7 (1 August 2011); Department of Health, Submission No 11 (17 August 2011); David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Dr Adrian Charles, Perinatal/Paediatric Pathologist, Submission No 22 (23 August 2011); Evelyn Vicker, Deputy State

submitted that a specialist healthcare-related death investigation team 'should be adopted in all coronial jurisdictions'[10] and Queensland State Coroner Michael Barnes, who had previously reviewed the operation of the Coroners Court in Western Australia, stated that such a team is 'urgently needed'.[11] The Department of Health submitted that:

> [T]he investigation of healthcare-related deaths is challenging and complex. The establishment of a specialist healthcare-related death investigation team would increase the quality of coronial investigations, and also be more efficient in the sense of ensuring resources are focussed on matters that would benefit most from the scrutiny of a coronial investigation.[12]

The Commission notes that there will also be significant resource benefits to Western Australia Police, which was also extremely supportive of the proposal. Presently, hospital deaths account for approximately 27% of deaths investigated by the Coronial Investigation Unit (CIU)[13] and represent 54% of CIU's scene attendances.[14] The savings to that agency should completely offset the attachment of at least one police detective to the specialist healthcare-related death investigation team and enable the continuance of CIU involvement in certain deaths (discussed below).[15] In the Commission's opinion, police involvement in the team is essential to ensure that any potential criminality in respect of a death or during the investigation can be investigated or referred, and to ensure that directions can be easily and appropriately made to police assisting the team to investigate hospital deaths in regional areas.[16] In his submission the State Coroner raised the point that there are a number of deaths which occur at a hospital that were the inevitable result of an injury sustained, for example in a motor accident, prior to admission. He noted that in these cases 'very little evidence is required from the hospital, if any, and … it is appropriate for police to conduct the investigations'.[17] The Commission agrees. This is not the type of death that would or should be referred to the specialist healthcare-related death investigation team. Deaths resulting from traffic accidents would ordinarily be dealt with by the Major Crash Investigation Unit and that involvement should not change. In addition, the State Coroner noted that a number of natural causes deaths that ultimately occur in hospital but that result from a prior event such as a heart attack should also continue to be investigated by police.[18] The Commission believes that the police detective/s attached to the specialist healthcare investigation unit will be in a position to make a quick assessment in respect of such cases and refer them to the CIU for investigation.

The need for a person with nursing experience to be involved in the investigation of healthcare-related deaths was urged in three submissions.[19] The Commission agrees that a nursing member would be an important part of the team and could not only give advice in respect of nursing practice, but also assist in liaison with nurse witnesses.[20] The Commission has added the requirement of a nurse member to its recommendation. It also notes the submission of Dr Adrian Charles that investigators must have a current understanding of techniques and expectations within the healthcare sector.[21] The Commission notes that the part-time medical advisers to the coroner work part-time in practice and it suggests that consideration should be given to ensuring that other members of the specialist healthcare-related death investigation team maintain a connection with their profession and attend professional training and conferences.

While supporting the proposal the Deputy State Coroner expressed concern that the team may restrict the input from 'a healthy cross section of experts' who currently contribute to the coronial

Coroner, Submission No 24 (24 August 2011); Public Interest Advocacy Centre, Submission No 26 (24 August 2011); Health Consumers' Council, Submission No 27 (24 August 2011); MDA National, Submission No 30 (24 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Western Australia Police, Submission No 35 (1 September 2011).

10. Public Interest Advocacy Centre, Submission No 26 (24 August 2011).
11. Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011).
12. Department of Health, Submission No 11 (17 August 2011).
13. Based on current case statistics as at 6 April 2011: Detective Sergeant Rohan Ingles, CIU, email (6 April 2011).
14. Western Australia Police, Submission No 35 (1 September 2011).
15. The Commission's Discussion Paper considered various options for the involvement of police within the specialist healthcare-related death investigation team: LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 99–100.
16. The submission of the Western Australia Police raised the need for consideration of regional hospital deaths to ensure consistency throughout the state and also to the need for referral of a matter to the Major Crime Squad where any significant criminal involvement in a death is detected: Ibid.
17. Alistair Hope, State Coroner, Submission No 18 (23 August 2011).
18. Ibid.
19. Perinatal Loss Service – King Edward Memorial Hospital, Submission No 7 (1 August 2011); David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011).
20. Hope, ibid.
21. Dr Adrian Charles, Perinatal/Paediatric Pathologist, Submission No 22 (23 August 2011).

system.[22] The Commission cannot see how this would be the case. The team is focussed on improving the front end of healthcare investigations prior to a decision being made whether or not to inquest. The need for expert input into particular aspects of medical treatment to inform the investigation will no doubt be enhanced by the presence of such a team, while the gathering of expert overview reports for inquest or otherwise will continue. In the Commission's view, the team can only enhance the contribution of experts to the coronial system by identification of and liaison with experts and by enabling a specific briefing on the particular coronial concerns in any given case.

RECOMMENDATION 44

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 coroner's investigators be established within the Office of the State Coroner. The coroner's investigators attached to this team should include at least one police detective and one investigator with experience in the nursing profession. The functions of this team should include:

- investigation of deaths in hospitals and healthcare facilities;
- provision of medical advice to the coroner on all relevant cases 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 Department of Health and professional bodies, 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.

22. Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011).

DEATHS IN MENTAL HEALTH FACILITIES

As noted in the Discussion Paper, most investigations into deaths in mental health facilities in the metropolitan area are now conducted by officers from the Coronial Investigation Unit (CIU), but sometimes they are 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 and examples were mentioned in the Discussion Paper.[23] In response to these concerns the Commission proposed that the Western Australia Police CIU consult with the Office of the Chief Psychiatrist to determine ways of diminishing patient distress in cases of deaths in mental health facilities and to develop protocols for police investigation of such deaths.[24] The Commission suggested that investigation protocols could be communicated to operational police officers and cadets through CIU-run training.[25]

The Commission received overwhelming support for its submission.[26] The Department of Health noted that it was the appropriate stakeholder for consultation, rather than the Office of the Chief Psychiatrist (which falls within the Department of Health) and this change is reflected in the recommendation below.[27] The Western Australia Police did not support this proposal on the basis that its officers are 'not suitably qualified or trained to investigate deaths in this category'.[28] It preferred that such deaths be investigated by the specialist healthcare-related death investigation team discussed above.[29] The Commission does not agree with Western Australia Police in this respect. It stresses that deaths in mental health facilities are not at all comparable to hospital deaths or deaths following surgical procedures which may require some specialist knowledge to facilitate a thorough investigation. In contrast, deaths in mental health facilities are more likely to be of natural causes, accident or occasionally suicide,

23. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 101.
24. Ibid Proposal 42.
25. Ibid 102.
26. Registry of Births, Deaths, and Marriages, Submission No 9A (24 August 2011); Department of Health, Submission No 11 (17 August 2011); David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011).
27. Department of Health, Submission No 11 (17 August 2011).
28. Western Australia Police, Submission No 35 (1 September 2011).
29. Ibid.

which police routinely investigate on behalf of the coroner. The Commission highlights that the only difference between such deaths in the community and those within a mental health facility are found in the facility's institutional setting and the potential vulnerability of witnesses. The protocols recommended below should ensure that police are sufficiently aware of these vulnerabilities while conducting their routine investigation.

RECOMMENDATION 45

Investigation of deaths in mental health facilities

That the Western Australia Police Coronial Investigation Unit, in consultation with the Department of Health, develop protocols for police investigation of deaths in mental health facilities.

Investigation of possible mental health-related deaths

A specific proposal was made in relation to the issuing of guidelines for the investigation of deaths which do not occur in mental health facilities but which may nonetheless be mental health-related. In particular, it has been noted that 'people are often most vulnerable after discharge' from a mental health facility.[30] In its Discussion Paper the Commission noted that the CIU had developed a specific protocol where, in cases of suicide or suspicious death, the 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. This is a good practice, but since CIU do not investigate all coronial deaths in Western Australia it is feasible that vital information about a person's mental health history may be missing from some coronial investigations. In these circumstances the Commission proposed 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 heath service in the five years preceding the death.[31]

The Commission received 10 submissions on this proposal with all but the Western Australia Police expressing support.[32] In its submission the Western Australia Police argued that the 'vetting of the deceased's medical history should not be placed onto the police as [it is] an onerous administrative role'.[33] The Police submitted that instead this task should be undertaken by the Office of the State Coroner. However, in the Commission's opinion this submission seems to proceed on a misconception. The proposal does not ask the police to 'vet' a deceased's medical history, merely to make an inquiry of the Department of Health as to whether the deceased had been in contact with mental health services in the past five years. In the Commission's view this task is appropriately within the normal course of a police investigation and failure to follow such a course in relevant cases could result in a significantly deficient investigation. In its submission supporting the proposal, the Department of Health noted that it would be appropriate for the State Coroner to consult with the Department in the development of relevant guidelines in this respect.[34] The Commission agrees and makes the following recommendation.

RECOMMENDATION 46

State Coroner's Guidelines: Investigation of possible mental health-related deaths

That the State Coroner, in consultation with relevant agencies, 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.

30. Federation of Community Legal Centres (Victoria), submission to Victorian Parliament on the Coroners Bill 2008 (10 November 2008) 2.
31. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) Proposal 18.
32. Registry of Births, Deaths, and Marriages, Submission No 9A (24 August 2011); Department of Health, Submission No 11 (17 August 2011); Commissioner for Children and Young People, Submission No 15 (22 August 2011); David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011); Australian Medical Association, Submission No 29 (25 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Australian Inquest Alliance, Submission No 39 (2 September 2011).
33. Western Australia Police, Submission No 35 (1 September 2011).
34. Department of Health, Submission No 11 (17 August 2011).

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 1996* (WA) ('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.

The Commission's Discussion Paper noted that 'a draft model provision for the giving of aid by one coroner to another'[2] had been proposed by the Standing Committee of Attorneys-General in 2007. The Commission commented that 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.[3] At the time of writing only two jurisdictions had implemented the model provision. Noting that the provision had the support of the State Coroner the Commission proposed that it be implemented in Western Australia.[4] This proposal received the full support of submissions.[5] In addition the Commission invited submissions on whether, as with the Victorian provision, the provision for (discretionary) assistance should extend to assisting coroners or their counterparts in other countries. Submissions supported this extension[6] and this has consequently been added to Recommendation 47.

RECOMMENDATION 47

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.

1. Barnes M, *Review of the Coroners Act 1996 (WA)* (August 2008) 27.
2. 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.
3. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 103.
4. Ibid Proposal 47.
5. David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011); Baha'i Council of WA, Submission No 31 (26 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Department of the Attorney General, Submission No 40 (31 August 2011).
6. David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Department of the Attorney General, Submission No 40 (31 August 2011).

(6) 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 to investigate a death as if that death were a reportable death.

Chapter Five

Coronial Findings and Inquests

Contents

Introduction

The majority of coronial cases in Western Australia are disposed of by way of administrative findings.[1] Only 35–40 cases go to inquest each year.[2] Approximately half of these cases are mandated by the *Coroners Act 1996* ('the Coroners Act'),[3] while the remaining are held at the discretion of the coroner investigating the death.[4] Regardless of the way in which a coronial case is resolved, a record of investigation containing the coroner's findings (and sometimes comments and recommendations) is produced in each case. 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 recommendations 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 recommendations 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 'Administrative Findings', below.
2. There are approximately 1,800 coronial cases each year, see LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) Appendix B, table 1.
3. See 'Mandated Inquests', below. These include deaths in custody, police-related deaths, suspected deaths and deaths of involuntary mental health patients.
4. See 'Discretionary Inquests', below.

Coronial findings and comments

CORONIAL FINDINGS AND THE RECORD OF INVESTIGATION

Section 25 of the *Coroners Act 1996* (WA) ('the Coroners Act') provides that a coroner must make certain findings in respect of a death for which a coronial investigation is undertaken.[1] Coroners' findings are contained in the formal 'record of investigation into death'.[2] 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).[3] 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. These are the requirements of s 25(1) and collectively they are known as 'the findings'.

The Commission's Discussion Paper examined the nature of coronial findings and discussed the limitation on findings (and comments) expressed in s 25(5) of the Coroners Act which precludes a coroner from determining or appearing to 'determine any question of civil liability or to suggest that any person is guilty of any offence'. However, it noted that under s 27(5) of the Coroners Act a coroner may report to the Director of Public Prosecutions (DPP) (for an indictable offence) or the Commissioner of Police (for a simple offence) where he or she believes that an offence has been committed in connection with the death under investigation. Although the Act does not expressly state that such referral may be noted in the coroner's findings, the Commission found that this was the occasional practice of coroners in Western Australia and noted that the legislative authorisation for such a course was recommended by Queensland State Coroner Michael Barnes in his 2008 review of the Act.[4] Having examined the practice in Western Australia and legislation elsewhere, the Commission proposed that in the interests of transparency of the coronial function the Coroners Act should legislatively authorise the making of referral statements; however, these should be positioned at the end of the record of investigation and should not identify any person who may be implicated in a possible offence.[5]

Submissions showed considerable support for this proposal[6] with the DPP commenting that the proposal 'will ensure that the legislation reflects current practice and, further, will ensure transparency'.[7] Only one submission did not support the proposal and it did so on the basis that a statement of referral may lead to speculation that any person of whom the coroner has been critical in the findings was the subject of a referral.[8] In light of the current practice and the fact that it is the death the subject of investigation that is referred, rather than any person who may have committed an offence in connection with the death, the Commission is not persuaded by this submission. It therefore makes the following recommendation.

RECOMMENDATION 48

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.

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. See *Coroners Regulations 1997* (WA) Form 3.
3. *Coroners Act 1996* (WA) s 26.
4. See LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 112–13.
5. Ibid, Proposal 45.
6. Department of Health, Submission No 11 (17 August 2011); David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011); Director of Public Prosecutions (WA), Submission No 33 (26 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Australian Inquest Alliance, Submission No 39 (2 September 2011).
7. Director of Public Prosecutions (WA), Submission No 33 (26 August 2011).
8. Dominic Bourke, Consultant, Clayton Utz, Submission No 10 (16 August 2011).

2. That the statement must not name any person 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.

COMMENTS

As well as the specific findings set out in s 25(1) of the Coroners Act, 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'.[9] In circumstances where the deceased was a 'person held in care' as defined in s 3 of the Coroners Act, the coroner is *required* by s 25(3) to comment 'on the quality of the supervision, treatment and care of the person while in that care'.[10] Form 3 requires that comments be set out at the end of the record of investigation under a separate heading including the word 'comments'. Comments made under ss 25(2) or 25(3) are, therefore, distinguished from the narrative that contains the findings made under s 25(1). In addition, unlike findings, comments cannot be the subject of review by a superior court.[11]

Discretionary 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 its Discussion Paper, the Commission considered whether, in light of the recommendation function, the power to make discretionary comments served any useful purpose.[12] The Commission found that comments did play a role where coroners felt obliged to alert individuals or entities to issues that did not warrant a formal recommendation or to acknowledge that steps have already been taken to implement appropriate changes in response to the death.[13] However, in view of submissions that the present power to comment 'on any matter connected with the death' was too wide, the Commission examined whether it was necessary to legislatively confine the comment function. After reviewing legislation in other jurisdictions and judicial guidance on the role of comments in Western Australia, the Commission proposed that the function be confined to inquest and be restricted to comments on public health or safety, the administration of justice or the prevention of deaths in similar circumstances.[14] The Commission's proposal received the full support of submissions[15] and is confirmed in the following recommendation. A further recommendation for legislative guidance in the matters that should be considered by coroners when exercising powers under the Coroners Act to make recommendations and comments is made in Chapter Six.[16]

RECOMMENDATION 49

Coroner's discretionary comment function

That the power of coroners to make discretionary comments (currently s 25(2) of the Coroners Act) 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.

RE-OPENING OF INVESTIGATION OR INQUEST 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). The Commission's

9. *Coroners Act 1996* (WA) s 25(2).
10. *Coroners Act 1996* (WA) s 25(3).
11. *Re Inquest into the death of Romauld Todd Zak: Ex parte Zak* [2006] WASC 186 [28]. For discussion about superior court review of findings, see 'Review of findings by superior court', below.
12. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 110–11.
13. Ibid.
14. Ibid, Proposal 44.
15. Department of Health, Submission No 11 (17 August 2011); David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Department of the Attorney General, Submission No 40 (31 August 2011).
16. See 'Guidance to Coroners Considering Whether to Make Comments or Recommendations', Chapter Six.

Discussion Paper noted that mechanisms for the internal review of administrative findings (ie, by re-opening the coronial investigation into the death) now exist in all Australian jurisdictions except Western Australia and Tasmania, which have the oldest coronial legislation in the country.[17] The Commission reviewed the position in other jurisdictions and determined that re-opening of investigations or inquests in certain circumstances by application or on a coroner's own initiative was desirable and should be legislatively authorised in Western Australia.

The Commission's proposals for the re-opening of an investigation or inquest on the coroner's initiative or by application[18] received the full support of submissions.[19] Expressing his support for the proposals, the State Coroner noted that similar provisions in other states had not resulted 'in excessive and unmeritorious applications for the reopening of inquests'.[20] Although supportive of the proposals, Queensland State Coroner Michael Barnes stated that the State Coroner should have discretion as to who should convene the court if an inquest is reopened. He suggested that the impartiality of the original coroner may appear to be compromised if he or she was to re-open the investigation in response to an application.[21] The Commission notes these comments but believes that its Recommendation 51 makes sufficient allowance for any concerns about impartiality communicated by an applicant by permitting a different coroner to consider an application to re-open an investigation or inquest if there are 'special circumstances'.

To improve accessibility, transparency and consistency in the review process, the Commission also proposed 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 the form be prominently featured and made available for download on the Coroners Court website.[22] This proposal also received the full support of submissions commenting on the subject[23] and is confirmed below in Recommendation 52.

RECOMMENDATION 50

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.

RECOMMENDATION 51

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 an order under paragraph 1 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.

17. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 113.
18. Ibid, Proposals 46 & 47.
19. Dominic Bourke, Consultant, Clayton Utz, Submission No 10 (16 August 2011); David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Australian Inquest Alliance, Submission No 39 (2 September 2011).
20. Alistair Hope, State Coroner, Submission No 18 (23 August 2011).
21. Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011).
22. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) Proposal 48.
23. David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Australian Inquest Alliance, Submission No 39 (2 September 2011); Department of the Attorney General, Submission No 40 (31 August 2011).

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.

RECOMMENDATION 52

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

Only the 'findings'[24] of an inquest made under s 25(1) may be challenged by application to a superior court. Section 52 of the Coroners Act permits '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. 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.[25]

The Commission noted that this provision had been interpreted infrequently in Western Australia and that a similar provision in Victoria (prior to reforms in that state) had been subject to significant judicial criticism, including that aspects of the provision were 'unclear and somewhat incomprehensible'.[26] The Commission considered that the Western Australian coronial jurisdiction would benefit from legislative clarification of the review process. Following examination of provisions in other jurisdictions and the merits of various grounds for review,[27] the Commission proposed that a person may apply to the Supreme Court to have a finding or findings of a coroner set aside on the grounds that the coroner had 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.[28]

The Commission's proposal received considerable support from submissions.[29] The Department of Health was the only submission to express concern about the proposal, stating that it appeared 'to propose a narrower right of review than is currently contained in the Coroners Act'.[30] The Commission acknowledges that in respect of the grounds found in s 52(3)(d) its proposal represents a slight technical narrowing of the present position; however, it believes that this is appropriate, particularly in light of judicial criticism of the grounds.[31] Further, it is noted that the most recent judicial interpretations of s 52(3)(d) 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'.[32] The Commission

24. 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 and cause of death: *Re the State Coroner; Ex parte the Minister for Health* [2009] WASCA 165, [52] (Buss J, Martin CJ and Miller JA agreeing).
25. *Coroners Act 1996* (WA) s 52(3)(d).
26. *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).
27. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 114–16.
28. Ibid, Proposal 49.
29. Dominic Bourke, Consultant, Clayton Utz, Submission No 10 (16 August 2011); David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Australian Inquest Alliance, Submission No 39 (2 September 2011). It should be noted that while Dominic Bourke supported the proposal he did not agree that findings of the State Coroner should be reviewed by the Court of Appeal. However, because under the Commission's proposals the State Coroner will be drawn from the District Court, review of a final 'judgment' by the Court of Appeal is required under s 79(1) of the *District Court of Western Australia Act 1969* (WA). While Mr Bourke suggested that the District Court Act be amended to enable appeal to a single judge of the Supreme Court, the Commission does not agree that this is necessary or appropriate.
30. Department of Health, Submission No 11 (17 August 2011).
31. *Re Inquest into the Death of Romauld Todd Zak: Ex parte Zak* [2006] WASC 186 [30] (Murray J); *Re the State Coroner; Ex parte the Minister for Health* [2009] WASCA 165, [55] (Buss J, Martin CJ and Miller JA agreeing).
32. *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); *Re the State Coroner; Ex parte the Minister for Health* [2009] WASCA 165, [55] (Buss J, Martin CJ and Miller JA agreeing).

notes that if there is no evidence to support a finding then this would usually be considered an error of law and, therefore, appealable under the Commission's recommendation. In addition, the Commission highlights that its recommendation in fact *extends* the right of review by including the review of administrative findings by a superior court whereas previously this was confined to inquest findings. The Commission makes the following recommendation.

RECOMMENDATION 53

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.

POWER TO CORRECT THE RECORD OF INVESTIGATION

As part of its research for the reference the Commission examined inquest records from the past decade and found a large number of clerical errors and inconsistencies. In many cases the errors were typographical, but in others the mistakes were more significant. The Commission noted that the ability of the Coroners Court to internally correct typographical errors in records of investigations (including inquests) was unclear and that it was an area that could benefit from legislative clarification. The Discussion Paper noted that jurisdictions in which recent reform processes have been undertaken provide for coroners to correct the record of findings in certain circumstances.[33] The Commission considered s 76 of the *Coroners Act 2008* (Vic) to be a useful model for legislative reform and proposed that a similar section be introduced in Western Australia.[34] This proposal received the complete support of submissions[35] and the following recommendation is therefore made.

RECOMMENDATION 54

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.

33. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 117.
34. Ibid, Proposal 50.
35. Registry of Births, Deaths, and Marriages, Submission No 9A (24 August 2011); Department of Health, Submission No 11 (17 August 2011); David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Australian Inquest Alliance, Submission No 39 (2 September 2011); Department of the Attorney General, Submission No 40 (31 August 2011).

Administrative findings

As noted in the introduction to this chapter, the vast majority of coronial cases in Western Australia are disposed of by way of an administrative finding. An administrative finding 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. It was noted in the Commission's Discussion Paper that s 25(1)(b) has been held by the Western Australian Court of Appeal 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). In light of the significant backlog in the coronial system in Western Australia (and particularly the delays in producing administrative findings in uncontentious cases) the Commission considered ways to streamline the process for making coronial administrative findings, including the authorisation of non-narrative findings and the power to discontinue certain coronial cases.

NON-NARRATIVE FINDINGS

As noted in the Commission's Discussion Paper, 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.[2] 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. In Western Australia the practice is for administrative findings in natural causes cases to be drafted by very junior clerks. These findings contain nothing but the details required by the Registrar of Births, Deaths and Marriages to register the death.[3] The finding as to how the death occurred in these cases is limited to a coroner's verdict of 'natural causes', which is not adequate to satisfy the obligation conferred upon the coroner under s 25(1)(b) of the Coroners Act.

The Commission noted that a number of jurisdictions permit non-narrative, limited findings (of the type just described) in respect of all non-inquested deaths. The Commission was attracted to the recently enacted Victorian provision[4] which permits a coroner (at his or her discretion) to avoid making a finding about the circumstances of the death (as distinct from the manner and cause of death), permitting non-narrative findings in every non-inquested case. The Commission proposed that a similar provision be enacted in Western Australia to both legitimate the current practice of the Coroners Court in regard to natural causes deaths and to enable the swift registration of deaths following a coronial investigation, particularly in respect of non-controversial sudden deaths.[5] The Commission's proposal was only applicable to non-inquested deaths where the deceased was not a 'person held in care' (as defined in the Commission's Recommendation 59) and required the coroner to determine that there was no public interest to be served by including in the finding a narrative as to the circumstances attending the death. It should be noted that the death of a 'person held in custody' (under the Commission's Recommendation 58) is subject to mandatory inquest and therefore may not be the subject of a non-narrative finding.

Submissions were very supportive of this proposal with many noting its benefit to reducing delays in the coronial system.[6] The Department of the

1. *Re the State Coroner; Ex parte the Minister for Health* [2009] WASCA 165, [42] (Buss J, Martin CJ and Miller JA agreeing).
2. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 118.
3. That is, the name and age of deceased, the date and place of death and the cause of death.
4. *Coroners Act 2008* (Vic) s 67.
5. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011), Proposal 51.
6. Registry of Births, Deaths, and Marriages, Submission No 9 (24 August 2011); Department of Health, Submission No 11 (17 August 2011); David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Australian Inquest Alliance, Submission No 39 (2 September 2011);

Attorney General supported the discretion of a coroner to make a finding without having to narrate the 'description of how the death occurred' submitting that avoidance of this requirement would sometimes be 'in the public interest'.[7] The Registry of Births, Deaths and Marriages provided examples of short summaries of narrative findings prepared by registry staff to record with the registration of the death and stated that it was unclear whether the manner and cause of death without the narrative would satisfy the registration summary.[8] The Commission notes that since the practice with natural causes deaths has been to provide manner and cause of death in non-narrative form and there is no evidence that this had affected the registration of deaths, a non-narrative finding will contain sufficient information to effect registration of the death.

While supporting the proposal, two submissions argued that the coroner's discretion to make a non-narrative finding should be confined to natural causes deaths.[9] The Commission notes that there are many non-controversial sudden deaths (including some suicides and single motor vehicle accidents) where narrative descriptions of the circumstances of the death in the findings may be unnecessarily distressing for families and where a statement as to manner and cause of death is enough to satisfy the public interest. The Commission does not see a need to restrict the legislative provision to natural causes deaths, but suggests that the State Coroner may issue guidelines about the circumstances in which a non-narrative finding may be made by a coroner.

RECOMMENDATION 55

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 (under Recommendation 59), 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

As noted earlier, there are significant delays in the coronial system and a great number of delayed cases are those where a post mortem examination has determined that the deceased died of natural causes and no controversy surrounds the death. In its Discussion Paper, the Commission noted that although non-narrative natural causes death findings are generated by 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.[10] With reference to the objective of reducing delays in the coronial system, the Commission examined a Victorian provision which permits a coroner to discontinue the coronial investigation into a death where a forensic pathologist has examined the body of a deceased and has determined that the death was due to natural causes.[11] The Commission proposed that a similar provision be introduced in Western Australia and that the power of discontinuance in natural causes cases that meet the relevant criteria should be delegable to the Principal Registrar.[12] Like the Victorian provision, the Commission proposed that the power to discontinue a case could not be exercised where the death was during or following and causally connected to a medical procedure.[13] Because the Commission had proposed in its Discussion Paper that the definition of 'person held in care'[14] be separated into two categories (one of which permits the exercise of discretion in relation to whether an inquest is held),[15] the proposal made clear that the power to discontinue a case was not exercisable in cases where the

Department of the Attorney General, Submission No 40 (31 August 2011).

7. Department of the Attorney General, Submission No 40 (31 August 2011).
8. Registry of Births, Deaths, and Marriages, Submission No 9 (24 August 2011).
9. David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011).
10. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 120.
11. *Coroners Act 2008* (Vic) s 17.
12. It is also noted that determinations made pursuant to any such provision would be reviewable by the State Coroner under Recommendation 11.
13. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) Proposal 52.
14. See discussion, ibid 122–29.
15. Ibid, Proposal 53.

deceased was a person held in custody or care.[16] The Commission observed that for this provision to effectively reduce delays, the forensic pathologist must express an opinion that the death was or appeared to be due to natural causes.[17]

The Commission's proposal received the support of all submissions commenting on the issue.[18] However, the Department of Health noted that the level of post mortem examination (ie, full internal examination or external examination) would dictate the preparedness of a forensic pathologist to express an opinion about whether or not the death was due to natural causes.[19] It submitted that in cases where a full post mortem examination had not been completed 'an opinion could only be expressed to be "consistent with" natural causes'.[20] The Commission accepts this submission and has therefore amended paragraph 1 of its recommendation to reflect this wording.

RECOMMENDATION 56

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 consistent with 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.

16. It should be noted that in any event the death of a 'person held in custody' is subject to mandatory inquest both under the Commission's recommendations and under the present legislative scheme.
17. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 121.
18. Registry of Births, Deaths, and Marriages, Submission No 9 (24 August 2011); Department of Health, Submission No 11 (17 August 2011); David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Australian Inquest Alliance, Submission No 39 (2 September 2011).
19. It was also noted that in Victoria the fact that all bodies were imaged by a CT scanner gave forensic pathologists in that state an increased ability to express a firm opinion in cases where an external examination only has been undertaken. As observed in Chapter Seven of the Commission's Discussion Paper, it is clear that Western Australia is lagging behind other jurisdictions in the availability and use of imaging technology in post mortem procedures. The Commission was informed by the State Coroner that a proposal for a dedicated CT scanner for forensic use is currently being considered by government: Alistair Hope, State Coroner, Submission No 18 (23 August 2011).
20. Department of Health, Submission No 11 (17 August 2011).

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] As noted in the introduction to this chapter approximately half of all inquests each year are inquests that are mandated by the Coroners Act under s 22(1), which 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]

DEATH OF A 'PERSON HELD IN CARE'

Currently the definition of 'person held in care' in s 22(1)(a) of the Coroners Act 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 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.[3] In its Discussion Paper the Commission noted that 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.[4] It was observed that 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. The Commission observed that in Queensland deaths in custody and deaths in care are separated[5] and that, while deaths in custody are mandatorily inquested, deaths in care are only subject to mandatory inquest if the circumstances of the death raise issues about the deceased person's care.[6] The Commission believed this to be a sensible approach and proposed that the single category of death of a person held in care be separated into two categories representing custody and care along the lines of the Queensland provision.[7] Submissions were very supportive of this proposal.[8] Some reservations were expressed by the Deputy State Coroner who felt that police investigations may not be of the same quality if the case was not the subject of mandatory inquest.[9] The Commission acknowledges these reservations but observes that under its recommendations dedicated coroners will play a greater role in directing coronial investigations. In addition, it is noted that the State Coroner may issue guidelines to police dictating the questions that must be answered about the circumstances of the death of a person held in care to inform a coroner's decision whether or not to inquest. It is also highlighted that the Commission's recommendation dictates a *presumption* of mandatory inquest unless, in the

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. *Coroners Act 1996* (WA) s 3.
4. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 122–23.
5. *Coroners Act 2003* (Qld) ss 9 & 10.
6. *Coroners Act 2003* (Qld) s 27(1)(a)(ii). The coroner retains discretion to hold an inquest into any death regardless of the circumstances: s 28.
7. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) Proposal 53.
8. Commissioner for Children and Young People, Submission No 15 (22 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Disability Services Commission, Submission No 20 (23 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Western Australia Police, Submission No 35 (1 September 2011); Australian Inquest Alliance, Submission No 39 (2 September 2011); Department of the Attorney General, Submission No 40 (31 August 2011).
9. Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011). Another submission did not support the proposal on the basis that persons held in custody and care are of similar vulnerability: David McCann, Former Perth Coroner, Submission No 16 (19 August 2011). The Commission believes that its recommendation is justified for the reasons expressed above and in its Discussion Paper.

coroner's opinion, the circumstances of the death do not raise any issues about the deceased person's care. Further, the coroner retains discretion to hold an inquest into any death regardless of the circumstances.

Given the manifest support for its proposal, the Commission confirms it as a recommendation. The respective definitions of 'person held in custody' and 'person held in care' are discussed below.

RECOMMENDATION 57

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 Recommendation 58) and that deaths of persons falling within the definition of 'person held in care' (defined in Recommendation 59) 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 Recommendation 58) be the subject of a mandatory inquest.
4. That deaths of persons falling within the definition of 'person held in care' (defined in Recommendation 59) 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'

The Commission retained all 'in custody' aspects of the current definition of 'person held in care' under s 3 of the Coroners Act in its 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 circumstances will continue to be the subject of mandatory inquest under the Commission's recommendations. In addition, the Commission proposed that persons detained on a custody order under the *Criminal Law (Mentally Impaired Accused) Act 1996* (WA), persons who are apprehended or detained as involuntary patients within the meaning of the *Mental Health Act 1996* (WA) and persons who are detained under the authority of a Commonwealth Act should fall within the definition of 'person held in custody'.[10]

The response to this proposal was overwhelmingly positive[11] with the Western Australia Police submitting that the mandatory inquest for persons held in custody

> is aligned to a community expectation that where a person has been deprived of their liberties, as the result of a person in authorities' actions, their death will be scrutinised. This provides a forum to examine if duty of care requirements or administrative necessities were performed appropriately, to derive contemporary methods to prevent deaths occurring of a similar nature.[12]

The Department of Health objected to the inclusion of involuntary patients under the *Mental Health Act* within the definition of 'person held in custody' on the basis that 'the detention is secondary to the principal objective, which is the provision of treatment'.[13] The Department argued that such patients should be categorised as being 'in care' to avoid any 'negative connotations [that may] detract from the treatment focus'.[14] The Commission acknowledges the Department's submission, but believes that the argument is semantic rather than real. To fail to include such persons within the 'in custody' definition for the purposes of the Coroners Act would be inconsistent with the rationale underpinning this category. In the Commission's opinion, it is fundamental that the death of any person who is deprived of their liberty by the operation of a state or Commonwealth law must be subject to mandatory inquest to allow the actions of the authority to be

10. See in depth discussion of these categories in LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 123–26.
11. Commissioner for Children and Young People, Submission No 15 (22 August 2011); David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Disability Services Commission, Submission No 20 (23 August 2011); Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Western Australia Police, Submission No 35 (1 September 2011); Department of Corrective Services, Submission No 38 (1 September 2011); Australian Inquest Alliance, Submission No 39 (2 September 2011).
12. Western Australia Police, Submission No 35 (1 September 2011).
13. Department of Health, Submission No 11 (17 August 2011).
14. Ibid.

scrutinised in a public forum.[15] The Commission makes the following recommendation.[16]

RECOMMENDATION 58

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 ss 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.

On 15 December 2011 the Commission received a late submission from the Mental Health Law Centre which argued that voluntary patients in authorised hospitals should be subject to mandatory inquest.[17] It was argued that such patients are effectively equivalent to involuntary patients (which are included in the definition of person held in custody under Recommendation 58) because they often present with physical illnesses that prevent them from leaving the hospital even though they are 'technically' able to do so.[18] The Commission has considered this submission but is not persuaded that it is necessary to include voluntary patients in authorised hospitals in the definition of 'person held in custody' (mandatory inquest) or of 'person held in care' (presumption of mandatory inquest). In the Commission's opinion this would unnecessarily inflate these categories. In coming to this conclusion the Commission notes that any unexpected death of a patient in an authorised hospital (like any unexpected death of a person in the community) is reportable to the coroner and will be the subject of a coronial investigation. The Commission is aware of several inquests into the deaths of voluntary patients in the past decade,[19] which demonstrates that coroners will appropriately exercise their discretion to hold an inquest into the death of a voluntary patient in authorised hospitals where the circumstances of the death require it.

Definition of 'person held in care'

The Commission's proposed definition of 'person held in care' retained all 'in care' aspects of the current definition found in s 3 of the Coroners Act.[20] 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 under the *Alcohol and Drug Authority Act 1974* (WA), and people who are involuntary inpatients or on community treatment orders under the *Mental Health Act.* In its Discussion Paper the Commission examined whether people with profound or severe disabilities living in supported residential facilities should be included in the definition of 'person held in care'.[21] It determined that the definition

15. The Commission notes a late submission received from the Mental Health Law Centre specifically supporting maintaining involuntary patients and referral patients detained in an authorised hospital in the category of 'person held in custody': Mental Health Law Centre, Submission No 43 (15 December 2011).
16. The Commission notes the submission of the Department of Corrective Services that paragraph 4 of Recommendation 58 may need to be clarified to ensure that it excludes young people on supervised release. The Commission has considered the recommendation in light of the definition of 'detainee' in the *Young Offenders Act 1994* (WA) and does not consider any amendment is needed.
17. Mental Health Law Centre, Submission No 43 (15 December 2011).
18. Ibid. In addition, it was noted that some voluntary patients are unable, for practical reasons, to leave the hospital as they cannot get suitable accommodation in the community.
19. For example, Inquests 44/00; 45/00; 6/06 and 3/10. These inquests represent a range of circumstances of deaths of voluntary mental health patients from suicide to accidental falls.
20. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) Proposal 55.
21. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 128.

should be extended to encompass this category of vulnerable people.[22] In addition, the Commission proposed a minor change to the wording of the category dealing with persons admitted to a centre under the *Alcohol and Drug Authority Act* to reflect the intention that its application be limited to persons admitted for residential treatment under the Act.[23]

The Commission received strong support from submissions for its proposed definition of 'person held in care'. Surprisingly the Disability Services Commission (DSC) submitted that it did not think people residing in disability residential facilities should be included in the definition of 'person held in care' under the Coroners Act, arguing that disabled people engage with residential disability services on a voluntary basis, whereas others falling within the definition of 'person held in care' are under court compulsion 'and do not exercise basic decision-making rights in regard to particular areas of their lives'.[24] With respect, this is a misreading of the definition: people in residential drug and alcohol facilities also engage with the residential service on a voluntary basis and yet they are also (and have always been) included as a person held in care. The Commission notes that the DSC concedes in its submission that disabled people are vulnerable 'and more likely to be victim to abuse or neglect than other sections of the community'. It is for this reason that the Commission has added disabled people in residential facilities to the definition of 'person held in care' and the DSC submission (in conjunction with other explicitly supportive submissions on this category) strengthens the Commission's resolve to retain it. In doing so, the Commission highlights that similar provisions exist in the four Australian jurisdictions with the most recently reviewed coroners legislation and that other jurisdictions are likely to follow as their Coroners Acts are reviewed.[25] In light of the overwhelming support for its proposal the Commission makes the following recommendation.

RECOMMENDATION 59

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

In its Discussion Paper the Commission noted that 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.[26] It proposed that the State Coroner produce guidelines specifying by example the types of cases that fall within the respective definitions and that the Office of the State Coroner work together with relevant agencies to develop ways of informing people of relevant changes to the Coroners Act. Both proposals were fully supported by submissions[27] and the Commission therefore makes the following recommendations.

RECOMMENDATION 60

State Coroner's Guidelines: Persons held in custody and 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.

22. Ibid Proposal 55.
23. Ibid 127.
24. Disability Services Commission, Submission No 20 (23 August 2011).
25. See discussion, LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 128.
26. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 129.
27. Registry of Births, Deaths, and Marriages, Submission No 9A (24 August 2011); Department of Health, Submission No 11 (17 August 2011); Commissioner for Children and Young People, Submission No 15 (22 August 2011); David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Western Australia Police, Submission No 35 (1 September 2011); Australian Inquest Alliance, Submission No 39 (2 September 2011); Department of the Attorney General, Submission No 40 (31 August 2011).

RECOMMENDATION 61

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 work together with relevant departments or agencies (including the Department of Corrective Services, the Department for Child Protection, the Department of Health, 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

Section 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.[28] It is therefore classified as a mandated inquest. In its Discussion Paper the Commission noted that only one other Australian jurisdiction mandated the requirement of an inquest for suspected deaths and that a review of suspected death inquests in Western Australia over the past decade showed that some were undertaken merely as a formality to satisfy the Act.[29] The Commission therefore proposed that the coroner should have discretion whether to hold an inquest into a suspected death or to determine the case administratively.[30] The Commission received a mix of submissions on this proposal.[31] The State Coroner expressed reservations about the proposal on the basis that the inquest can give publicity to the suspected death citing a case in another jurisdiction where a person was later found alive.[32] Former Perth coroner David McCann agreed, stating that the publicity surrounding an inquest may result in some further information about the suspected death being produced.[33] The Deputy State Coroner and the Department of the Attorney General both preferred to retain mandatory inquests into suspected deaths recognising that they had some therapeutic benefit to families and that they represented only a small proportion of inquests.[34] The Commission is persuaded by these submissions that the current requirement of suspected death should remain and withdraws its proposal.

Standard of proof

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. The Commission discussed Barnes' arguments for this position in its Discussion Paper and observed that no other Australian jurisdiction requires the coroner to find that the fact of death be established beyond reasonable doubt. The Commission therefore proposed that the standard of proof for suspected deaths be removed.[35] This proposal received the full support of submissions[36] and is confirmed in the following recommendation.

RECOMMENDATION 62

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 (currently s 23(2)).

28. *Coroners Act 1996* (WA) s 23(2).
29. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011)129–30.
30. Ibid, Proposal 58.
31. Three submissions supported the proposal: Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Western Australia Police, Submission No 35 (1 September 2011); Australian Inquest Alliance, Submission No 39 (2 September 2011). Those opposing the proposal are discussed below.
32. Alistair Hope, State Coroner, Submission No 18 (23 August 2011).
33. David McCann, Former Perth Coroner, Submission No 16 (19 August 2011).
34. Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011); Department of the Attorney General, Submission No 40 (31 August 2011).
35. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) Proposal 59.
36. David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Western Australia Police, Submission No 35 (1 September 2011); Australian Inquest Alliance, Submission No 39 (2 September 2011); Department of the Attorney General, Submission No 40 (31 August 2011).

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 the Commission's Discussion Paper pointed out, typically only 35 cases each year are the subject of an inquest in Western Australia, at least half of which are mandated under the Coroners Act.[2] The Commission's Discussion Paper examined in some detail the purpose of an inquest and the accepted limits to the scope of inquiry that a coroner may make at an inquest (ie, that the inquiries made by a coroner must be causally related to the death under investigation).[3] The Discussion Paper then considered what should impact upon a coroner's exercise of discretion to hold an inquest in a particular case.

GUIDANCE TO CORONERS CONSIDERING WHETHER TO HOLD AN INQUEST

It emerged during consultations for this reference that a primary catalyst to an exercise of a coroner's discretion to hold an inquest at present in Western Australia was family pressure. Reform was urged upon the Commission to institute criteria to guide coroners in their decision to inquest and to protect them from having to capitulate 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.[4] With reference to s 28 of the *Coroners Act 2003* (Qld), the Commission proposed that a provision be inserted into the Coroners Act to provide guidance to coroners in their decision whether or not to inquest a particular case.[5] The Commission further proposed that, like Queensland, the State Coroner produce guidelines for coroners to assist them in the exercise of their discretion.[6] Submissions fully supported the Commission's proposals[7] and it makes the following recommendations.

RECOMMENDATION 63

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.

1. 'Mandated Inquests', above.
2. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) Appendix B, table 3.
3. Ibid, 131–33.
4. See discussion, ibid 133–35.
5. Ibid, Proposal 60.
6. Ibid, Proposal 61.
7. Department of Health, Submission No 11 (17 August 2011); David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011); Public Interest Advocacy Centre, Submission No 26 (24 August 2011); MDA National, Submission No 30 (24 August 2011);Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Western Australia Police, Submission No 35 (1 September 2011); Australian Inquest Alliance, Submission No 39 (2 September 2011).

RECOMMENDATION 64

State Coroner's Guidelines: When inquest should be held

That the State Coroner produce 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 that a person may apply to the coroner in writing (and containing reasons) for a coroner to hold an inquest. If the coroner refuses to hold an inquest, he or she must give reasons in writing to the applicant. In practice, the applicant is also advised of his or her right to have the Supreme Court review the coroner's decision.[8]

The Commission was informed of a number of concerns about the current process including that there was no clear direction on the website or elsewhere to assist people to make an application to the coroner, and that where an application is made by letter it is not always the subject of a clear reviewable decision with correspondence between the coroner and the applicant sometimes stretching over a long period. The Commission noted that a number of Australian jurisdictions have formal application forms for a request to hold an inquest, which are downloadable from their website, and made a proposal that such a form be instituted in Western Australia.[9] This proposal received complete support from submissions.[10]

RECOMMENDATION 65

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

As noted above, a person whose application for an inquest has been refused by a coroner may apply to the Supreme Court for an order that an inquest be held.[11] Section 24(2) of the Coroners Act provides that such an order may be made if the court is satisfied that an inquest 'is necessary or desirable in the interests of justice'. In its Discussion Paper the Commission considered submissions about the 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 and observed that Western Australia was the most restrictive of all Australian jurisdictions in this regard.[12] Having regard to the provisions of other jurisdictions, the Commission proposed that the time limit in which an applicant may seek superior court review should be extended to 30 days.[13] Again, the Commission received the full support of submissions for its proposal[14] and the following recommendation is made.

RECOMMENDATION 66

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

8. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 135–36.
9. Ibid, Proposal 62.
10. David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Australian Inquest Alliance, Submission No 39 (2 September 2011).
11. *Coroners Act 1996* (WA) s 24(2).
12. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 136–37.
13. Ibid, Proposal 63.
14. David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Australian Inquest Alliance, Submission No 39 (2 September 2011).

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 inquest into deaths arising from separate incidents where the deaths have occurred in similar circumstances or have similar features. 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.

The Commission's Discussion Paper listed a number of joint inquests undertaken over the past decade, many of which have resulted in important recommendations for the prevention of future deaths.[15] It was noted that s 40 of the Coroners Act, which permits the holding of an inquest into more than one death, can only be exercised on the direction of the State Coroner. The Commission observed that other jurisdictions did not confine the power in this way.[16] It proposed 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.[17]

15. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 137–38.
16. Ibid.
17. Ibid, Proposal 64.

Submissions fully supported the Commission's proposal.[18] The Department of Health supported the proposal but expressed concern about the broad scope of some joint inquests undertaken by Western Australian coroners. The Department commented that recommendations and investigations sometimes strayed into broader issues that had only tenuous links with the deaths under investigation and for which only limited evidence had been adduced.[19] This was an issue discussed at length in the Commission's Discussion Paper,[20] and recommendations have been made in this report to confine the discretionary comment and recommendation function of coroners to specific matters connected with the death under investigation.[21] In addition, it is expected that the practice of pre-inquest hearings will assist coroners and counsel alike to identify matters within the scope of the inquest and to ensure that relevant witnesses are identified.[22] The Department of Health suggested that consideration could be given to the development of guidelines to assist coroners with respect to the conduct of joint inquests.[23] The Commission highlights that it has already proposed that the State Coroner produce guidelines about the conduct of hearings and that this proposal is confirmed as a recommendation in this Report.[24]

RECOMMENDATION 67

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.

18. Department of Health, Submission No 11 (17 August 2011); David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Australian Inquest Alliance, Submission No 39 (2 September 2011).
19. Department of Health, Submission No 11 (17 August 2011).
20. See eg, LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 131–33.
21. Recommendations 49 and 84.
22. Recommendation 71.
23. Department of Health, Submission No 11 (17 August 2011).
24. Recommendation 75.

Appearance at an inquest

INTERESTED PERSONS

The Commission's Discussion Paper examined the rights of interested persons to appear at an inquest. These rights are currently provided for by ss 43 and 44 of the *Coroners Act 1996* (WA) ('the Coroners Act'). Neither section specifies a test by which a coroner may identify interested persons. This is unlike other jurisdictions whose Coroners Acts provide that a person or organisation may be an interested person 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] However, unlike other jurisdictions the *Coroners Regulations 1997* (WA) ('the Coroners Regulations') provide a list of 'prescribed' interested persons, which includes a spouse, de facto partner, child, parent or other personal representative of the deceased person; any of the deceased's next of kin under s 37(5); insurers and beneficiaries; persons who may have been involved in the death; an employee union (in the case of a workplace death); and the Commissioner of Police.[2] At the urging of Queensland State Coroner Michael Barnes, the Commission considered whether a limited right of appearance should be accorded those who do not have a direct personal interest in the death where it is in the public interest for such persons to appear.[3] This could include special interest advocacy groups, regulatory or watchdog bodies, ministerial taskforces and people such as the Public Advocate.

The Commission examined the position in other jurisdictions with respect to interested persons and the rights that may be granted to them at inquest. It proposed that a sufficient interest test be introduced in Western Australia and that rights of appearance of persons satisfying this test should include the right to examine or cross examine witnesses and make submissions.[4] The Commission further proposed that limited rights of appearance (eg, 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) should be granted to persons who have sufficient interest in an inquest solely because it is in the public interest.[5] This proposal was supported by all submissions that commented on it.[6] While offering its support for the proposal, the Australian Inquest Alliance preferred that members of the deceased's family (including spouse or de facto) in the list of interested persons currently found in the Coroners Regulations be expressly included in the Coroners Act, rather than in subordinate legislation which may be more-easily changed.[7] The Commission has considered this comment but has determined that it is unnecessary to include specific reference to these persons in the Coroners Act as they will always satisfy the sufficient interest test recommended by the Commission.

RECOMMENDATION 68

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 and 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

1. See LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 139–40.
2. *Coroners Regulations 1997* (WA) reg 17.
3. Barnes M, *Review of the Coroners Act 1996 (WA)* (August 2008) 29.
4. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) Proposal 65.
5. Ibid.
6. Department of Health, Submission No 11 (17 August 2011); David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Australian Inquest Alliance, Submission No 39 (2 September 2011).
7. Australian Inquest Alliance, Submission No 39 (2 September 2011).

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. In its Discussion Paper the Commission examined a number of ways to assist interested persons to prepare for inquest, and to assist the efficiency and effectiveness of the inquest process. The proposals and responses to proposals in these areas are discussed below.

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 interested persons appearing at an inquest. During consultations counsel expressed concerns about the consistency, completeness and timeliness of provision of inquest briefs and the general availability of documentary evidence. The Commission took the view that the preparation and provision of an inquest brief must be provided for in the Coroners Act and proposed reform modelled on a recently enacted legislative provision from Victoria.[8] The Commission received a large number of submissions on this proposal with all expressing support.[9] However, both the State Coroner and Perth-based coroner Dominic Mulligan commented on the 'huge' amount of resources and time it takes to prepare an inquest brief.[10] It appears that the current practice is for the administrative staff to compile the brief and make a master copy for the court (with some documents requiring colour reproduction and resizing). Then the document is reproduced a number of times by photocopying and each copy has to be arranged in order and checked. The Commission understands that senior administrative staff are involved in this task for many days, which does indeed represent an unnecessary waste of time and resources (both human and financial). In addition, the Commission heard that, when documents are provided to the court at a late stage, it is difficult to incorporate them into a hardcopy (and often bound) brief and to ensure that all parties receive them. This may well be why counsel reported that people in an inquest often had different versions of the same documents and some were not in possession of all relevant evidence.

In this regard, the Commission received a very helpful submission from counsel assisting the coroner Jeremy Johnston, who suggested that the provision of inquest briefs in electronic form would overcome many of the difficulties experienced both by the Coroners Court and counsel.[11] Mr Johnston noted that many of the documents included in an inquest brief are provided to the court in electronic form and those which are not could be scanned at the time the matter is deemed suitable for inquest and sent to counsel assisting.[12] He stated that counsel assisting could then review the documents, and arrange the brief and index in electronic form. The brief (consisting of individual document files and an index) could then be sent on disk to interested parties. It was noted that 'as new documents come in prior to the inquest, it would simply be a matter of sending them out by email and amending the index from time to time'.[13]

The Commission sees significant benefits to such an approach. First, it would free up the administrative staff who are burdened with photocopying and checking hardcopy briefs, sometimes for days at a time. Secondly, it is extremely cost-effective by

8. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) Proposal 66, based on *Coroners Act 2008* (Vic) s 115.
9. Dominic Bourke, Consultant, Clayton Utz, Submission No 10 (16 August 2011); Department of Health, Submission No 11 (17 August 2011); Dominic Mulligan, Coroner, Office of the State Coroner WA, Submission No 14 (20 August 2011); David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Jeremy Johnston, Counsel Assisting the State Coroner, Office of the State Coroner WA, Submission No 17 (23 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011); MDA National, Submission No 30 (24 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Western Australia Police, Submission No 35 (1 September 2011); Department of Corrective Services, Submission No 38 (1 September 2011); Australian Inquest Alliance, Submission No 39 (2 September 2011).
10. Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Dominic Mulligan, Coroner, Office of the State Coroner WA, Submission No 14 (20 August 2011).
11. Jeremy Johnston, Counsel Assisting the State Coroner, Office of the State Coroner WA, Submission No 17 (23 August 2011).
12. Ibid.
13. Ibid.

reducing the costs of the court in staff time, printing, copying and postage. Thirdly, the documents may be more easily managed both prior to and at the inquest, and may be electronically transmitted to another location where witnesses are appearing by videolink. Fourthly, with character recognition software, electronic documents are searchable, resulting in a time saving both for the court and for counsel. And finally, it is likely to ensure greater consistency of inquest briefs among all counsel and assist the court to distribute the inquest brief at an earlier stage (even if it requires amendment or addition at a later time). Of course, there will remain the need for hard copies of the brief to be made available by the court for the family of the deceased and for use by witnesses at the inquest, but this does not diminish the benefits described above. The Commission has therefore recommended that, in addition to its recommendation about the content, provision and use of inquest briefs, the Coroners Court should institute a strategic trial of the provision of inquest briefs in electronic form at the earliest opportunity.

RECOMMENDATION 69

Inquest brief to be provided by Coroners Court

That the Coroners Act provide that:

1. 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. An inquest brief does not include any part of a medical file that the coroner considers to be irrelevant to the inquest.
3. 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.

RECOMMENDATION 70

Inquest brief in electronic form

That, at the earliest opportunity, the Coroners Court institute a strategic trial for the provision of inquest briefs to interested persons in electronic form.

Pre-inquest hearings

During consultations the Commission raised the potential of pre-inquest hearings, which are used widely in other jurisdictions, 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.[14] There was a 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 was clear to the Commission that provision for such hearings is both warranted and overdue. The Commission therefore proposed that a provision modelled on s 34 of the *Coroners Act 2003* (Qld) be inserted into the Coroners Act to provide for pre-inquest hearings and for notification and publication of a notice of such hearings.

As expected, the Commission received strong support for its proposal from submissions[15] and it confirms the legislative provision for pre-inquest hearings in the following recommendation. However, the State Coroner submitted that a legislated 28-day timeframe for publication of a notice of pre-inquest hearings was too long because several pre-inquest hearings may be held on the one matter with gaps of less than this time period.[16] In light of this legitimate point, the Commission has removed the notice provisions from Recommendation 71 and has

14. See discussion, LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 143–45.
15. Dominic Bourke, Consultant, Clayton Utz, Submission No 10 (16 August 2011); Department of Health, Submission No 11 (17 August 2011); David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011); MDA National, Submission No 30 (24 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Western Australia Police, Submission No 35 (1 September 2011); Australian Inquest Alliance, Submission No 39 (2 September 2011).
16. Alistair Hope, State Coroner, Submission No 18 (23 August 2011).

combined its recommendation for notification of interested persons and publication of notices for both pre-inquest hearings and inquest hearings in Recommendation 72.

RECOMMENDATION 71

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 the Coroners Court may order a person concerned with the investigation to attend the pre-inquest hearing.

Notification of inquest and pre-inquest hearing dates

The Commission's consultations identified instances where the Coroners Court had failed to notify interested persons appearing at inquest about important events in the inquest process. In addition, the Commission heard that some 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.[17] Among other things, it was noted that 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.[18] Being aware that many jurisdictions set dates for inquest hearings between four and six months in advance, the Commission proposed that reasonable notice (of between four and six months) be given to interested persons of dates set down for the hearing of an inquest and that as soon as dates are set for an inquest they be published on the Coroners Court website.[19] In addition, the Commission proposed 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 (to align with the Commission's proposal for notice of pre-inquest hearings).[20] Submissions were strongly supportive of the Commission's proposal.[21] The Department of Health submitted that it currently receives inadequate notice of listings. Given the discussion in Chapter Four about the role that the Department has, to date, been required to play in assisting coronial police with specialist medical investigations, the timeliness of notification is extremely important and a period of more than four months might well be required. It submitted that:

> On occasion, the notice of listing is the first advice from the Coroners Court that a particular matter is the subject of a coronial investigation. This means that with little notice, interested parties are not only preparing for inquest, but they are undertaking the entire investigation of the matter (including gathering relevant documents, identifying witnesses, taking witness statements).[22]

Queensland State Coroner, Michael Barnes, submitted that while he was supportive of the proposal, a timeframe of between four and six months was probably too long.[23] The Deputy State Coroner submitted that four to six months notice was 'not reasonable', but declined to elaborate further.[24] The State Coroner submitted that there was a need for some flexibility in the time for notice to interested persons in case there was a need for a last minute change of listing.[25] In light of all submissions, the Commission has determined that some flexibility is required and that this is an area upon which the State Coroner may produce guidelines. It has therefore amended its recommendation. As noted above, the following recommendation has been expanded

17. 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'.
18. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 142–43.
19. Ibid, Proposal 67.
20. Ibid.
21. Dominic Bourke, Consultant, Clayton Utz, Submission No 10 (16 August 2011); Department of Health, Submission No 11 (17 August 2011); David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); MDA National, Submission No 30 (24 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Western Australia Police, Submission No 35 (1 September 2011); Department of Corrective Services, Submission No 38 (1 September 2011); Australian Inquest Alliance, Submission No 39 (2 September 2011).
22. Department of Health, Submission No 11 (17 August 2011)
23. Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011).
24. Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011).
25. Alistair Hope, State Coroner, Submission No 18 (23 August 2011).

to include notification and publication of dates for pre-inquest hearings.

RECOMMENDATION 72

Notification and publication of pre-inquest and inquest hearing dates

1. That the Coroners Act provide that notice of the date, time, place and subject of a pre-inquest and inquest hearing shall be provided to interested persons and be published by the Coroners Court.
2. That the State Coroner produce guidelines about the manner and time of publication of pre-inquest and inquest hearing dates and of notification of interested persons.

Procedural fairness – identifying interested persons

Section 44(2) of the Coroners Act requires a coroner to give an interested person the opportunity to present submissions against the making of an adverse finding. To satisfy this obligation, persons against whom an adverse finding may be made must have sufficient notification of the risk of such a finding. The Commission heard that notification of such a risk was rarely (or inconsistently) given in advance of inquest and that witnesses who should be represented (and could have been identified as such prior to inquest) are not. The Commission was concerned to discover that often a party was alerted to the potential of an adverse finding against a witness through the nature of the questioning by counsel assisting and that it was left to them to suggest to the person that he or she should seek legal representation.

The Commission found that the Coroners Court was not sufficiently discharging its duty under s 44.[26] It noted that it would be a rare occasion where counsel assisting or the coroner was not in a position to identify a *risk* of an adverse finding prior to the inquest (most likely at the stage of investigation). The Commission therefore proposed 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*.[27] It was observed that, in combination with the legislative requirement to notify interested persons of an inquest (Recommendation 72) and the provision for pre-inquest hearings (Recommendation 71), the likelihood that the requirements of s 44(2) are satisfied will be significantly improved.[28]

The Commission received full support for its proposal from submissions including from both the State Coroner and Deputy State Coroner.[29] In his submission, Queensland State Coroner Michael Barnes noted the usefulness of pre-inquest hearings in his jurisdiction for identifying parties and the potential for adverse comment.[30] The Commission therefore confirms its proposal as a recommendation and trusts that the Coroners Court will put immediate administrative measures in place to ensure that its duty under s 44 is satisfied.

RECOMMENDATION 73

Procedural fairness – identifying interested persons

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

Section 44 of the Coroners Act provides for interested persons to be represented by a legal practitioner at an inquest. In its Discussion Paper, the Commission noted that the most represented persons at inquests appeared to be nurses, doctors, hospitals and police officers called as

26. See LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 145–46.

27. Ibid, Proposal 69.
28. Ibid 146.
29. Dominic Bourke, Consultant, Clayton Utz, Submission No 10 (16 August 2011); Department of Health, Submission No 11 (17 August 2011); David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Western Australia Police, Submission No 35 (1 September 2011); Australian Inquest Alliance, Submission No 39 (2 September 2011).
30. Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Western Australia Police, Submission No 35 (1 September 2011).

witnesses.[31] A relatively low incidence of lawyers appearing for the family of a deceased at inquest was found in Western Australia.[32]

Respondents to the Commission's public survey commented on the need for legal aid funding for families at inquests, particularly in light of the adversarial approach to proceedings frequently adopted by counsel (discussed below). The Commission noted that 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 hospitals and government agencies) did have legal representation.[33] The Commission considered a 2008 study, which examined the legal aid funding criteria for coronial inquests in all Australian jurisdictions.[34] It was noted that Western Australia had extremely restrictive funding criteria as compared with other Australian jurisdictions.[35] In order to bring Western Australia into line with other Australian jurisdictions the Commission proposed that the Western Australian government should fund relevant legal aid organisations to provide legal representation and assistance to families for the purposes of an inquest where such representation is in the public interest.[36]

Again, the Commission received full support from submissions commenting on this proposal.[37] While agreeing 'absolutely' with this proposal, the Deputy State Coroner commented that many families found counsel assisting the coroner to be 'very helpful'.[38] The Commission agrees and refers to its statement to that effect in its Discussion Paper;[39] however, it highlights the submission of the Public Interest Advocacy Centre which stated that:

> If families cannot find accessible legal representation at inquests, there is a power imbalance that cannot be easily remedied, even with the best efforts of a diligent counsel assisting the Coroner … if they come from a disadvantaged group or English is not their first language, the power imbalance is amplified.[40]

In light of complete support from submissions for this proposal the Commission makes the following recommendation.

RECOMMENDATION 74

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

The Commission's Discussion Paper highlighted that the nature of inquest proceedings was intended to be inquisitorial rather than adversarial like other courts in Western Australia.[41] It discussed consultations and responses to its public survey that suggested that the behaviour of lawyers, counsel assisting and coroners at inquests was often quite adversarial. Comments of witnesses in the Commission's survey showed that this adversarial approach forced them to 'clam up' rather than to reveal all that they might know about the circumstances of the death under investigation.[42] It was observed that coroners, having ultimate control of the proceedings, are in a position to curb the adversarial inclinations of all counsel at an inquest and that they should exercise the power to do so when necessary. To assist coroners in this regard the Commission proposed that the State Coroner issue guidelines relating to the conduct of inquests and pre-inquest hearings making clear that the purpose of an inquest is to investigate the circumstances and cause of death, and that an inquest is not the forum in which the allocation of blame is considered or determined.[43] For the sake of clarity, the Commission suggested

31. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 146–47 & Appendix B, table 10.
32. Ibid.
33. Ibid 146.
34. Ibid.
35. Ibid 147.
36. Ibid, Proposal 70.
37. David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Jennifer Searcy, Adjunct Professor, Murdoch University, Submission No 19 (23 August 2011); Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011); Public Interest Advocacy Centre, Submission No 26 (24 August 2011); MDA National, Submission No 30 (24 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Australian Inquest Alliance, Submission No 39 (2 September 2011).
38. Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011).
39. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 146.
40. Public Interest Advocacy Centre, Submission No 26 (24 August 2011).
41. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 34–35.
42. See ibid 147.
43. Ibid, Proposal 71.

that s 58 of the Coroners Act, which governs the State Coroner's power to make guidelines be amended to include specific reference to the power to create guidelines about the conduct of hearings.[44]

This proposal received the full support of submissions.[45] In its submission, the Australian Inquest Alliance considered that coroners did have a role in identifying persons who might have contributed to the death and suggested that the wording of the Commission's recommendation be changed from 'not the forum in which the allocation of blame is considered or determined' to 'not the forum in which criminal guilt or civil liability is considered or determined'.[46] The Commission agrees and makes the following recommendation.

RECOMMENDATION 75

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 it is not the forum in which criminal guilt or civil liability 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.

The Discussion Paper also observed that there was no specific training for lawyers in the coronial jurisdiction either at law school or in professional development courses.[47] The Commission proposed 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 its compulsory Continuing Professional Development program) to lawyers about the inquisitorial functions, procedures and culture of the Coroners Court.[48] Again this proposal received strong and complete support from submissions[49] and the Commission confirms it as a recommendation.

RECOMMENDATION 76

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 its compulsory Continuing Professional Development program) to lawyers about the inquisitorial functions, procedures and culture of the Coroners Court.

44. Ibid.
45. Dominic Bourke, Consultant, Clayton Utz, Submission No 10 (16 August 2011); Department of Health, Submission No 11 (17 August 2011); David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Australian Inquest Alliance, Submission No 39 (2 September 2011).
46. Australian Inquest Alliance, Submission No 39 (2 September 2011)
47. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 148–49.
48. Ibid, Proposal 72.
49. David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Australian Inquest Alliance, Submission No 39 (2 September 2011); Department of the Attorney General, Submission No 40 (31 August 2011).

Inquest practice and procedure

EXPERT ADVICE TO CORONERS AT INQUEST

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. Some respondents suggested that, because there 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. 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. It was noted that New Zealand had provision within its *Coroners Act 2006* to appoint specialist advisers 'to sit with and help coroners', but that these advisers had no decision-making role and that their advice may be given any weight the coroner thought fit.[1]

The Commission supported the idea of specialist advisers; however, it believed that 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 invited submissions on whether there should be facility for a person with appropriate expertise to sit with the coroner at inquest to assist him or her in understanding and testing complex, technical evidence and, if so, what power and responsibility should attach to the role.[2] Submissions on this matter showed little support for the use of specialist advisers at inquest.[3] Some submitted that resourcing and availability of experts would be an issue, while others had legitimate concerns about the potential of advisers without a decision-making role to provide opinion that was not given or tested in open court. The Commission is persuaded by submissions that no recommendation should be made.

Concurrent expert evidence

In its Discussion Paper the Commission offered an alternative means of discursive testing of expert evidence using the facility of concurrent evidence. It was noted that concurrent evidence is widely used in Australian tribunals (including the State Administrative Tribunal in Western Australia) and was well suited to use in an inquisitorial jurisdiction.[4] The Commission therefore proposed that coroners consider the use of concurrent expert evidence during inquests where appropriate and practicable.[5] It further proposed 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.[6] The Commission received good support for its recommendation.[7] The State Coroner noted an inquest he conducted into a mining death where

> a number of experts were involved and were present in court while each other gave evidence. Each of the experts, having heard the other evidence, recognised that his own opinion required some correction and together the experts came to a common view which resulted in an important safety discovery.
>
> The fact that the witnesses were in court able to observe the other witnesses give evidence was of assistance and it is possible that it would have been helpful if the evidence could have been given concurrently.[8]

1. *Coroners Act 2006* (NZ) s 83. See discussion, LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 150–52.
2. Ibid, Question E.
3. Only one of seven submissions on this subject supported the idea of specialist advisers, but noted that any advice given by a specialist should be available to interested persons.
4. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 152–53.
5. Ibid, Proposal 73.
6. Ibid.
7. Dr Tom Hitchcock, Clinical Director of the Directorate of Critical Care, Fremantle Hospital, Submission No 3 (20 July 2011); Dominic Bourke, Consultant, Clayton Utz, Submission No 10 (16 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Australian Inquest Alliance, Submission No 39 (2 September 2011).
8. Alistair Hope, State Coroner, Submission No 18 (23 August 2011).

The Commission confirms its proposal for the use of concurrent evidence in the coronial jurisdiction with the following recommendation.

RECOMMENDATION 77

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.

USE OF AFFIDAVITS

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. The Western Australia Police urged the Commission to make a recommendation to clarify the format and use of affidavits at inquest. The Commission saw certain benefits in this approach with regard to the greater use of affidavits where witnesses could not, for whatever reason, appear at an inquest to give sworn evidence and made an appropriate proposal.[9] The proposal was widely supported by submissions.[10] Only the State Coroner and Deputy State Coroner did not support the proposal noting that current practice was adequate and that if evidence is sufficiently covered in an unsworn statement or report then witnesses are usually not required to attend to give evidence.[11] This view appeared to be at odds with the submission of the Western Australia Police.[12] While the Commission accepts that affidavits may be used rarely in the coronial jurisdiction, it is pertinent that they are provided for under the Coroners Act and, given the potential for their use in certain situations, it is appropriate that their use in inquests and the form they should take is clarified in the Coroners Act and Regulations. The Commission therefore makes the following recommendation.

RECOMMENDATION 78

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 with penalties ranging up to $6,500 with an alternative term of six months' imprisonment. The Commission proposed that the penalty for breach of the offence of interrupting an inquest include a term of not more than six months' imprisonment or a fine of $5,000.[13] The Commission's proposal received full support from submissions;[14] however, it was noted that s 86 of the *Sentencing Act 1995* (WA) precludes the imposition of a term of six months or less. The Commission has therefore adjusted the penalty in the following recommendation to a term of imprisonment of 12 months. To reflect the relationship between fines and terms of imprisonment under s 41 of the

9. See discussion, LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 154–55 & Proposal 75.
10. Dominic Bourke, Consultant, Clayton Utz, Submission No 10 (16 August 2011); Department of Health, Submission No 11 (17 August 2011); David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); MDA National, Submission No 30 (24 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Western Australia Police, Submission No 35 (1 September 2011); Australian Inquest Alliance, Submission No 39 (2 September 2011).
11. Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011).
12. Western Australia Police, Submission No 35 (1 September 2011).
13. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) Proposal 76.
14. David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Australian Inquest Alliance, Submission No 39 (2 September 2011).

Sentencing Act and some of the more common penalty provisions under the *Criminal Code*,[15] the Commission has further determined to amend its recommendation to increase the penalty to a fine of $12,000. As noted earlier, other penalty provisions recommended throughout this Report are similarly amended.

RECOMMENDATION 79

Interruption of an inquest

That the penalty for breach of the offence of interrupting an inquest include a term of not more than 12 months' imprisonment or a maximum fine of $12,000.

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. The Commission proposed that this power be extended to pre-inquest hearings.[16] Submissions were in support[17] of such extension and the following recommendation is therefore made.

RECOMMENDATION 80

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

Section 49 of the Coroners Act gives coroners the power to restrict publication of some or all of the evidence given at inquest if the coroner reasonably believes that it might prejudice the fair trial of a person or be contrary to the public interest. The penalty for breach of this section is $5,000. The Commission considered comparable provisions and penalties existing in other jurisdictions, and found that the Northern Territory and Tasmanian provisions were superior to that in Western Australia because they permitted 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. In addition, it was noted that they allowed coroners to respond to concerns of senior next of kin in the naming of an Aboriginal deceased, where such naming was taboo.[18] The Commission proposed that the relevant section be extended to enable a coroner to 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.[19] The Commission further proposed that the penalty be increased to $10,000 and that a corporate penalty of five times that rate be introduced in Western Australia.[20]

The Commission received the full support of submissions commenting on this proposal.[21] In his submission, the State Coroner argued that the Commission's proposal should be extended to 'include a prohibition on all unauthorised publication of information obtained in non-inquested cases'.[22] The Commission has considered the State Coroner's full submission in this respect but is not persuaded. It therefore confirms its original proposal in the following recommendation with a minor amendment to the penalty provision to bring it into line with other penalties recommended in this Report.

15. That is, one month's imprisonment equates to a fine of $1,000.
16. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) Proposal 77.
17. David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Australian Inquest Alliance, Submission No 39 (2 September 2011).
18. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 156–57. It was also noted that this was a specific matter raised by Commissioner Johnstone in the Royal Commission into Aboriginal Deaths in Custody: RCIADIC, *National Report* (1991) vol 1, 149.
19. Ibid, Proposal 78.
20. Ibid.
21. Department of Health, Submission No 11 (17 August 2011); David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Australian Inquest Alliance, Submission No 39 (2 September 2011).
22. Alistair Hope, State Coroner, Submission No 18 (23 August 2011).

RECOMMENDATION 81

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 $12,000 for individuals and $60,000 for corporations.

PUBLICATION OF INQUEST FINDINGS, COMMENTS AND RECOMMENDATIONS

The Commission examined all Coroners Court websites in Australia and found that, with the exception of Western Australia, all provided electronic links to coronial inquest findings and associated recommendations. It noted that while Western Australia has a dedicated webpage for inquest findings, this page has not featured inquest findings for many years.[23] Following consideration of issues raised during consultations the Commission proposed 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.[24]

The Commission's proposal received complete support from submissions,[25] with some submissions expressing strong support. The Queensland State Coroner Michael Barnes submitted that the Commission's recommendation should go further so that all findings (including administrative findings) are published in 'circumstances where it would be in the public interest for the information gathered during the investigation and the coroners conclusion in relation to it to be more widely disseminated that simply to the next of kin or those directly involved in the investigation'.[26] The Commission is attracted to this proposition but feels this should be a matter for the State Coroner and has, therefore, retained its recommendation as applying to findings, comments and recommendations following an inquest.

RECOMMENDATION 82

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.

23. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 158.
24. Ibid, Proposal 82.
25. Department of Health, Submission No 11 (17 August 2011); David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Department of Corrective Services, Submission No 38 (1 September 2011); Australian Inquest Alliance, Submission No 39 (2 September 2011).
26. Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011).

Chapter Six

Coroner's Prevention Role

Contents

Coroner's prevention role

Coroners in Western Australia often use the recommendation function under s 27 of the *Coroners Act 1996* (WA) ('the Coroners Act') to make recommendations aimed at preventing future deaths in similar circumstances.[1] This 'prevention role' is one that 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.[2] The Commission has embraced the prevention role of the coroner in many of the recommendations featured throughout this Report.[3] 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, comments and recommendations made by coroners and by the timely provision by coroners of relevant data to appropriate authorities and research bodies.[4]

This chapter examines ways in which this object may practically be achieved.

USING CORONIAL DATA TO SUPPORT THE PREVENTION ROLE

As noted in the Discussion Paper, there was a wide belief among those consulted that for the coroner to fulfil the prevention role effectively, it was necessary for the Office of the State Coroner to 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.[5] The Discussion Paper therefore looked at how coronial data is currently collected, analysed, disseminated and used.[6] The Commission noted that Western Australia was fortunate to have a Coronial Ethics Committee constituted by medical, research and lay members (as well as by the Deputy State Coroner) who review and approve applications by research bodies and others for access to coronial records.[7]

It is the Commission's view that if the coroner is to effectively discharge a death prevention role then 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. The Discussion Paper noted that although in the past a small number of death prevention groups had been given supervised local access to limited coronial data to focus their research and awareness raising activities, there was very little direct information sharing at the time of writing. It was also noted that resource limitations had played a role in restricting the activities of the Office of the State Coroner in this regard.

With the strong support and encouragement of people consulted on this issue, the Commission proposed extending the current role 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.[8] It was suggested that 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 deaths.[9] It would also inform education and liaison activities

1. See 'Coronial Recommendations', below.
2. 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.
3. See, eg, Recommendations 1, 13, 42, 44, 49, 76 & 82 above and Recommendations 83–87 below.
4. See Chapter One, 'Objects of the Coroners Act', Proposal 1.
5. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 161.
6. Ibid 161–64.
7. Ibid 162.
8. Ibid, Proposal 80.
9. 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 inquested, thereby avoiding possible inconsistent recommendations among coroners on the same subject matter and providing greater impetus for implementation of any resulting coronial recommendations.

undertaken by coronial counsellors and the proposed specialist healthcare death investigation team, as well as monitoring and evaluating responses to coronial recommendations.[10] Though small, 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.

The Commission's proposal received full support from submissions.[11] The Australian Inquest Alliance strongly supported a 'definitive prevention role' for the coroner and stated that 'the development of a "prevention team" within the court would constitute an important contribution to death prevention in Western Australia'.[12] In its submission, the Department of the Attorney General mentioned that the role of monitoring and evaluating coronial recommendations could be undertaken by 'one of the existing statutory review agencies or a parliamentary committee' to reduce the possible resource implications of the Commission's proposal.[13] The Commission agrees that that discrete function could be given to another body if government desired. In the Commission's opinion the data analysis, information sharing and coronial support roles are the key roles for the proposed prevention team and this could be achieved by a very modest augmentation of the existing systems information team in the Office of the State Coroner.[14]

RECOMMENDATION 83

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.

10. See further, 'Coronial Recommendations' below.
11. Department of Health, Submission No 11 (17 August 2011); David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Western Australia Police, Submission No 35 (1 September 2011); Australian Inquest Alliance, Submission No 39 (2 September 2011); Department of the Attorney General, Submission No 40 (31 August 2011).
12. Australian Inquest Alliance, Submission No 39 (2 September 2011).
13. Department of the Attorney General, Submission No 40 (31 August 2011).
14. For example, by employment of a researcher/analyst and a junior administrative officer.

Coronial 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 remain distinct from coroner's findings and, like comments, are not subject to judicial review.

CORONER'S POWER TO MAKE RECOMMENDATIONS

Although in practice recommendations are made by all coroners (where appropriate), the Commission's Discussion Paper pointed out that the *Coroners Act 1996* (WA) ('the Coroners Act) does not explicitly permit a coroner other than the State Coroner to make a recommendation.[2] In addition, it was noted that under s 27(3) all recommendations made by the State Coroner must be addressed to the Attorney General and are made in the context of the State Coroner's Annual Report to the Attorney General. To reflect the current practice and to bring Western Australia into line with other Australian jurisdictions, the Commission proposed that all coroners be legislatively permitted to make recommendations in the context of an inquest directly to the Minister, public statutory authority, public or private entity or individual[3] the subject of the recommendation.[4] As discussed in Chapter Five in the context of coronial comments,[5] 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 and this formulation was reflected in the Commission's proposal.

1. See LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) Appendix B, table 13.
2. *Coroners Act 1996* (WA) s 27.
3. 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.
4. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) Proposal 81.
5. See Chapter Five, 'Comments'.

The current formulation of s 27(3) permits the State Coroner to make recommendations arising out of non-inquested deaths. It was noted that this power was unusual in Australia[6] and that its use in Western Australia was extremely rare.[7] The Commission expressed the opinion that it was not appropriate that coroners be permitted to make recommendations outside the context of an inquest because an inquest provides the environment for the proper testing of evidence and enables those entities that are likely to be the subject of recommendations the opportunity to provide input that may inform the recommendations.[8] The Commission therefore proposed that the making of recommendations by coroners be limited to the context of an inquest.[9] This proposal (which would replace the current recommendations power in s 27) received the full support of submissions and is confirmed as a recommendation.[10]

RECOMMENDATION 84

Coroner's 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 person.

6. Only two other jurisdictions (Tasmania and Victoria) permit a coroner to make recommendations in respect of cases that have not been the subject of an inquest.
7. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 166.
8. Ibid.
9. Ibid, Proposal 81.
10. Department of Health, Submission No 11 (17 August 2011); David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Australian Inquest Alliance, Submission No 39 (2 September 2011); Department of the Attorney General, Submission No 40 (31 August 2011).

Guidance to coroners considering whether to make comments or recommendations

The above recommendation provides guidance to coroners by specifying the matters upon which a coroner may make recommendations. Such matters must pass the threshold test of being sufficiently connected with the death 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. A number of other recommendations in this Report will assist coroners exercising their power to make recommendations by ensuring those recommendations are well informed and appropriate.[11] The following recommendation gives further guidance to coroners in determining whether the power to make recommendations and comments should be exercised.[12] The Commission's proposal in this respect earned complete support from submissions.[13]

RECOMMENDATION 85

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; and

(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.

11. Recommendations 42, 44 & 83.
12. The Commission's original proposal (Proposal 82) included a paragraph relating to the advice of any specialist advisers appointed to assist the coroner. Whether such advisers should be recommended was the subject of Question E in the Commission's Discussion Paper. In view of the insufficient support for the concept of specialist advisers the Commission has deleted the relevant paragraph in Recommendation 85.
13. Department of Health, Submission No 11 (17 August 2011); David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Australian Inquest Alliance, Submission No 39 (2 September 2011).

RESPONSE TO CORONIAL RECOMMENDATIONS

The Commission's Discussion Paper reviewed the response to coronial recommendations in Western Australia over a 12-month period. It discussed the responses from different government agencies and found generally high levels of responsiveness, but varying levels of support for and implementation of coronial recommendations.[14] The Commission found that recommendations directed to private entities or vaguely directed to 'the government' received poor or no responses. Recommendations that were broad in nature or not targeted to specific actions tended to receive platitudinous responses with little likelihood of implementation. 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.[15] This highlighted the need for the assistance of a prevention team and consultation with relevant parties to inform the formulation of coronial recommendations.

The Discussion Paper set out a number of factors that affected the implementation of coronial recommendations in a national study undertaken in 2005–2006.[16] The Commission observed that the same factors appeared to have impacted on the implementation of the recommendations reviewed in its own study of Western Australian coronial recommendations. The following recommendations seek to enhance consideration of implementation of coronial 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'.[17] The Commission observed that there was no legislative imperative for the Coroners Court to inform an agency of a coronial recommendation, except in the case of recommendations in the context of the death of a person held in care (eg,

14. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 168–69.
15. For examples, see ibid, 168, n 25.
16. Ibid 168–9, citing Watterson R, Brown P & McKenzie J, 'Coronial Recommendations and the Prevention of Indigenous Death' (2008) 12(2) *Australian Indigenous Law Review* 4, 5.
17. Ibid.

the death of a prisoner or an involuntary mental health patient).[18] Although, 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, the Commission felt that the jurisdiction would benefit from legislative entrenchment of notification. This was considered to be particularly crucial in light of the Commission's proposal (discussed below) that public entities be required to provide written responses to coronial recommendations within a specified time period. The Commission also noted that a legislative requirement to notify those who are the subject of a coronial recommendation would, 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.[19] The Commission therefore proposed that the requirement of the Coroners Court to provide a written copy of any recommendations be stipulated in the Coroners Act.[20] This proposal received full support from submissions[21] and the Commission makes the following recommendation.

RECOMMENDATION 86

Notification of coroner's 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 Recommendation 87.

Mandatory response to recommendations

The Commission's Discussion Paper noted that the issue of responsiveness to coronial recommendations generally has been the subject of consideration by the Standing Committee of Attorneys General since 2009, which indicates a certain level of concern among Australian governments about the rate of response and implementation of such recommendations. In Western Australia, it was noted, this concern reached its height following the Ward Inquest into the death of an Aboriginal Elder in a privately operated prisoner transport vehicle. The Discussion Paper highlighted that in all Australian jurisdictions, other than Western Australia and Tasmania, the requirement of certain parties to respond to coronial recommendations or reports is encapsulated in legislation or whole-of-government policy.[22] The Commission was attracted to the legislative formulation of the Victorian model which requires the coroner to publish findings, recommendations and the responses to recommendations on the internet.[23] It was noted that this model received strong support from those consulted by the Commission. After discussing the merits of a mandatory response system the Commission proposed that public entities the subject of a coronial recommendation must provide a written response to the State Coroner within three months of receiving the recommendation specifying a statement of action

18. *Coroners Act 1996* (WA) s 27(4).
19. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 170.
20. Ibid, Proposal 83.
21. Department of Health, Submission No 11 (17 August 2011); Commissioner for Children and Young People, Submission No 15 (22 August 2011); David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011); Public Interest Advocacy Centre, Submission No 26 (24 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Department of Corrective Services, Submission No 38 (1 September 2011); Australian Inquest Alliance, Submission No 39 (2 September 2011).
22. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 170.
23. *Coroners Act 2008* (Vic) s 73.

(if any) that has, is or will be taken in relation to the recommendations made by the coroner.[24]

The Commission received overwhelming support for its proposal.[25] While the Department of Corrective Services supported the proposal and its three-month timeframe for responses, it noted that there are cases where there may be delays in responding due to exceptional circumstances and that there should be provision to advise the State Coroner in such instances.[26] The Commission agrees and has therefore amended paragraph 2 of its recommendation. The Department also suggested that in some cases responses to the coroner contain confidential information that should not be published as proposed.[27] The Commission notes that this has not been an issue in Victoria where responses are published on the internet as a matter of course. It is up to the agency to provide a response suitable for publication; however, the Commission does concede that there will be some instances where the coroner may agree that certain information contained in the response not be published. The Commission has therefore added to paragraph 3 of its recommendation that an agency's response must be published as soon as reasonably practicable after receipt, unless otherwise ordered by the State Coroner.

In making the following recommendation the Commission notes that the Western Australian Parliament's Standing Committee on Environment and Public Affairs, which was tasked to inquire into the death of Mr Ward, has since reported. Taking into account the Commission's proposal and submissions to the inquiry the Parliamentary Committee recommended that:

> [T]he *Coroners Act 1996* be amended to require the Government to respond to coronial recommendations within three months. The Committee recommends that the amending legislation provides that the Government response shall be tabled in both Houses of Parliament.[28]

The Parliamentary Committee also recommended that 'government departments and agencies establish processes to appropriately inform family, stakeholders and the public of the progress of Government action taken to implement coronial recommendations on a regular basis'.[29] The Commission sees these recommendations as a sign of wider government support for the concept of a mandatory response system with a three-month response timeframe.

Should mandatory responses extend beyond public entities?

The Commission's Discussion Paper invited submissions on whether private entities and individuals should be subject to the same mandatory reporting requirements in response to coronial recommendations as public entities.[30] It noted that many groups had argued for mandatory responses to apply across the board in light of the circumstances of the death of Mr Ward in the back of a privately operated prisoner transport vehicle.[31] The Commission noted that private entities could include 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).[32]

The Commission received eight submissions on this question with the concept of extending the mandatory response regime to private entities[33] receiving substantial support.[34] In support of the idea, Dr Tom Hitchcock and the Department of Health argued that a significant amount of healthcare is private and should be under the same law as public healthcare particularly as 'boundaries between private and public are

24. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011), Proposal 83.
25. Dr Tom Hitchcock, Clinical Director of the Directorate of Critical Care, Fremantle Hospital, Submission No 3 (20 July 2011); Department of Health, Submission No 11 (17 August 2011); Commissioner for Children and Young People, Submission No 15 (22 August 2011); David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Public Interest Advocacy Centre, Submission No 26 (24 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Western Australia Police, Submission No 35 (1 September 2011); Department of Corrective Services, Submission No 38 (1 September 2011); Australian Inquest Alliance, Submission No 39 (2 September 2011). The Deputy State Coroner was the only respondent who did not support this proposal. However, because she did not specify why (except to say that she was 'not as concerned as other parties'), the Commission has not discussed this submission: Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011).
26. Department of Corrective Services, Submission No 38 (1 September 2011).
27. Ibid.
28. Western Australia Legislative Council, Standing Committee on Environment and Public Affairs, *Inquiry into the Transportation of Detained Persons* (2011), recommendation 16.
29. Ibid, recommendation 9.
30. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) Question F.
31. Ibid 173.
32. Ibid.
33. Only one submission (which was not in support of the idea) properly addressed the potential of application to individuals: Dominic Burke, Consultant, Clayton Utz, Submission No 10 (16 August 2011).
34. Dr Tom Hitchcock, Clinical Director of the Directorate of Critical Care, Fremantle Hospital, Submission No 3 (20 July 2011); Department of Health, Submission No 11 (17 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Western Australia Police, Submission No 35 (1 September 2011); Department of Corrective Services, Submission No 38 (1 September 2011); Australian Inquest Alliance, Submission No 39 (2 September 2011).

continuously changeable and evolving'.[35] Dominic Burke did not support the idea of a mandatory response scheme applying to private entities.[36] His submission reiterated a concern previously expressed (and discussed in the Commission's Paper) that private entities or individuals will 'almost always be restricted by issues of insurance or disciplinary considerations'.[37] It was argued that it was inappropriate to require responses from individuals as they 'run the risk of being forced to admit liability'.[38] The State Coroner of Queensland, Michael Barnes, supported the idea but was of the view that any proposal to this effect should be 'floated for further public consultation'.[39] In the circumstances, the Commission does not feel it has received enough submissions to support an extension of its recommendation to private entities. However, it suggests that the state government give consideration to whether private entities performing public functions be subject to the same mandatory response requirement as public statutory authorities and public entities and has added this to paragraph 4 of its recommendation.

Should there be an offence for failing to respond?

The Commission also invited submissions on whether there should be an offence for failure to respond to coronial recommendations within the required time and, if so, what the penalty should be.[40] In its Discussion Paper the Commission noted that no jurisdiction had such an offence and that most relied upon a 'name and shame' approach to encourage entities the subject of recommendations to provide a timely response.[41] Almost all submissions on this question preferred the name and shame approach as being more effective than penalty in these circumstances.[42] Only one submission supported an offence and penalty[43] with one other supporting it only if private entities came within the response regime.[44] In light of submissions the Commission has not made any recommendation as to offence or penalty and suggests that, if Recommendation 87 is implemented, Western Australia follow the Victorian model of 'name and shame' set out in its Discussion Paper.[45]

RECOMMENDATION 87

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, or such other time as agreed between the public statutory authority or public entity and the State Coroner, 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, unless otherwise ordered by the State Coroner, 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.
4. That the state government give consideration to whether private entities performing public functions be subject to the same mandatory response requirement as public statutory authorities and public entities.

35. Dr Tom Hitchcock, Clinical Director of the Directorate of Critical Care, Fremantle Hospital, Submission No 3 (20 July 2011). The Department of Health echoed these sentiments: see Department of Health, Submission No 11 (17 August 2011).
36. Dominic Burke, Consultant, Clayton Utz, Submission No 10 (16 August 2011).
37. Ibid.
38. Ibid.
39. Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011).
40. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) Question G.
41. Ibid 173–4.
42. Dominic Burke, Consultant, Clayton Utz, Submission No 10 (16 August 2011); Department of Health, Submission No 11 (17 August 2011); David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Department of Corrective Services, Submission No 38 (1 September 2011); Australian Inquest Alliance, Submission No 39 (2 September 2011).
43. Western Australia Police, Submission No 35 (1 September 2011).
44. Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011).
45. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 173–74.

Chapter Seven

Role and Support of the Family in the Coronial Process

Contents

Introduction

This chapter examines the role of the family in the coronial process, their rights under the *Coroners Act 1996* (WA) and the systems that are in place to support families as they navigate the coronial process. The Commission has encouraged public participation for this reference by publishing a Background Paper explaining the coronial jurisdiction; creating an online survey; and placing advertisements in *The West Australian* and in the newsletters of a number of organisations that assist people during their time of bereavement. As shown in its Discussion Paper, the Commission received a high public response to its survey and these responses have helped to inform the Commission's proposals.

This chapter discusses the responses to those proposals and makes final recommendations for reform. It 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, and discusses 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, finally, it looks at the issue of release of bodies under control of the coroner.

Catering for a culturally and linguistically diverse community

The Commission's Discussion Paper noted that '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'.[1] It drew attention to the need for culturally appropriate delivery of coronial information to Indigenous people, and similar needs in relation to other culturally and linguistically diverse (CaLD) groups within the Western Australian community. It explained the consultation processes that the Commission undertook to garner the views of different ethnic groups and of Indigenous peoples[2] in Western Australia about any cultural matters that should be taken into account by the Commission when drafting its proposals for reform of the coronial system.

CULTURAL COMPETENCY TRAINING

As noted in its Discussion Paper, the Commission received a very helpful submission from the Office of Multicultural Interests (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. 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). The OMI drew the Commission's attention to the need for 'cultural competency' training to ensure that police 'know how and when to obtain an interpreter and/or translator'[3] when delivering coronial information to grieving families and that such training should also be provided for all staff of the Office of the State Coroner who are required to deal with relatives of a deceased.[4] The Commission proposed that the Office of the State Coroner and the Coronial Investigation Unit of the Western Australia Police consult with the OMI about the provision of cultural competency training for relevant staff.[5] This proposal attracted a very positive response from submissions with all submissions expressing support.[6] The Commission notes that the OMI has now released its online cultural competency training package for Western Australian public sector employees and suggests that this could be a useful starting place for staff of the Office of the State Coroner and Western Australia Police.[7] However, the Commission confirms its recommendation that each agency should consult with the OMI to seek service providers to present tailored training about dealing with different cultures during periods of grief.

RECOMMENDATION 88

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.

1. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 178 citing Office of Multicultural Interests, 'Diversity Statistics' < http://www.omi.wa.gov.au/omi_diversity_statistics.cfm> (accessed 30 May 2011).
2. Major consultations with Indigenous peoples on coronial matters were undertaken throughout Western Australia as part of the Commission's previous reference on Aboriginal customary laws.
3. Office of Multicultural Interests, Submission (March 2011) 1–2. The issues of provision of interpreters and translated material are discussed further below.
4. Ibid.
5. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) Proposal 85.
6. Office of Multicultural Interests, Submission No 6 (1 August 2011); Brian Begg, Funeral Director, Just Cremations, Submission No 13 (19 August 2011); David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Kristine Trevaskis, Counsellor, Office of the State Coroner, Submission No 21 (18 August 2011); Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011); Australian Funeral Directors Association, Submission No 25 (24 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Western Australia Police, Submission No 35 (1 September 2011); Australian Inquest Alliance, Submission No 39 (2 September 2011); Department of the Attorney General, Submission No 40 (31 August 2011).
7. See < http://www.diversewa.omi.wa.gov.au>.

Coronial counselling service

Section 16 of the *Coroners Act 1996* (WA) ('the Coroners Act') provides 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'.[1] Currently there are three coronial counsellors employed by the Office of the State Coroner, all of whom have qualifications in social work or psychology. The Commission's Discussion Paper explained the role of the Coronial Counselling Service, which is primarily to provide information to families about the coronial process with a lesser focus on community education and short-term clinical counselling.[2]

Concerns were raised during 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'.[3] The Commission heard (and research has shown) 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'.[4] The term 'coronial liaison' was widely preferred by those consulted and, the Commission observed, it is in fact more reflective of the range of services provided by the coronial counsellors. The Commission therefore proposed that the name of the service be changed from the Coronial Counselling Service to the Coronial Liaison Unit.[5]

There were mixed submissions to this proposal. Organisations dealing directly with grieved individuals (such as the Perinatal Loss Service, the Australian Funeral Directors' Association and individual funeral directors) supported the proposal to remove the word 'counselling' from the service name.[6] The proposal was also supported by the Australian Inquest Alliance, which represents Aboriginal legal services throughout Australia recognising the importance of this proposal for the Indigenous community.[7] In addition, the proposal was supported by former Perth coroner David McCann and Queensland State Coroner Michael Barnes (who reviewed the Office of the State Coroner in 2008).[8]

The proposal was not supported by the senior coronial counsellor, the Department of the Attorney General or the State and Deputy State Coroners. Senior counsellor Kristine Trevaskis felt that the counselling component of the service was important because it helps to 'minimise any negative public perception of the coronial process'.[9] She conceded that a 'negative stigma attached to the term counselling' but felt that it appeared to be 'mostly limited to country areas and specifically to Aboriginal people'. In her opinion, 'liaison and relationship building with regional Aboriginal services [as proposed by the Commission] may yield more positive outcomes'.[10] The Department of the Attorney General submitted that the service could be renamed the 'Coronial Counselling and Support Service' to recognise that unqualified

1. 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.
2. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011)181–82.
3. Ibid, 182.
4. 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 to the Law Reform Commission of Western Australia Review of Coronial Practice (December 2010).
5. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) Proposal 86.
6. Perinatal Loss Service – King Edward Memorial Hospital, Submission No 7 (1 August 2011); Brian Begg, Funeral Director, Just Cremations, Submission No 13 (19 August 2011); Australian Funeral Directors Association, Submission No 25 (24 August 2011).
7. Australian Inquest Alliance, Submission No 39 (2 September 2011) constituted by the Deaths in Custody Watch Committee (WA), the Aboriginal Legal Service (WA); the Federation of Community Legal Centres Inc (Vic), the Aboriginal Legal Service Ltd (NSW/ACT); the Aboriginal Legal Rights Movement Inc (SA), the Aboriginal and Torres Strait Islander Legal Service Ltd (Qld), the Victorian Aboriginal Legal Service Cooperative Ltd, and the North Australian Aboriginal Justice Agency.
8. David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011).
9. Kristine Trevaskis, Counsellor, Office of the State Coroner, Submission No 21 (18 August 2011).
10. Ibid.

volunteers also contribute to the service.[11] The State Coroner helpfully submitted that there was a possibility that 'both terms [coronial counselling and coronial liaison] could be used depending on the circumstances to avoid problems'.[12] The Deputy State Coroner merely submitted that 'you don't avoid a stigma by pandering to it'.[13]

Although the balance of submissions weighs in favour of changing the name of the counselling service to Coronial Liaison Unit as proposed, the Commission acknowledges the opposition within the court and has amended its recommendation accordingly. However, it highlights that there is sufficient research and evidence to support that a significant stigma does attach to the word 'counselling' for the Indigenous community.[14] It is a real and present concern and may well be the reason that the Coronial Counselling Service has been unable to satisfactorily engage with this community either in metropolitan Perth or in regional areas. In the Commission's view, it is vitally important that greater efforts be made by the Coroners Court to ensure that the counselling service is available in a meaningful way to all people in Western Australia and it makes the following recommendation.

The recommendation below also includes that consideration be given to providing the counselling service with a dedicated administrative assistant. This was proposed in the Commission's Discussion Paper in response to concerns that the service had no administrative support and that this took counsellors away from other important tasks.[15] With the exception of the submission of the Deputy State Coroner, all submissions discussed above agreed with this aspect of the Commission's proposal.

RECOMMENDATION 89

Coronial Counselling Service

1. That the State Coroner consider renaming the Coronial Counselling Service to remove any stigma that may attach to seeking 'counselling' for users of the service and to better describe the coronial liaison and information services provided.
2. That consideration be given to providing the service 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; however, the Commission's recommendations in this regard remain unimplemented.[16] The Discussion Paper set out the results of the Commission's consultations in regional areas. Primary concerns among regional respondents were that the Coronial Counselling Service failed to cater adequately to Aboriginal people and that difficulties were experienced in delivering information about the coronial process (including post mortem examination results and findings) to remote communities.[17] It was apparent that the concern was primarily for Aboriginal people who had limited means of contact. 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.[18]

After examining the options for reform in this area the Commission proposed that the Office of the State Coroner make arrangements with appropriate agencies in the regions to enable Aboriginal health workers to provide coronial counselling and information liaison services to Aboriginal people.[19] In addition, it was proposed that staff of the Office of the State Coroner undergo Aboriginal-specific cultural awareness training to assist in the organisation and delivery of culturally appropriate services to Aboriginal people in Western Australia.[20] This proposal

11. Department of the Attorney General, Submission No 40 (31 August 2011).
12. Alistair Hope, State Coroner, Submission No 18 (23 August 2011).
13. Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011).
14. See LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 182, fn 17.
15. Ibid 182.
16. LRCWA, *Aboriginal Customary Laws: The interaction of Western Australian law with Aboriginal law and culture,* Project No 94, Final Report (September 2006) 256. The Commission's recommendation 77 that a full-time Indigenous coronial counsellor/educator be employed and that resourcing for the expansion of coronial counselling services to rural areas be investigated has not been implemented, reportedly due to lack of resources.
17. See discussion LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 182–84.
18. Ibid.
19. Ibid, Proposal 87.
20. Ibid.

received full support from submissions.[21] While the recommendation below is Aboriginal-specific (to bring much-needed attention to this neglected community), it is suggested that the Office of the State Coroner also build relationships with non-Aboriginal regional health services to ensure that face-to-face counselling is available when required. In its submission, the Department of Health nominated the Country Health Services as a potential provider of coronial counselling in regional areas.[22]

RECOMMENDATION 90

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

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.[23] The delivery of general education and awareness programs has been a role traditionally undertaken by the Coronial Counselling Service. However, as the Discussion Paper noted, 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.[24] The Commission has made a number of recommendations about training and information for certain key players in the coronial process (eg, coroners, lawyers, doctors and police) throughout this Report.[25] In addition, recommendations are made below for the establishment of a dedicated secure online coronial information service for families[26] and for the development of a more informative Coroners Court website.[27] However, there is also a need to ensure 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. In the Commission's opinion, this is crucial to bridging the gap between the Coroners Court and the public and to combating misinformation and unrealistic expectations. With this in mind, the Commission proposed that the Office of the State Coroner 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.[28]

There was strong support from submissions for the Commission's proposal, with no opposition.[29] The Australian Funeral Directors Association submitted that its regional members had highlighted the lack of education and would appreciate any training that could be provided by the Coroners Court.[30] The Association offered its assistance with the

21. Department of Health, Submission No 11 (17 August 2011); David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Kristine Trevaskis, Counsellor, Office of the State Coroner, Submission No 21 (18 August 2011); Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011); Australian Funeral Directors Association, Submission No 25 (24 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Department of Corrective Services, Submission No 38 (1 September 2011); Australian Inquest Alliance, Submission No 39 (2 September 2011); Department of the Attorney General, Submission No 40 (31 August 2011).
22. Department of Health, Submission No 11 (17 August 2011).
23. *Report of the Committee of Inquiry into Aspects of Coronial Autopsies* (December 1992) recommendation 9.
24. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011)
25. See Recommendations 13, 20, 40, 44 & 76.
26. Recommendation 94.
27. Recommendation 96.
28. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) Proposal 88.
29. Office of Multicultural Interests, Submission No 6 (1 August 2011); David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Kristine Trevaskis, Counsellor, Office of the State Coroner, Submission No 21 (18 August 2011); Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011); Australian Funeral Directors Association, Submission No 25 (24 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Department of Corrective Services, Submission No 38 (1 September 2011); Australian Inquest Alliance, Submission No 39 (2 September 2011); Department of the Attorney General, Submission No 40 (31 August 2011).
30. Australian Funeral Directors Association, Submission No 25 (24 August 2011).

development of information packages for its members.[31] The Commission makes the following recommendation.

RECOMMENDATION 91

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, in consultation with relevant stakeholders, develop information packages that can be distributed to relevant industries and included, where possible, in industry training initiatives.

31. Ibid.

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, which includes that a post mortem examination is likely to be performed on the body of the deceased and that the senior next of kin may object to the post mortem examination. 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. In its Discussion Paper the Commission commended the court for this response; however, it was noted that references to these publications on the Coroners Court website were in English rather than the language of the brochure. In addition, the Commission was advised by the Office of Multicultural Interests that there was a need for the range of languages and translated material on the Coroners Court website to be expanded to include communities of newly settled migrants (eg, from Africa) who are most in need of translated material. The Commission therefore proposed that the Coroners Court expand its available translated material and provide links (in the relevant language) on the homepage of its website to translated information, including the brochure.[2] All submissions received in respect of this proposal were in support[3] and the following recommendation is made.

RECOMMENDATION 92

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.

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'.[4] 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.[5] The Commission's consultations with police in metropolitan and regional areas revealed that interpreters and translators are rarely, if

1. For a copy of this brochure, see LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) Appendix C.
2. Ibid 187–88.
3. Office of Multicultural Interests, Submission No 6 (1 August 2011); Brian Begg, Funeral Director, Just Cremations, Submission No 13 (19 August 2011); David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011); Australian Funeral Directors Association, Submission No 25 (24 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Australian Inquest Alliance, Submission No 39 (2 September 2011); Department of the Attorney General, Submission No 40 (31 August 2011).
4. State Coroner of Western Australia, 'Guidelines for Police' (undated) guideline 5.
5. 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.

ever, used by police when communicating this important information.[6] 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 Commission's Discussion Paper noted the risks of using family members or friends as interpreters. In particular, it was noted that the Commonwealth Ombudsman had recommended against such use because 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.[7]

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.[8]

> 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.[9]

The Discussion Paper also highlighted that the Western Australian Language Services Policy dictates that professional or competent interpreters and translators should be used in any situation where people are being informed of legal rights or obligations or where they are required to give their informed consent.[10] This is clearly the case with the delivery of coronial information – in particular in view of the important nature of the rights and obligations to be conveyed to next of kin under the Coroners Act and the fact that this information must be effectively delivered in a time of grief. The Commission therefore proposed that police officers and Coroners Court staff should assess the need for a professional language interpreter and provide such an interpreter if required when delivering or seeking information.[11] In addition, the Commission proposed that family or 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 had been exhausted.[12]

While all submissions were in agreement with the need to provide a language interpreter if required,[13] the State Coroner, Deputy State Coroner and Western Australia Police did not agree with the proposition that family or friends should not generally be used as interpreters. They argued that families generally prefer having information interpreted by another family member and they may be distressed.[14] The Commission highlights that its proposal does not preclude family members from being present while information is interpreted. Indeed, it would be preferable that family are present to provide support and comfort. But it should not be the responsibility of family members or friends to deliver such important information to the next of kin. Apart from family members and friends themselves being potentially very distressed (making their use as interpreters quite inappropriate), the risks of miscommunication (set out in the Discussion Paper)[15] are significant.

In addition, the Western Australia Police submitted that resources might preclude the provision of interpreters and this requirement may be unduly restrictive in remote areas.[16] The Commission examined these arguments in its Discussion Paper, but noted that the government's position, as expressed in the Western Australian Language Services Policy, was that

> Government agencies are required to have policies for funding and delivering translating and interpreting services that take account of relevant Government policy, legal

6. 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.
7. Commonwealth Ombudsman, 'Use of Interpreters (March 2009) 16.
8. Kimberley Interpreting Service, 'Frequently Asked Questions', < http://www.kimberleyinterpreting.org.au/faq.html >.
9. Ibid.
10. Office of Multicultural Interests, *Western Australian Language Services Policy* (2008) 9.
11. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) Proposal 90.
12. Ibid.
13. Office of Multicultural Interests, Submission No 6 (1 August 2011); Brian Begg, Funeral Director, Just Cremations, Submission No 13 (19 August 2011); David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011); Australian Funeral Directors Association, Submission No 25 (24 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Western Australia Police, Submission No 35 (1 September 2011); Australian Inquest Alliance, Submission No 39 (2 September 2011); Department of the Attorney General, Submission No 40 (31 August 2011).
14. Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011); Western Australia Police, Submission No 35 (1 September 2011).
15. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 188–90.
16. Western Australia Police, Submission No 35 (1 September 2011).

circumstances and the needs of current and potential clients.[17]

The Commission is not persuaded by this minority of submissions that people's rights under state legislation should be impacted simply because it is not convenient or it is a draw upon resources. If all reasonable means to engage an interpreter have been exhausted, then family or friends may be used, but it is important that it is recognised that this should never be the default position.

RECOMMENDATION 93

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 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

As noted in the Discussion Paper, a principal issue driving the introduction of the Coroners Act was inadequate communication between the Coroners Court and families.[18] However, the results of the Commission's public survey showed that lack of information about the process continues 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. The Discussion Paper lists the comments of some respondents to the survey which clearly show considerable frustration at the low level of court-initiated communication. In some cases, it was noted, families received only two letters from the Coroners Court – the first dealing with the post mortem examination and a final letter to deliver the finding. In the context of current delays this latter correspondence may be several years after the death.[19]

The Discussion Paper examined the results of the public survey in respect of preferred means of contact and found that only a very small minority (6.4%) stated that communication by letter was their preference. Most preferred more immediate communication such as by telephone, email or face-to-face meeting.[20] One submission to the Commission's survey suggested 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. Developing this idea, the Commission suggested that such a service should anticipate the questions families might have by providing information about what happens at each stage in the coronial 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. In the Commission's view this would 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. It was noted that 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.[21] The Commission therefore proposed 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

17. Office of Multicultural Interests, *Western Australian Language Services Policy* (2008) 7.
18. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 190.
19. Ibid 190–92.
20. Ibid.
21. Ibid.

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.

This proposal received strong support from submissions.[22] The State Coroner noted that a software system from Queensland (expected to be installed in the near future) would assist the court to realise this initiative.[23] The Western Australia Police submitted that such a database would also 'ensure milestones and set timeframes are reviewed … by coronial administrators'.[24] It was suggested that access to the online portal be limited to senior next of kin to maintain the 'privacy of the deceased' and prevent unnecessary exposure of information.[25] The Commission agrees that the information should be limited, but notes that there may be circumstances (such as split families) where information should be able to be accessed by family members other than the nominated senior next of kin. The Commission therefore recommends that access lie with the senior next of kin in all cases, but that the coroner have discretion to extend access to other family members.

RECOMMENDATION 94

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 the senior next of kin of a deceased, and other family members at the coroner's discretion.

22. Registry of Births, Deaths, and Marriages, Submission No 9A (24 August 2011); David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011); Australian Funeral Directors Association, Submission No 25 (24 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Western Australia Police, Submission No 35 (1 September 2011); Australian Inquest Alliance, Submission No 39 (2 September 2011); Department of the Attorney General, Submission No 40 (31 August 2011).
23. Alistair Hope, State Coroner, Submission No 18 (23 August 2011).
24. Western Australia Police, Submission No 35 (1 September 2011).
25. Ibid.

Access to post mortem examination report

Section 26A of the Coroners Act provides that a senior next of kin may have access to evidence obtained for the purpose of investigating the death, 'unless the coroner believes it is not desirable or practicable to do so'. During consultations for its Discussion Paper, the Commission received a number of strong 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. Currently families may request to see the post mortem examination report and such a request will usually be accommodated by the Coroners Court. Families are required to attend at the Office of the State Coroner in Perth where the post mortem results are explained by coronial counsellors. Alternatively, a person may request that a copy of the report be sent to their nominated general practitioner who can explain the post mortem results to them. Families are rarely (if ever) given a copy of the report.

In its Discussion Paper the Commission examined the arguments for and against provision of post mortem examination reports to families and determined that families should be given a copy of the report after it had been explained by their general practitioner or coronial counsellors. In coming to this conclusion the Commission noted s 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's proposal[26] that a similar provision be enacted in Western Australia was overwhelmingly supported.[27] While supporting the proposal in principle, the State Coroner and Queensland State Coroner Michael Barnes both argued that a post mortem

26. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) Proposal 92.
27. Office of Multicultural Interests, Submission No 6 (1 August 2011); David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Australian Funeral Directors Association, Submission No 25 (24 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Western Australia Police, Submission No 35 (1 September 2011); Australian Inquest Alliance, Submission No 39 (2 September 2011). The Commission received only one submission that did not support the proposal for release of post mortem examination reports to family members. The Deputy State Coroner argued that the post mortem examination report should be confidential; however, the Commission can find no relevant legal principle or legislation in any Australian jurisdiction to support the contention that information gathered post-mortem is subject to privacy laws or should otherwise be confidential.

examination report should not be sent to families in every case as some may find it distressing and unwelcome.[28] The Western Australia Police also submitted that the Commission's proposal should apply only to senior next of kin (rather than family generally) to prevent the release of any sensitive information.[29] The Commission agrees with these submissions and has appropriately confined its recommendation to provide that a post mortem examination report should only be made available upon written request by the senior next of kin of the deceased (unless otherwise ordered by the coroner). However, to ensure that senior next of kin of deceased persons are aware of their rights in this regard the Commission has also recommended that a notice be placed on the Coroners Court website stating that a senior next of kin may request a copy of the report.

RECOMMENDATION 95

Release of post mortem examination report

1. That, upon written request of the senior next of kin of a deceased person, and 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 senior next of kin 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 senior next of kin after the contents of the report have been interpreted and explained, if requested.
3. That a notice be placed on the Coroners Court website stating that the senior next of kin of a deceased person may request a copy of the post mortem examination report.

28. Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011).
29. Western Australia Police, Submission No 35 (1 September 2011).

CORONERS COURT WEBSITE

In addition to a secure online service for families wishing to monitor the progress of their relative's case through the coronial process, the Commission recognised a need for a more informative web presence for the Coroners Court. The Discussion Paper noted that the present website of the Coroners Court provides limited information about the process, which is helpful but clearly does not sufficiently address the needs of families and other users, such as lawyers, researchers and health professionals.[30] It was also noted that the 'court lists' page of the website, which is supposed to be updated regularly with information about upcoming inquests, had not been changed since January 2010.[31] The Commission examined other Coroners Court websites in Australia and proposed that the Office of the State Coroner review the content of the Coroners Court websites in Queensland, South Australia and Victoria with a view to improving the Coroners Court website in Western Australia.[32] The Commission also discussed comments made by members of the public and by others consulted for the Discussion Paper and proposed that the website should 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.[33]

The Commission's proposal received complete support from submissions[34] with the Department of Health commenting that this was an 'important step in creating a greater degree of transparency and accountability for decision making'.[35] The

30. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 193–94.
31. This was still the case at the time of writing in December 2011.
32. Ibid, Proposal 93.
33. Ibid.
34. Department of Health, Submission No 11 (17 August 2011); David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011); Australian Funeral Directors Association, Submission No 25 (24 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Australian Inquest Alliance, Submission No 39 (2 September 2011); Department of the Attorney General, Submission No 40 (31 August 2011).
35. Department of Health, Submission No 11 (17 August 2011).

Commission therefore confirms its proposal in the following recommendation.

RECOMMENDATION 96

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.

GUIDELINES AND FORMS

State Coroner's guidelines

As explained in the Discussion Paper, s 58 of the Coroners Act provides that the State Coroner must issue guidelines with respect to the principles, practices and procedures of the state coronial system.[36] The Commission noted that guidelines released by the State Coroner had, for the most part, not been updated since 1997 and that they were not publicly available. It was proposed that all existing guidelines should be reviewed, updated and published at the earliest opportunity.[37] All submissions[38] supported the Commission's proposal and the following recommendation is made.

36. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 195–96.
37. Ibid Proposal 94.
38. Department of Health, Submission No 11 (17 August 2011); David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011); Australian Funeral Directors Association, Submission No 25 (24 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Australian Inquest Alliance, Submission No 39 (2 September 2011); Department of the Attorney General, Submission No 40 (31 August 2011).

RECOMMENDATION 97

State Coroner's Guidelines: Review, update and publish

1. That, in addition to issuing guidelines about the specific matters addressed in recommendations throughout this Final Report, 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;[39] however, none appear to have been created for the use of senior next of kin or others when exercising rights under the Act. The Commission pointed out that other jurisdictions provide comprehensive sets of relevant forms on their Coroners Court websites. It was proposed that the Office of the State Coroner develop and publish forms to assist families and others to exercise their rights or discharge their obligations under the Coroners Act.[40] A list of forms required by the Commission's proposals and the terms of the Coroners Act was provided in the Discussion Paper.[41] Again this proposal received full support[42] and is confirmed below.

39. See, eg, the forms appendixed to the *Coroners Regulations 1997* (WA).
40. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) Proposal 95.
41. Ibid, 196–97.
42. Department of Health, Submission No 11 (17 August 2011); David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011); Australian Funeral Directors Association, Submission No 25 (24 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Australian Inquest Alliance, Submission No 39 (2 September 2011); Department of the Attorney General, Submission No 40 (31 August 2011).

RECOMMENDATION 98

Coronial forms

1. That forms to assist families and others to exercise their rights or discharge their obligations under the Coroners Act be developed by the Office of the State Coroner and be 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.

Post mortem rights and issues

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.[1]

Under the *Coroners Act 1996* (WA) ('the Coroners Act'), the senior next of kin of a deceased becomes the point of contact for the Coroners Court and has certain rights in the coronial process. A list is provided in the Act as to who is considered the senior next of kin in respect of any deceased person. Essentially it provides that the senior next of kin is the 'first person available' from the spouse or de facto partner of the deceased, followed by children, parents, siblings, the executor of the deceased's will or 'any person nominated by the person to be contacted in an emergency'.[2] Although certain rights (such as the right to object to a post mortem examination) accrue only to the senior next of kin, other rights in the Coroners Act can be exercised by any of the persons in this list. The first right to be discussed in this section is one that may be exercised by any of the next of kin provided for in s 37(5) of the Coroners Act.

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.

As noted in the Discussion Paper, the Commission's consultations uncovered a number of concerns in relation to how this section operates in practice. These included that occasionally next of kin included in s 37(5) have been precluded from viewing or touching the deceased; that there was a need for coronial counselling presence at some viewings; that there should be a choice to view the deceased through glass or from behind a waist-high barrier in the rare case that the coroner orders that a body may not be touched; and that the Office of the State Coroner needed to make arrangements with body transport contractors and police for viewings in regional area morgues. The Commission examined these concerns and made a proposal to address each issue.[3] The proposal received the full support of submissions[4] and the following recommendation is made.

RECOMMENDATION 99

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.

1. The Commission was told during consultations that 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.
2. *Coroners Act 1996* (WA) s 37(5). Section 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.
3. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) Proposal 96.
4. Kevin James, Country Contractor, Esperance Funeral Services, Submission No 8 (15 August 2011);Department of Health, Submission No 11 (17 August 2011); David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Dr Adrian Charles, Perinatal/Paediatric Pathologist, Submission No 22 (23 August 2011); Australian Funeral Directors Association, Submission No 25 (24 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Australian Inquest Alliance, Submission No 39 (2 September 2011).

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.

POST MORTEM EXAMINATION

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'. In Western Australia it appears that, in the vast majority of coronial cases, unless there has been a successful objection lodged by the next of kin, a full post mortem examination will be performed. Chapter Four of the Commission's Discussion Paper set out the steps to a typical external post mortem examination and internal post mortem examination and examined issues that may affect the ability of forensic pathologists to conduct a thorough or optimal post mortem examination.[5] These included the need for the early provision of medical notes in cases of hospital deaths and the need for comprehensive initial description of the scene of death and other important matters by police on the mortuary admission form or accompanying paperwork.[6]

Provision of body in optimal condition for post mortem examination

The other matter examined in Chapter Four of the Discussion Paper was the need for provision of the body in optimal condition for post mortem examination. The difficulties of retarding decomposition (especially of the bodies of young children) while transporting bodies over long distances in very hot climatic conditions were discussed. In addition, the Commission discussed problems that might arise from the failure of some regional police to seal body bags for transport.[7] It was noted that a body may go through a number of hands on its journey to Perth from regional Western Australia and that 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 was not aware how widespread this practice was, but believed it was important that it be addressed by police authorities at the earliest opportunity and made a proposal 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.[8]

This proposal was supported by submissions[9] including, most importantly, by the Western Australia Police.[10] Queensland State Coroner Michael Barnes commented that the sealing of body bags in his state has 'saved many thousands of police hours' by avoiding the necessity of bodies being accompanied by police during transport.[11] Kevin James, a funeral director and body transport contractor noted that it was essential that identification was placed on the outside of the bag after sealing so that transport contractors know they are collecting the right body from a regional morgue.[12] The Commission agrees and has amended its recommendation accordingly.

The State Coroner noted that for suspicious cases police must be present at the mortuary to cut the seal but that in non-suspicious cases this is not necessary and may therefore render sealing of the bag impractical.[13] However, the Western Australia Police suggested that for non-suspicious deaths a procedure could be adopted whereby the body bag is

5. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 84–88.
6. Ibid 85–86.
7. Ibid.
8. Ibid, Proposal 35.
9. Kevin James, Country Contractor, Esperance Funeral Services, Submission No 8 (15 August 2011); Department of Health, Submission No 11 (17 August 2011); David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Western Australia Police, Submission No 35 (1 September 2011).
10. Western Australia Police, Submission No 35 (1 September 2011).
11. Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011).
12. Kevin James, Country Contractor, Esperance Funeral Services, Submission No 8 (15 August 2011).
13. Alistair Hope, State Coroner, Submission No 18 (23 August 2011).

> sealed at the incident site (where possible) and evidence tape placed over the entry point with the officer's details endorsed. The pathologist could then verify when the body was received that the tape was in place, undisturbed and had the details inscribed on it. This would satisfy all evidentiary requirements. [14]

The Commission notes that there may well have to be, as the Western Australia Police suggest, a different method of sealing body bags to distinguish between suspicious cases (where police must be present to cut the seal) and non-suspicious cases (where they do not). The Commission has therefore amended its recommendation to reflect this.

RECOMMENDATION 100

Police to seal body bags

That the Western Australia Police adopt a practice 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 loss or contamination of evidence prior to post mortem examination. Separate sealing techniques or procedures may need to be considered to differentiate between suspicious deaths and non-suspicious deaths and identification of the deceased should be clearly noted on the outside of the bag.

External or preliminary post mortem examinations

As noted in the Discussion Paper, 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.[15] In other states the number of coronial cases subject to a full internal post mortem examination is generally between 70% and 75%.[16] The Commission noted that very high rate of internal autopsies in Western Australia has implications on available resources (both economic and human) and may also impinge on the cultural and religious beliefs of Western Australians.[17] The apparent presumption of a full internal post mortem examination in all cases in Western Australia (unless an objection is made by the senior next of kin) was a cause of concern for the Commission. The Commission noted that a coroner is, under s 34, required 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. In the Commission's opinion, this requires the coroner to give consideration to whether the cause of death can be determined without an internal examination in every case.[18] However, it was noted that the power to direct a post mortem examination had been delegated to coroner's registrars who did not exercise the power as required under s 34, but simply authorised an internal post mortem examination as soon as the objection period had passed.

The Discussion Paper examined the trend toward less-invasive post mortem examination procedures in other jurisdictions. It highlighted the need for timely and expanded information to be available to forensic pathologists to ensure that external examinations can be undertaken with as much background as possible. The Commission noted that proposals throughout its Discussion Paper (eg, adoption of the national police form and enhanced powers for seeking medical records) would assist in this regard.[19] It proposed 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.[20]

There was strong support for the Commission's proposal.[21] The Department of Health submitted that if the coroner elects to authorise an external examination, then the forensic pathologist will provide the best advice possible within the limits

14. Western Australia Police, Submission No 35 (1 September 2011).
15. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 201.
16. Ibid.
17. Ibid.
18. Ibid 201–02. The State Coroner had observed that 'it is a rare case in which there are no external factors which would give some insight into a likely cause of death': Office of the State Coroner, *Annual Report 2007–2008* (2008) 7.
19. LRCWA, ibid 201.
20. Ibid Proposal 97.
21. Office of Multicultural Interests, Submission No 6 (1 August 2011); Department of Health, Submission No 11 (17 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Jewish Community Council of WA, Submission No 23 (23 August 2011); Australian Funeral Directors Association, Submission No 25 (24 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Western Australia Police, Submission No 35 (1 September 2011); Australian Inquest Alliance, Submission No 39 (2 September 2011). Only one submission did not support the proposal on the basis that the quality of an external post mortem examination is dependent upon the quality of the information available to the forensic pathologist: David McCann, Former Perth Coroner, Submission No 16 (19 August 2011). The Commission believes it has adequately dealt with this argument in its Discussion Paper and has made relevant recommendations to enhance the timely provision of improved information to forensic pathologists.

of this type of examination.[22] It was noted that, unlike other jurisdictions that have embraced external examinations, Western Australia did not yet have a dedicated CT scanner for forensic purposes.[23] The importance of the availability of good quality imaging was also highlighted by the State Coroner in his submission; however, he stated that he understood a proposal to provide a dedicated scanner for forensic purposes was currently being considered.[24] The Commission places on record its full support for the provision of a dedicated CT scanner for forensic purposes to PathWest.

RECOMMENDATION 101

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.

22. Department of Health, Submission No 11 (17 August 2011).
23. Ibid.
24. Alistair Hope, State Coroner, Submission No 18 (23 August 2011)

Use of less-invasive post mortem procedures

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 histopathology[25] will return a less-precise finding in every case. In the Commission's opinion, for 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, has been enshrined in legislation in New South Wales.[26] The Commission proposed that the Coroners Act should include principles governing the conduct of post mortem examinations modelled on the New South Wales provision.[27]

The proposal received strong support from submissions.[28] Religious groups strongly supported the legislative reference to dignity for the deceased.[29] The Jewish Community Council submitted it was confident (and the Commission agrees)[30] that deceased's remains were currently

25. Eg, of biopsied cells or tissue taken in a preliminary post mortem examination procedure.
26. *Coroners Act 2009* (NSW) s 88.
27. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 98.
28. Department of Health, Submission No 11 (17 August 2011); Jewish Community Council of WA, Submission No 23 (23 August 2011); Australian Funeral Directors Association, Submission No 25 (24 August 2011); Baha'i Council of WA, Submission No 31 (26 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Western Australia Police, Submission No 35 (1 September 2011); Australian Inquest Alliance, Submission No 39 (2 September 2011).
29. Baha'i Council of WA, Submission No 31 (26 August 2011); Jewish Community Council of WA, Submission No 23 (23 August 2011).
30. The Department of Health and the State Coroner submitted that post mortem examinations are always undertaken with

being treated with 'the utmost respect' in Western Australia, but nonetheless it felt that the Commission's proposal was important to 'enhance the probability of this practice continuing'.[31] The Australian Funeral Directors Association submitted that 'many families find it reassuring that the least invasive procedure appropriate to the situation is used'.[32] Queensland State Coroner Michael Barnes stated:

> I am of the view that throughout Australia there is a tendency to conduct internal autopsies unnecessarily. I am concerned there is a basis to believe that family members are not aware of how invasive and obstructive internal autopsies are and that were they made aware many more would object. I am of the view the coroners should be directed to limit the use of internal autopsies to those cases in which it is thought to be central for the discharge of coroners' functions.[33]

The State Coroner did not agree with the Commission's proposal, preferring instead that any move toward less-invasive procedures be in the context of 'increased availability of access to quality imaging and increased resourcing to coroners … rather than as a result of legislative changes'.[34] The Commission appreciates this submission but believes that legislative direction is appropriate and necessary. Western Australia has significantly lagged behind the rest of Australia in this regard and has one of the highest internal autopsy rates in the nation. Indeed, as noted throughout the Discussion Paper, there is currently a presumption of internal autopsy in every case in Western Australia regardless of the circumstances of the death. As the Commission understands it, the only case where an internal autopsy is not undertaken is when an objection is made by the senior next of kin and upheld by a coroner. As observed above, a meaningful move toward less-invasive post mortem procedures requires an increased use of imaging technologies. It is not appropriate that PathWest is required to use the CT scanner located in Sir Charles Gairdner Hospital (which is otherwise used by live patients). There should be a scanner dedicated for forensic use on deceased people and the Commission welcomes current efforts to obtain funding for greater use of imaging technologies for forensic purposes. In the meantime, it is highlighted that the Commission's recommendation suggests that, in principle, the least invasive procedures that are *available and appropriate in the circumstances* should be used.

RECOMMENDATION 102

Principles governing 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, 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 should use the least invasive procedures that are available and 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:
   (a) an external examination of the remains,
   (b) a radiological examination of the remains,
   (c) blood and tissue sampling,
   (d) a partial post mortem examination.

Factors to consider in ordering a post mortem examination

Unlike other jurisdictions – notably New Zealand and Queensland[35] – there is currently no statutory guidance for Western Australian coroners considering whether to direct that a post mortem examination be conducted.[36] As pointed

great respect for the dignity of the deceased. The Commission has no reason to believe otherwise and its recommendation simply seeks to affirm this current practice in legislative form.

31. Jewish Community Council of WA, Submission No 23 (23 August 2011).
32. Australian Funeral Directors Association, Submission No 25 (24 August 2011).
33. Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011).
34. Alistair Hope, State Coroner, Submission No 18 (23 August 2011). Former Perth Coroner David McCann also did not agree with this proposal; however, unlike the State Coroner who expressed support for external post mortem examination, McCann based his objection to this proposal on his opposition to external examinations: Submission No 16 (19 August 2011)
35. *Coroners Act 2006* (NZ) s 30; *Coroners Act 2003* (Qld) s 19(5).
36. As noted in the Discussion Paper, very limited guidance is contained in the 'Guidelines to Coroners': LRCWA, *Review of*

out in the Discussion Paper, the Commission had addressed this issue earlier in the context of its Aboriginal customary laws reference.[37] It was 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.[38] A similar recommendation was made by the Victorian Parliamentary Law Reform Committee (VPLRC) in its 2006 *Review of the Coroners Act 1985 (Vic)*.[39] However, the VPLRC went further to require that coroners consider a raft of other factors in deciding whether or not to order an internal post mortem examination.[40]

Having regard to the position in other jurisdictions, the Commission's consultations and its previous recommendation, the Commission proposed that the Coroners Act should require coroners to consider certain factors in exercising their discretion to order an internal post mortem examination.[41] It was highlighted that to assist in making this decision, coroners could take advice from the medical advisers attached to the Office of the State Coroner or order an external or preliminary examination.[42] The Commission's proposal received overwhelming support from submissions.[43] Queensland State Coroner Michael Barnes submitted his strong support for the proposal but noted that consideration of 'the potential healthcare benefits of an internal post mortem examination for the deceased's family or the community' (paragraph 3 of the proposal) could 'militate against any reduction in the use of internal autopsies' because it could be argued in every case that a potential benefit to the community is achieved by an internal autopsy.[44] The Commission has considered this submission and, while it was not prepared to remove the factor altogether, it has removed the word 'potential' from its recommendation to make it less wide. The Deputy State Coroner neither supported nor opposed the Commission's proposal; however, she reflected that coroners already take into account relevant factors when considering whether to order an internal post mortem examination and queried why this current practice needed regulation.[45] However, as discussed earlier and throughout the Discussion Paper, the power to direct an internal post mortem examination is currently (and in the Commission's opinion, inappropriately)[46] delegated completely to coroner's registrars and there is a presumption of internal post mortem examination in all cases *unless an objection is made*. It is therefore only in the case of an objection[47] that coroners consider whether or not to order an internal post mortem examination in the present system. The Commission believes there is sufficient justification why this needs to be legislatively clarified in the detailed arguments presented in its Discussion Paper.[48] Noting the overwhelming support from other submissions, including the State Coroner, the Australian Inquest Alliance, the Australian Funeral Directors Association and the Office of Multicultural Interests (among others), the following recommendation is made.

RECOMMENDATION 103

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;

Coronial Practice in Western Australia, Discussion Paper (June 2011) 204–5.

37. *Aboriginal Customary Laws: The interaction of Western Australian law with Aboriginal law and culture,* Project No 94, Final Report (September 2006) 253-55.
38. Ibid Recommendation 76.
39. VPLRC, *Coroners Act 1985 – Final Report* (2006) recommendation 100.
40. See discussion, LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 204–5.
41. Ibid Proposal 98.
42. Ibid 205.
43. Office of Multicultural Interests, Submission No 6 (1 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Jewish Community Council of WA, Submission No 23 (23 August 2011); Australian Funeral Directors Association, Submission No 25 (24 August 2011); Baha'i Council of WA, Submission No 31 (26 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Western Australia Police, Submission No 35 (1 September 2011); Australian Inquest Alliance, Submission No 39 (2 September 2011).
44. Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011).
45. Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011).
46. The Commission has recommended that this power not be delegable to coroner's registrars other than the Principal Registrar: Recommendation 12.
47. Approximately 10% of cases.
48. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 200–09.

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 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.

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. The Discussion Paper set out how the objection process works in practice and discussed objection data in Western Australia.[49] It explained that currently an objection to post mortem examination included an objection to an external and an internal post mortem examination. The Discussion Paper responded to arguments that an external examination should be permitted in every case to enable the coroner to fulfil his or her obligations to the deceased. The Commission proposed 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.[50] Submissions were in full support[51] of this proposal and it is confirmed below.

49. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 206.
50. Ibid Proposal 100.
51. David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011); Australian Funeral Directors Association, Submission No 25 (24 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Western Australia Police, Submission No 35 (1 September 2011); Australian Inquest Alliance, Submission No 39 (2 September 2011).
52. 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.
53. Coroners Court of Western Australia, 'When a Person Dies Suddenly'. A copy of the brochure appears in LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) Appendix C.
54. LRCWA, ibid 207–8.

RECOMMENDATION 104

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 under the coroners guidelines 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.[52] In practice, the next of kin is advised of the right to object to post mortem examination by police at the time they are advised of the death (or attend the scene of death). The information is given in the form of a brochure ('When a Person Dies Suddenly'), which states that 'any objection should be lodged by the next of kin within 24 hours of receiving this brochure'.[53]

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 argued that family members often find it difficult to understand and exercise their right to object to post mortem examination within 24 hours of being informed of the death. In its Discussion Paper the Commission noted that similar concerns had been raised during its reference on Aboriginal customary laws.[54] In that context the Commission heard that the Aboriginal cultural aspects of grief are so disabling that 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. In addition it was observed that

Aboriginal language interpreters are never used to interpret the brochure containing the reference to the right to object; that there is no coronial counselling available to regional Aboriginal people to help them to understand those rights; and that often the brochure and information is given to someone other than the senior next of kin capable of exercising the rights (eg, an extended family member).[55]

The Commission outlined the arguments for and against extending the objection period.[56] Noting that a 48-hour objection period existed in other Australian jurisdictions, the Commission proposed that the objection period be extended to 48 hours including one working day as previously recommended in its Aboriginal customary laws reference.[57] In making this proposal it was observed that although an increase to 48 hours would have a beneficial impact on families by reducing the pressure placed upon them in the first 24 hours following a death, in many cases, increasing the objection period to 48 hours including one full working day would have no real impact upon the time that a post mortem examination would otherwise be performed.[58] It was also highlighted that under the Commission's proposals an objection may only be made to an internal post mortem examination and that in all cases the body of a deceased may immediately be admitted to the State Mortuary for external examination (including imaging and the taking of bodily fluids and tissue samples for testing).[59]

The Commission received mixed responses to its proposal. While not disagreeing with the proposal, the Australian Funeral Directors Association submission expressed reservations about the extension of the objection period; however, it proceeded on the misapprehension that the Commission had proposed that two working days must elapse before an objection is received.[60] This is not correct: the proposal was to extend the objection period to 48 hours including one working day from the present period of 24 hours including one working day. A similar misapprehension was also made by the State Coroner in his original submission, which was later retracted.[61] In his replacement submission on this proposal, the State Coroner noted that he had made an error in his first response but still had a concern about any delays in performance of a post mortem examination.[62] Both the Department of Health and the Deputy State Coroner argued that any delay in commencing post mortem examination would result in an increase in decomposition.[63] The Office of Multicultural Interests, the Australian Inquest Alliance (representing Aboriginal legal services throughout Australia), Western Australia Police and Queensland State Coroner Michael Barnes all supported the proposal.[64] The Commission has weighed all submissions received in response to the proposal and has determined that it should delete the 'one working day' requirement from its formula so that the time period for objection is simply expressed as '48 hours' and this time may run over a weekend or public holiday. In real terms this will not represent any increase in delay between death and post mortem examination because the current formula of 24 hours including one working day would often result in a delay of at least 48 hours before a post mortem examination is begun. In fact, if the brochure was delivered on a Friday afternoon the elapse of 48 hours could see the post mortem examination being performed as early as the following Monday morning.[65] This would be at least one full day earlier than the current formulation would allow.[66] The Commission is satisfied that arguments relating to decomposition of bodies and delay in beginning the post mortem examination and release of the body fall away with this amendment to its recommendation. As noted in the Discussion Paper, the coroner retains the discretion to order an immediate internal post mortem if he or she believes that it must be done without delay. In addition, families who have no objection to post-mortem examination and/or wish to have the body released as soon as possible for burial may waive the right to objection so that there is no delay prior to post mortem examination (subject of course to the schedule of the forensic pathologist). The Australian Funeral Directors Association

55. Ibid.
56. Ibid.
57. Ibid Proposal 101. See 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 yet been implemented.
58. Ibid 208.
59. Ibid 207–8.
60. Australian Funeral Directors Association, Submission No 25 (24 August 2011).
61. Alistair Hope, State Coroner, Submission No 18A (2 September 2011).
62. Ibid.
63. Department of Health, Submission No 11 (17 August 2011); Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011).
64. Office of Multicultural Interests, Submission No 6 (1 August 2011); Western Australia Police, Submission No 35 (1 September 2011); Australian Inquest Alliance, Submission No 39 (2 September 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011).
65. It should be noted that objections are able to be taken by the Coroners Court 24 hours a day via a dedicated telephone service.
66. Because a full working day is required under the current formulation, the post mortem examination could not be held until the Tuesday in this example.

submitted that this right should be communicated to families.[67] The Commission agrees and has amended its recommendation accordingly.

Even though the practical outcome of the Commission's recommendation is likely to be the same or similar as under the present formulation, the extension to 48 hours will nonetheless impact positively on families because they will have an extra 24 hours to make an informed decision about objection, to seek and receive counselling, or to contact the 'true' senior next of kin where the person given the brochure is an extended family member. This will overcome some of the concerns relayed by families to the Commission.

RECOMMENDATION 105

Time for objection to internal 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 internal post mortem examination is conducted until at least a period of 48 hours 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 senior next of kin of a deceased may waive their right to object to an internal post mortem examination at any time after receiving the coroner's brochure 'When a Person Dies Suddenly'
3. That the coroner's brochure 'When a Person Dies Suddenly' be amended to reflect the increase in time for objection to 48 hours and that the senior next of kin of a deceased may waive their right to object to an internal post mortem examination.

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)[68] to the Supreme Court for an order that no post mortem examination be performed. The Commission considered the current review provisions in light of similar provisions in other Australian jurisdictions and found that they were appropriate and did not require change.[69] However, the Commission observed that more could be done to assist lawyers and unrepresented applicants to make such applications, particularly in light of the urgency of the application and the fact that families are not usually granted legal aid for coronial matters.[70] It therefore proposed that the Supreme Court 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.[71] The submission received the full support of submissions[72] and the following recommendation is made.

RECOMMENDATION 106

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.

OTHER POST MORTEM ISSUES

Removal and retention of organs

The Discussion Paper examined the current laws and practice relating to the removal and retention of organs and tissue.[73] It observed that issues surrounding the retention of organs had been

67. Australian Funeral Directors Association, Submission No 25 (24 August 2011).

68. 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).
69. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 208–9.
70. Ibid.
71. Ibid Proposal 102.
72. Department of Health, Submission No 11 (17 August 2011); David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011); Australian Funeral Directors Association, Submission No 25 (24 August 2011); Australian Inquest Alliance, Submission No 39 (2 September 2011); Department of the Attorney General, Submission No 40 (31 August 2011).
73. Ibid 210–12.

the subject of a 1992 report which ultimately informed the provisions of the current Coroners Act.[74] During consultations the Commission had received very few comments on this issue and, as noted in the Discussion Paper, there were no criticisms about organ retention made in the Commission's public survey.[75] The Commission invited submissions as to whether there were any issues it should be aware about in relation to organ retention and return practices.[76] The Commission received only three submissions in response to this invitation. One submission, from a doctor, emphasised the usefulness of retained organs for research and teaching purposes.[77] Another, from a religious organisation which forbids cremation or embalming, made clear that such methods should not be used during post mortem examinations or for disposal of organs for followers of that faith.[78] The Australian Funeral Directors Association submitted that organ retention may cause delays to funerals.[79] The Commission is of the view that the submissions received on this issue have not provided a sufficient basis for reform of the current regime for removal and retention of organs.

Condition of bodies following post mortem

During consultations 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 particular, it was noted that bodies returned from post mortem examination were required to be reopened and packed to eliminate seepage and that care needed to be taken by pathologists and technicians in making incisions (particularly those near the carotid artery which is required intact for embalming) and suturing. The Discussion Paper set out these complaints and comments from a number of funeral directors (both metropolitan and regional) who responded to a dedicated survey on this subject.[80] Regional funeral directors made the Commission aware that there is often no facility to re-open or even wash down bodies in regional areas and that care needed to be taken to ensure they arrived in a good state for viewing.[81] The Commission proposed:

> 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.[82]

This proposal received complete support from submissions with very strong support from funeral directors.[83] The Department of Health submitted that all steps are taken to release bodies in the best condition possible and that PathWest is exploring ways of improving its service, including using a modified incision to avoid damage to the carotid artery and increasing the quantity of absorbent material packed into the body cavity.[84] However, it noted that responsibility for wrapping bodies for transport falls to the metropolitan body transport contractor engaged by the Office of the State Coroner.[85] The Commission has noted this and has removed reference to transport from Recommendation 107 addressed to the State Mortuary and has created a new recommendation addressed to the State Coroner.

On a related subject the Australian Funeral Directors Association submitted that the funeral director should be advised if a body contains a pacemaker or other electronic device. It noted that 'the consequence of a deceased with a pacemaker being cremated can be catastrophic as the devices have the ability to explode in such conditions'.[86] The Commission has added to its recommendation to encompass this request, suggesting that clear notation be attached to the body and/or placed on the release documentation for the funeral director's attention.

74. *Report of the Committee of Inquiry into Aspects of Coronial Autopsies* (December 1992).
75. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 211.
76. Ibid Question H.
77. Dr Adrian Charles, Perinatal/Paediatric Pathologist, Submission No 22 (23 August 2011).
78. Baha'i Council of WA, Submission No 31 (26 August 2011).
79. Australian Funeral Directors Association, Submission No 25 (24 August 2011).
80. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 212–13.
81. Ibid.
82. Ibid Proposal 103.
83. Kevin James, Country Contractor, Esperance Funeral Services, Submission No 8 (15 August 2011); Registry of Births, Deaths, and Marriages, Submission No 9A (24 August 2011); Department of Health, Submission No 11 (17 August 2011); David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Australian Funeral Directors Association, Submission No 25 (24 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Australian Inquest Alliance, Submission No 39 (2 September 2011).
84. Department of Health, Submission No 11 (17 August 2011).
85. Ibid.
86. Australian Funeral Directors Association, Submission No 25 (24 August 2011).

RECOMMENDATION 107

Preparation of bodies for release from State Mortuary

1. 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.
2. That, if a body contains a pacemaker or other electronic device a notation to this effect is to be placed on the release documentation and/or body tag for the attention of the funeral director.

RECOMMENDATION 108

Preparation of bodies for transport outside the Perth metropolitan area

That the State Coroner ensure that contracts for body transport address the need to wrap bodies for transport purposes upon pick-up from the State Mortuary to prevent seepage of body fluids on journeys outside the Perth metropolitan area.

Conditions of the 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. The Discussion Paper described the conditions in detail noting that PathWest was aware of the 'sub-optimal waiting and viewing conditions' and that a business case for improvements had been presented to Treasury and was pending approval.[87] Given the large volume of comments the Commission had received on this issue it was proposed 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. This proposal was fully supported[88] and is confirmed as a recommendation.

RECOMMENDATION 109

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.

87. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 213–14.
88. Department of Health, Submission No 11 (17 August 2011); David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Australian Funeral Directors Association, Submission No 25 (24 August 2011); Australian Inquest Alliance, Submission No 39 (2 September 2011)

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. The practicalities of securing a certificate were set out in the Commission's Discussion Paper.[2]

DETERMINING DISPUTES ABOUT RELEASE

Although there is nothing in 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 the disagreement.[3] 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. These principles are discussed at length in the Commission's Discussion Paper.[4]

During consultations, 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. In its Discussion Paper, the Commission noted that the role of the coroner in determining disputes had recently been formalised in ss 47 and 48 of the *Coroners Act 2008* (Vic).[5] These sections replace the issuing of a certificate of disposal with an order specifying to whom the body is to be released for disposal. They also provide legislative guidance following 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.

The Commission expressed the opinion that the Victorian scheme provided much-needed clarity about to whom a body may be released and made the power of the coroner explicit in providing a first instance determination where a dispute exists.[6] The Commission made three related proposals, summarised below:

- That the current certification for disposal provisions found in s 29 of the Coroners Act be replaced by a provision stating 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.[7]
- That in cases where more than one application is made for release of the body the coroner may determine the person to whom the body is to be released on the basis of who has the better claim with legislative guidance modelled on s 48 of the *Coroners Act 2008* (Vic).[8]
- That within 48 hours of such a determination, a person may apply to a single judge of the Supreme Court for review of the coroner's decision on the basis of an error of law only.[9]

All three proposals were overwhelmingly supported by submissions[10] and the Commission makes the following recommendations.

1. The issuing of certificates for disposal of a body is currently delegated to coroner's registrars.
2. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) 215.
3. As noted in the Discussion Paper, under the current Coroners Act the coroner cannot make a legally binding determination about to whom a body may be released: ibid 216.
4. Ibid 216–18.
5. Ibid.
6. It was noted that in other cases the coroner will simply release the body to the senior next of kin or whoever makes the claim for release: Ibid.
7. Ibid Proposal 105.
8. Ibid Proposal 106.
9. Ibid Proposal 107.
10. Registry of Births, Deaths, and Marriages, Submission No 9 (15 August 2011); David McCann, Former Perth Coroner, Submission No 16 (19 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Australian Funeral Directors Association, Submission No 25 (24 August

RECOMMENDATION 110

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.

RECOMMENDATION 111

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 them or to a funeral director appointed by them.

(2) If two 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 two 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.

RECOMMENDATION 112

Supreme Court review of coroner's decision to release a body

1. 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 by a coroner pursuant to Recommendation 111 on the basis of an error of law.
2. That such application must be made within 48 hours of the coroner's determination.

Practical issues surrounding release

In its Discussion Paper the Commission explained that 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 heard during consultations that people are not always made aware that they must appoint a funeral director in order to apply for release of

2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Australian Inquest Alliance, Submission No 39 (2 September 2011). Only one submission was received in opposition to any of these proposals: Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011).

the deceased's body from the State Mortuary in Perth following a post mortem examination. This is particularly problematic in regional areas where bodies are transferred by a body transport contractor, but cannot be returned to the regional morgue without a specific request for release by a funeral director. The Commission proposed 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.[11]

This proposal received the very strong support of submissions.[12] In his submission the State Coroner advised that this information had appeared in an earlier version of the brochure 'When a Person Dies Suddenly', which is given to families by police following an unexpected death.[13] Evidently, when the brochure was last reprinted this information was omitted in error.[14] The Commission assumes that this will be reinstated but in any event makes the following recommendation that it be done and that it also be placed on the Coroners Court website.

RECOMMENDATION 113

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.

11. LRCWA, *Review of Coronial Practice in Western Australia,* Discussion Paper (June 2011) Proposal 108.
12. Office of Multicultural Interests, Submission No 6 (1 August 2011); Kevin James, Country Contractor, Esperance Funeral Services, Submission No 8 (15 August 2011); Department of Health, Submission No 11 (17 August 2011); Alistair Hope, State Coroner, Submission No 18 (23 August 2011); Evelyn Vicker, Deputy State Coroner, Submission No 24 (24 August 2011); Australian Funeral Directors Association, Submission No 25 (24 August 2011); Michael Barnes, State Coroner, Office of the State Coroner Queensland, Submission No 34 (31 August 2011); Australian Inquest Alliance, Submission No 39 (2 September 2011).
13. Alistair Hope, State Coroner, Submission No 18 (23 August 2011).
14. Ibid.

Appendices

Contents

Appendix A: List of recommendations

RECOMMENDATION 1 page 10

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, comments 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 offer a counselling service to family members, friends and others associated with a death the subject of a coronial investigation.

RECOMMENDATION 2 page 16

No ex officio coroners

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

RECOMMENDATION 3 page 17

Establish coronial regions

That three coronial regions be established in Western Australia 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).

RECOMMENDATION 4 page 17

Dedicated regional coroners

That dedicated coroners be assigned to service the northern region and the southern region (as defined in Recommendation 3), with the objective that those coroners ultimately be based in these regions.

RECOMMENDATION 5 ---------- page 17

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 at the earliest opportunity. 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.

Consultations with relevant stakeholders including the Registry of Births Deaths and Marriages, PathWest, Western Australia Police, 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.

RECOMMENDATION 6 ---------- page 19

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 State Coroner be appointed for a term not exceeding five years and is eligible for reappointment.
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.

RECOMMENDATION 7 ---------- page 19

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 Deputy State Coroner be appointed for a term not exceeding five years and is eligible for reappointment.
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.

RECOMMENDATION 8 ---------- page 19

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 a term not exceeding five years, eligible for reappointment.
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.

RECOMMENDATION 9 ---------- page 20

Acting coroners

1. That a person who is eligible to be appointed as a magistrate may be appointed as an acting coroner by the Attorney General on recommendation of the State Coroner.
2. That an appointment of an acting coroner shall be for a term not exceeding two years, eligible for reappointment.

RECOMMENDATION 10 ---------- page 20

Oath of Office

1. That a person appointed as coroner or acting 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.

RECOMMENDATION 11 ---------- page 22

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.

RECOMMENDATION 12 ---------- page 23

Delegation from the State Coroner to coroners' registrars

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 (other than 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) performing such other functions as are prescribed by regulation.

RECOMMENDATION 13---------- page 24

Training of coroners, acting coroners and coroners' registrars

1. That the State Coroner provide for persons appointed as coroners or acting 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; training in medical aspects of the role of coroner, including the purpose and conduct of a post mortem examination; 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.

RECOMMENDATION 14---------- page 29

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.

RECOMMENDATION 15 ---------- page 30

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 $12,000 or 12 months' imprisonment.

RECOMMENDATION 16 ---------- page 30

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 a reportable death, the police officer must report the suspected death to the coroner.

RECOMMENDATION 17 ---------- page 31

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.

RECOMMENDATION 18 ---------- pages 35

Reportability of healthcare-related deaths

Healthcare or purported healthcare-related death means the death of a person after receiving or seeking healthcare or purported healthcare in circumstances where –

(a) immediately before receiving the healthcare or purported healthcare the person's death was not the reasonably expected outcome; or

(b) the person might not have died at the time of the person's death if the person had received the healthcare which could be reasonably expected to have been provided to them.

"Healthcare" means assessment, examination, diagnostic test, treatment or a medical, surgical, dental or other health related procedure (including the administration of an anaesthetic, sedative or other drug or substance).

"Purported healthcare" includes all cases of purported *"healthcare"* whether or not the assessment, examination, diagnostic test, treatment or a medical, surgical, dental or other health related procedure has scientific efficacy.

"Reasonably expected" means expected by an objective person appropriately qualified in the relevant area of healthcare.

RECOMMENDATION 19 ---------- page 36

State Coroner's Guidelines: Reportable deaths

That the State Coroner, in consultation with medical advisers, relevant agencies and professional bodies, produce 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 the types of deaths that may fall into each of the categories of reportable death under the Coroners Act.

RECOMMENDATION 20 ---------- page 36

Informing medical practitioners of relevant changes to the Coroners Act

That the Office of the State Coroner work together with relevant agencies and professional bodies (including the Australian Medical Association 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.

RECOMMENDATION 21 ---------- pages 37–38

Authorisation to issue a cause of death certificate

1. 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, in the coroner's opinion, sufficiently certain; and
   (c) the coroner is satisfied that no further investigation of the death is warranted.
2. That the coroner report to the Registry of Births, Deaths and Marriages any cause of death certificates approved for issue under this section.

RECOMMENDATION 22 ---------- page 38

State Coroner's Guidelines: Authorisation to issue a cause of death certificate

1. That the State Coroner, in consultation with medical advisers, relevant agencies and professional bodies, 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.
2. That, in the development of such guidelines the State Coroner give consideration to the process in Queensland which requires medical practitioners to obtain input from family about concerns and provide to the coroner copies of the deceased's discharge summary, recent hospital admission notes and the draft cause of death certificate.

RECOMMENDATION 23 ---------- page 38

Review of 'Death in Hospital' form

That the State Coroner and the Department of Health jointly review the current 'Death in Hospital' form to incorporate changes to reporting requirements under the Coroners Act, and to ensure that information relevant to a coroner's decision to authorise the issue of a death certificate is adequately recorded.

RECOMMENDATION 24 ---------- pages 40

Review of 'Medical Certificate of Cause of Death' form

That the State Coroner and the Registry of Births, Deaths and Marriages jointly review the current 'Medical Certificate of Cause of Death' (Form BDM 202) with specific consideration to providing for the following requirements:

1. That, in the case of a reportable death, the certifying doctor must note on whose authority the cause of death certificate was issued.
2. That the certifying doctor must undertake an external examination of the deceased's body, where practicable, and note any observations on the death certificate.
3. That the certifying doctor must acknowledge that he or she is aware that it is a requirement of the Coroners Act to report a reportable death.

RECOMMENDATION 25 ---------- page 41

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 and, if known, the name and contact details of the Funeral Director who has been engaged to dispose of the deceased's remains.

RECOMMENDATION 26 ---------- page 42

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

That, where after a period of three months from the date of death has elapsed no coronial determination has been made and further delay is expected, the Office of the State Coroner provide the Registry of Births, Deaths and Marriages with an interim determination under s 28(2) of the Coroners Act. Such interim determination should have 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 any insurance, superannuation or other claims.

RECOMMENDATION 27 ---------- page 45

State Coroner's Guidelines: Police

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

RECOMMENDATION 28 ---------- page 46

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.

RECOMMENDATION 29 ---------- page 47

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 must 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: $12,000 or 12 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.

RECOMMENDATION 30 ---------- page 47

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 $12,000 or 12 months' imprisonment.

RECOMMENDATION 31 ---------- page 48

Regulations for dealing with items seized by coroner's investigators

That the State Coroner and the Department of the Attorney General produce regulations to deal with how things seized pursuant to the power under s 33 of Coroners Act are kept and dealt with during the period of investigation, and how they are returned or disposed of after the investigation into the death is finished or if it is determined that there is no jurisdiction under the Coroners Act to investigate the death.

RECOMMENDATION 32 ---------- pages 49–50

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 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 a lawful excuse for failure to comply with a requirement to provide the coroner a written report does not include that the provision of the written report will criminate or tend to criminate the medical practitioner.
5. That a medical practitioner may, within the time specified for providing the written report, notify the coroner that the medical practitioner objects to the provision of the report on the ground that it will criminate or tend to criminate the medical practitioner.
6. That, subject to s 47 of the Coroners Act (or its equivalent in future legislation), the coroner may require the medical practitioner to provide the report within such further period of time as is specified by the coroner.
7. That the Coroners Regulations be amended to provide for a fee for medical practitioners who are not in receipt of a salary from the state for the provision of a medical report requested by the coroner pursuant to this power.
8. That the State Coroner, in consultation with relevant agencies and professional bodies, develop protocols to govern what is a reasonable time for compliance with a request made under this power and that such protocols may include different times for the provision of reports depending upon the level of detail required.

RECOMMENDATION 33 ---------- pages 51–52

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, where a prepared statement is requested of a healthcare professional, the healthcare professional be provided, where directed by the coroner or where requested by the healthcare professional, with a copy of any post mortem examination report and results of tests ordered by forensic pathologists in respect of the deceased and that the healthcare professional be advised of any concerns relating to the treatment of the deceased that the statement should address.

4. 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.

5. That a lawful excuse for failure to comply with a requirement to provide a document to the coroner or to prepare and provide a statement to the coroner does not include that the provision of the document or preparation and provision of the statement to the coroner will criminate or tend to criminate the person.

6. That a person may, within the time specified for preparing and providing a statement to the coroner, notify the coroner that the person objects to the preparation and provision of the statement on the ground that it will criminate or tend to criminate the person.

7. That, subject to s 47 of the Coroners Act (or its equivalent in future legislation), the coroner may require the person to prepare and provide the statement within such further period of time as is specified by the coroner.

RECOMMENDATION 34 page 53

Extend protection against self-incrimination

1. That the provisions permitting a coroner to grant a certificate under the Coroners Act (currently s 47) be extended to apply where a person objects to preparing and providing a written report or statement required to be provided to the coroner on the ground that it will criminate or tend to criminate the person.

2. That the protection provided for a person by a certificate given under the Coroners Act (currently s 47) extend to protection against the use of the statement, report or evidence in subsequent criminal, civil or disciplinary proceedings against the person other than for an offence under the Coroners Act or arising from giving false or incomplete information or evidence.

RECOMMENDATION 35 page 53

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.

RECOMMENDATION 36 page 55

Cooperation between workplace safety inspectors and coronial police

That the Coronial Investigation Unit and workplace safety agencies (ie, the Department of Mines and Petroleum, EnergySafety and WorkSafe) 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.

RECOMMENDATION 37 ---------- page 56

Information sharing and confidentiality

1. 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.
2. That a coroner may only disclose information obtained pursuant to paragraph 1 for a purpose connected with the investigation being conducted by the coroner.
3. That a person who has been given access to confidential information by a coroner, must not directly or indirectly disclose the information other than for the purposes of the investigation or unless the disclosure is permitted or required under the Coroners Act or another Act and that breach of such provision be an offence punishable by a fine of $12,000 or 12 months' imprisonment.
4. That the Coroners Act be prescribed in the Regulations for the purposes of disclosure of information under proposed s 271 'Confidentiality of Information' of the Western Australian Model Health and Safety legislation.

RECOMMENDATION 38 ---------- page 59

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.

RECOMMENDATION 39 ---------- page 59

State Coroner's Guidelines: Deaths in custody

That the State Coroner review and update the guidelines for the investigation of deaths in custody.

RECOMMENDATION 40 ---------- page 60

Coronial training for Major Crime Squad

That, in consultation with the State Coroner, 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.

RECOMMENDATION 41 ---------- page 60

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.

RECOMMENDATION 42 ---------- page 61

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.

RECOMMENDATION 43 ---------- page 62

Oversight of police-related deaths by Corruption and Crime Commission

That the Corruption and Crime Commission actively monitor and review police investigations into all police-related deaths and provide a report to the coroner about the integrity, depth and nature of the investigation.

RECOMMENDATION 44 ---------- page 65

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 coroner's investigators be established within the Office of the State Coroner. The coroner's investigators attached to this team should include at least one police detective and one investigator with experience in the nursing profession. The functions of this team should include:

- investigation of deaths in hospitals and healthcare facilities;
- provision of medical advice to the coroner on all relevant cases 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 Department of Health and professional bodies, 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.

RECOMMENDATION 45 ---------- page 66

Investigation of deaths in mental health facilities

That the Western Australia Police Coronial Investigation Unit, in consultation with the Department of Health, develop protocols for police investigation of deaths in mental health facilities.

RECOMMENDATION 46 ---------- page 66

State Coroner's Guidelines: Investigation of possible mental health-related deaths

That the State Coroner, in consultation with relevant agencies, 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.

RECOMMENDATION 47 ---------- pages 67–68

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.

(6) 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 to investigate a death as if that death were a reportable death.

RECOMMENDATION 48 ---------- pages 72–73

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 any person 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.

RECOMMENDATION 49 ---------- page 73

Coroner's discretionary comment function

That the power of coroners to make discretionary comments (currently s 25(2) of the Coroners Act) 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.

RECOMMENDATION 50 ---------- page 74

Re-opening of investigation or inquest on coroner's initiative

1. That a section be inserted into the Coroners Act to provide:
2. 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.
3. 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.

RECOMMENDATION 51 ---------- pages 74–75

Application to coroner to re-open investigation or inquest

1. That a section be inserted into the Coroners Act to provide:
2. 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.
3. That the Coroners Court may only make an order under paragraph 1 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.
4. 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.
5. That the decision of the Coroners Court in respect of such an application must be in writing.

RECOMMENDATION 52 ---------- page 75

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.

RECOMMENDATION 53 ---------- page 76

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.

RECOMMENDATION 54 ---------- page 76

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.

RECOMMENDATION 55 ---------- page 78

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 (under Recommendation 59), 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.

RECOMMENDATION 56 ---------- page 79

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 consistent with 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.

RECOMMENDATION 57 ---------- page 81

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 Recommendation 58) and that deaths of persons falling within the definition of 'person held in care' (defined in Recommendation 59) 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 Recommendation 58) be the subject of a mandatory inquest.

4. That deaths of persons falling within the definition of 'person held in care' (defined in Recommendation 59) 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.

RECOMMENDATION 58 ---------- page 82

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 ss 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.

RECOMMENDATION 59 ---------- page 83

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.

RECOMMENDATION 60 ---------- page 83

State Coroner's Guidelines: Persons held in custody and 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.

RECOMMENDATION 61 ---------- page 84

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 work together with relevant departments or agencies (including the Department of Corrective Services, the Department for Child Protection, the Department of Health, 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.

RECOMMENDATION 62 ---------- page 84

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 (currently s 23(2)).

RECOMMENDATION 63 ---------- page 85

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.

RECOMMENDATION 64 ---------- page 86

State Coroner's Guidelines: When inquest should be held

That the State Coroner produce guidelines for coroners to assist them in the exercise of their discretion as to whether or not to hold an inquest.

RECOMMENDATION 65 ---------- page 86

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.

RECOMMENDATION 66 ---------- pages 86–87

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.

RECOMMENDATION 67 ---------- page 87

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.

RECOMMENDATION 68 ---------- pages 88–89

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 and 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.

RECOMMENDATION 69 ---------- page 90

Inquest brief to be provided by Coroners Court

That the Coroners Act provide that:

1. 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. An inquest brief does not include any part of a medical file that the coroner considers to be irrelevant to the inquest.

3. 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.

RECOMMENDATION 70 ---------- page 90

Inquest brief in electronic form

That, at the earliest opportunity, the Coroners Court institute a strategic trial for the provision of inquest briefs to interested persons in electronic form.

RECOMMENDATION 71 ---------- page 91

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 the Coroners Court may order a person concerned with the investigation to attend the pre-inquest hearing.

RECOMMENDATION 72 ---------- page 92

Notification and publication of pre-inquest and inquest hearing dates

1. That the Coroners Act provide that notice of the date, time, place and subject of a pre-inquest and inquest hearing shall be provided to interested persons and be published by the Coroners Court.
2. That the State Coroner produce guidelines about the manner and time of publication of pre-inquest and inquest hearing dates and of notification of interested persons.

RECOMMENDATION 73 ---------- page 92

Procedural fairness – identifying interested persons

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.

RECOMMENDATION 74 ---------- page 93

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.

RECOMMENDATION 75 ---------- page 94

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 it is not the forum in which criminal guilt or civil liability 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.

RECOMMENDATION 76 ---------- page 94

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 its compulsory Continuing Professional Development program) to lawyers about the inquisitorial functions, procedures and culture of the Coroners Court.

RECOMMENDATION 77 ---------- page 96

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.

RECOMMENDATION 78 ---------- page 97

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.

RECOMMENDATION 79 ---------- page 97

Interruption of an inquest

That the penalty for breach of the offence of interrupting an inquest include a term of not more than 12 months' imprisonment or a maximum fine of $12,000.

RECOMMENDATION 80 ---------- page 97

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.

RECOMMENDATION 81 ---------- page 98

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 $12,000 for individuals and $60,000 for corporations.

RECOMMENDATION 82 ---------- page 98

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.

RECOMMENDATION 83 ----------page 102

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.

RECOMMENDATION 84 ---------- page 103

Coroner's 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 person.

RECOMMENDATION 85 ---------- page 104

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; and

(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.

RECOMMENDATION 86 ---------- page 105

Notification of coroner's 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 Recommendation 87.

RECOMMENDATION 87 ---------- page 107

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, or such other time as agreed between the public statutory authority or public entity and the State Coroner, 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, unless otherwise ordered by the State Coroner, 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.

4. That the state government give consideration to whether private entities performing public functions be subject to the same mandatory response requirement as public statutory authorities and public entities.

RECOMMENDATION 88 ---------- page 112

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.

RECOMMENDATION 89 ---------- page 114

Coronial Counselling Service

1. That the State Coroner consider renaming the Coronial Counselling Service to remove any stigma that may attach to seeking 'counselling' for users of the service and to better describe the coronial liaison and information services provided.

2. That consideration be given to providing the service with a dedicated administrative assistant.

RECOMMENDATION 90 ---------- page 115

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.

RECOMMENDATION 91 ---------- page 116

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, in consultation with relevant stakeholders, develop information packages that can be distributed to relevant industries and included, where possible, in industry training initiatives.

RECOMMENDATION 92 ---------- page 117

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.

RECOMMENDATION 93 ---------- page 119

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 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.

RECOMMENDATION 94 ---------- page 120

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 the senior next of kin of a deceased, and other family members at the coroner's discretion.

RECOMMENDATION 95 ---------- page 121

Release of post mortem examination report

1. That, upon written request of the senior next of kin of a deceased person, and 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 senior next of kin 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 senior next of kin after the contents of the report have been interpreted and explained, if requested.

3. That a notice be placed on the Coroners Court website stating that the senior next of kin of a deceased person may request a copy of the post mortem examination report.

RECOMMENDATION 96 ---------- page 122

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.

RECOMMENDATION 97 ---------- page 122

State Coroner's Guidelines: Review, update and publish

1. That, in addition to issuing guidelines about the specific matters addressed in recommendations throughout this Final Report, 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.

RECOMMENDATION 98 ---------- page 123

Coronial forms

1. That forms to assist families and others to exercise their rights or discharge their obligations under the Coroners Act be developed by the Office of the State Coroner and be 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.

RECOMMENDATION 99 ---------- pages 124–25

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.

RECOMMENDATION 100 ---------- page 126

Police to seal body bags

That the Western Australia Police adopt a practice 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 loss or contamination of evidence prior to post mortem examination. Separate sealing techniques or procedures may need to be considered to differentiate between suspicious deaths and non-suspicious deaths and identification of the deceased should be clearly noted on the outside of the bag.

RECOMMENDATION 101 ---------- page 127

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.

RECOMMENDATION 102 page 128

Principles governing 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, 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 should use the least invasive procedures that are available and 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,
   (d) a partial post mortem examination.

RECOMMENDATION 103 pages 129–30

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 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.

RECOMMENDATION 104 page 130

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.

RECOMMENDATION 105 page 132

Time for objection to internal 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 internal post mortem examination is conducted until at least a period of 48 hours 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 senior next of kin of a deceased may waive their right to object to an internal post mortem examination at any time after receiving the coroner's brochure 'When a Person Dies Suddenly'
3. That the coroner's brochure 'When a Person Dies Suddenly' be amended to reflect the increase in time for objection to 48 hours and that the senior next of kin of a deceased may waive their right to object to an internal post mortem examination.

RECOMMENDATION 106 page 132

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.

RECOMMENDATION 107 page 134

Preparation of bodies for release from State Mortuary

1. 1. 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.
2. 2. That, if a body contains a pacemaker or other electronic device a notation to this effect is to be placed on the release documentation and/or body tag for the attention of the funeral director.

RECOMMENDATION 108 ----------page 134

Preparation of bodies for transport outside the Perth metropolitan area

That the State Coroner ensure that contracts for body transport address the need to wrap bodies for transport purposes upon pick-up from the State Mortuary to prevent seepage of body fluids on journeys outside the Perth metropolitan area.

RECOMMENDATION 109 ----------page 134

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.

RECOMMENDATION 110 ----------page 136

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.

RECOMMENDATION 111----------page 136

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 them or to a funeral director appointed by them.

(2) If two 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 two 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.

RECOMMENDATION 112 ---------- page 136

Supreme Court review of coroner's decision to release a body

1. 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 by a coroner pursuant to Recommendation 111 on the basis of an error of law.

2. That such application must be made within 48 hours of the coroner's determination.

RECOMMENDATION 113 ----------page 137

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: List of submissions and people consulted

SUBMISSIONS

Alistair Hope, State Coroner, Office of the State Coroner (WA)

Andrea Crichton-Browne, Director of Legal and Special Investigations, WorkSafe

Andrea McCallum, Senior Legal Officer, Health and Disabilities Service Complaints Office

Australian Inquest Alliance (incorporating the Deaths in Custody Watch Committee (WA); the Aboriginal Legal Service (WA); the Federation of Community Legal Centres Inc (Vic); the Aboriginal Legal Service Ltd (NSW/ACT); the Aboriginal Legal Rights Movement Inc (SA); the Aboriginal and Torres Strait Islander Legal Service Ltd (Qld); the Victorian Aboriginal Legal Service Cooperative Ltd; and the North Australian Aboriginal Justice Agency)

Belinda Jennings, Clinical Midwife Consultant, Perinatal Loss Service, King Edward Memorial Hospital

Brett Burns, Registrar, Registry of Births, Deaths and Marriages (WA)

Brian Begg, Funeral Director, Just Cremations

Chris Field, Ombudsman Western Australia

David McCann, Former Perth Coroner

Department of the Attorney General (WA)

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Dr Adrian Charles, Perinatal/Paediatric Pathologist

Dr Derek Pocock, Former State Forensic Pathologist

Dr Ron Chalmers, Director-General, Disability Services Commission

Dr Tom Hitchcock, Clinical Director, Directorate of Critical Care & Emergency Physician, Fremantle Hospital

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Evelyn Vicker, Deputy State Coroner, Office of the State Coroner (WA)

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Maria Osman, Executive Director, Office of Multicultural Interests (WA)

Michael Barnes, State Coroner, Office of the State Coroner (Qld)

Michelle Scott, Commissioner for Children and Young People (WA)

Peter Dodd, Solicitor Health Policy and Advocacy, Public Interest Advocacy Centre
Peter Forbes, Chief Executive Officer, MDA National
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Steven Heath, Chief Magistrate, Magistrates Court of Western Australia
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The Commission thanks the following people for their input, advice or assistance during this reference.

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Allan Anderson, Invocare
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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
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Magistrate Paul Roth, South Hedland Magistrates Court
Magistrate Stephen Sharratt, Geraldton Magistrates Court
Magistrate Steve Wilson, Northam Magistrates Court

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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.