Coroner's Court of Western Australia

Guideline: Aboriginal Deaths in Custody

December 2024

Guideline - Aboriginal Deaths in Custody

1. Preamble

1.1. One of the functions of the State Coroner is to issue guidelines in accordance with the *Coroners Act 1996* (WA) (Coroners Act).[1]

1.2. In particular, the State Coroner may issue guidelines relating to: [2]

1. the administration of the coronial system;
2. the functions of coroners, coroner's registrars and coroner's investigators; and
3. the manner in which those functions are to be carried out.[3]

Purpose of Guideline

1.3. This coronial Guideline concerns the investigation of "Deaths in Custody" of Aboriginal persons. The coroner is required to hold an inquest in respect of every death in custody and must comment on the quality of supervision, treatment and care of the person while in that care.[4] These inquests are sometimes referred to as mandatory inquests.

1.4. This Guideline is directed towards coroners, coroner's registrars, staff of the Coroner's Court of Western Australia (Coroner's Court), coroner's investigators, and investigative agencies[5] that submit reports to the coroner. It aims to provide clarity regarding the support available to Aboriginal families navigating the coronial process following the death of a loved one in custody. The Guideline also outlines the statutory obligations for investigative agencies and details the reporting timelines expected by the Coroner's Court. The State Coroner requests that investigative agencies use best endeavours to comply with these timelines, where possible, to support efficient case management.

1.5. With a focus on culturally appropriate practices and holistic support services, this Guideline seeks to bridge the gap between formal coronial processes and Aboriginal family structures and cultural sensitivities concerning their deceased loved ones, with the aim of ensuring that bereaved families receive the tailored assistance they need during their time of grief.

1.6. The Royal Commission into Aboriginal Deaths in Custody, established in 1987 and concluded in 1991, was a landmark inquiry in Australia. Among its significant recommendations were reforms targeting coronial practices and procedures. These recommendations aimed to enhance the transparency, accountability, and cultural sensitivity of investigations into Aboriginal Deaths in Custody, ultimately seeking to address systemic inequalities within the justice system. Relevantly, the Final Report's recommendation 8 stated:

> That the State Coroner be responsible for the development of a protocol for the conduct of coronial inquiries into deaths in custody and provide such guidance as is appropriate to Coroners appointed to conduct inquiries and inquests.[6]

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[1] *Coroners Act 1996* (WA), s 8(e).
[2] *Coroners Act 1996* (WA), s 58(2)(a).
[3] *Coroners Act 1996* (WA), s 58(2)(e).
[4] *Coroners Act 1996* (WA), s 22(1)(a) - (c), 25(3).
[5] Such as the Western Australia Police Force and the Corrective Services Division of the Department of Justice.
[6] *Royal Commission into Aboriginal Deaths in Custody* (Final Report, April 1991) vol 5. <RCIADIC - National Report Volume 5 (austlii.edu.au)>.

1.7. Similarly, the Law Reform Commission of Western Australia undertook a thorough review of coronial practice in this State, aimed at addressing systemic concerns, enhancing procedural fairness and ensuring cultural sensitivity, particularly in cases involving Aboriginal persons. Central to the Commission's recommendations was the call for revised guidelines prioritising transparency, thoroughness and inclusivity to improve outcomes for families, communities and the justice system as a whole. In particular, the Final Report's recommendation 39 stated:

> That the State Coroner review and update the guidelines for the investigation of deaths in custody.[7]

1.8. Informed by these recommendations, this Guideline emphasises a broader understanding of coronial inquiry beyond mere medico-legal determinations. It acknowledges the imperative to delve into underlying factors, structures and practices contributing to avoidable deaths, particularly within Aboriginal communities. By adopting a trauma-informed approach, the Coroner's Court commits to unravelling the truth behind each death and formulating actionable recommendations aimed at preventing further tragedies, thereby honouring the memory of the deceased.

1.9. Consistent with the Reconciliation Statement of the Heads of Jurisdiction of Western Australia made on 29 May 2023, the State Coroner and the Coroner's Court commits to ensuring that the court is culturally sensitive and safe for Aboriginal persons whose loved ones have died in custody. This is a whole of office responsibility, with the State Coroner expecting that all interactions with Aboriginal families who engage with the coronial system foster trust and confidence in the process. The Coroner's Court and its staff recognise the significant barriers that Aboriginal persons have historically faced in accessing justice, and the tragedy of their over-representation in the criminal justice system, and consequently, their deaths in custody.

1.10. The State Coroner has reviewed practices and procedures within the coronial jurisdiction and seeks to implement these recommendations through this Guideline.

Rationale for a specific Guideline

1.11. The necessity for a dedicated Guideline addressing Aboriginal Deaths in Custody is underscored by the challenges faced by Aboriginal communities, including intergenerational trauma and systemic disadvantages that have resulted in poor health outcomes and over-representation in the criminal justice system. By implementing the above recommendations from the Royal Commission and the Law Reform Commission, the State Coroner acknowledges the need for tailored practices that account for cultural considerations and historical context. While the underlying statutory procedural framework remains consistent, this Guideline serves to supplement existing practices with culturally sensitive support mechanisms, ensuring culturally appropriate treatment for Aboriginal families affected by such tragedies.

2. Objects

2.1. The object of this Guideline is to ensure that:

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[7] Law Reform Commission of Western Australia, *Review of Coronial Practice in Western Australia*, (Final Report, Project No 100, January 2012). <https://www.wa.gov.au/system/files/2021-02/LRC-Project-100-Final-Report_0.pdf>.

1. All inquests into the deaths of Aboriginal people in custody are conducted in a manner that is culturally sensitive and appropriate, respecting the needs of Aboriginal people and their families.

2. The families of Aboriginal people are engaged early in the coronial process, provided with timely support and information about their rights, and offered a dedicated pathway to raise cultural considerations throughout the process, including regular updates on the status of the coronial investigation and reasons for delays.

3. Overview of coronial process

3.1. The functions of the State Coroner include ensuring the efficient administration and operation of the State coronial system, as well as ensuring the investigation of all reportable deaths reported to the coroner.[8] As judicial officers of the Coroner's Court, coroners investigate sudden, unexplained, and/or custodial deaths to determine, if possible, the cause and circumstances of each death. [9]

3.2. The coroners are assisted by the coroner's investigators, the counsel assisting the coroner, coroner's registrars, counsellors, information officers, and administrative staff of the Coroner's Court. In particular, the State Coroner has a statutory obligation to ensure that a counselling service is attached to the Coroner's Court.[10]

3.3. The officers of the Coronial Counselling and Information Service (CCIS), as far as practicable assist any person coming into contact with the coronial system by providing information and initial counselling to those affected by the death being investigated.

3.4. To enhance Aboriginal representation and engagement with the CCIS, a dedicated Senior Aboriginal Liaison Officer (SALO) in the Coroner's Court is able to work alongside the counsellors and other coronial service providers in providing support and information to Aboriginal court users in a culturally appropriate manner where possible.

3.5. When a death in custody occurs, paramedics and police will usually attend and investigate the scene. Upon taking jurisdiction over a death in custody, the coroner must notify the senior next of kin about the likely post mortem examination and their rights. This notification is usually undertaken by police as detailed below.

3.6. In general terms, the senior next of kin is usually one of the closest and first available family members of the deceased at the time of death, out of all possible family members or representatives of the deceased.[11] Police will identify and notify the senior next of kin of the death and serve them with a brochure titled "When a Person Dies Suddenly." This brochure outlines the role of the coroner and the rights of the senior next of kin, including the right to object to the post mortem examination or to have an independent doctor present. Aboriginal families are also provided a culturally relevant version of the brochure and may have access to the coronial counselling and Aboriginal liaison support services when discussing the identification of the senior next of kin and the contents of the brochure (see below).

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[8] *Coroners Act 1996* (WA), ss 8(a), 8(c).
[9] *Coroners Act 1996* (WA), s 25.
[10] *Coroners Act 1996* (WA), s 16.
[11] Section 37(5) of the *Coroners Act 1996* (WA) sets out the seniority order for identifying the senior next of kin to ensure that the 'first available' senior next of kin is selected based on this order.

3.7. After a death in a custodial setting the deceased's body is conveyed to the State Mortuary and held there until the forensic pathologist is directed by the coroner to conduct a post mortem examination. A forensic pathologist is a medical specialist who performs post-mortem examinations, either externally, by inspecting the body's surface and conducting a CT scan, or internally, through an autopsy, to formulate a medical opinion on the cause and manner of death. This examination may also involve a review of the deceased's medical notes, if available.

3.8. Upon request, family members are generally able to visit the Bereavement Centre at the State Mortuary to view or in some cases touch the deceased's body when the body is held there. The timing and manner in which the viewing will occur will be determined by the coroner in consultation with family members, the staff members of the Coroner's Court, and the State Mortuary (see below). Once the forensic pathologist's examinations of the body are complete the body is released by the coroner to a funeral director nominated by the family, for burial or cremation by the family of the deceased.

3.9. Burial disputes can arise when there are multiple requests for the release of a deceased's body. The coronial counselling and Aboriginal liaison support services may assist in mediating such disputes directly or may refer the family members to the Department of Justice's Aboriginal Mediation Service (see below). If an agreement cannot be reached between family members, the coroner will make a decision based on the evidence provided by the involved parties, with an opportunity for applications for review to the Supreme Court of Western Australia.

3.10. The forensic pathologist may be able to form an early opinion on cause of death, or they may need to order further testing of tissue samples taken from the body of the deceased, to assist with formulating their opinion on cause of death. When all examinations are complete, the forensic pathologist provides the coroner with their opinion on the cause of death, which will include a formal written report. The length of time this takes will vary from case to case, depending on complexity of investigations required.

3.11. Officers from the Western Australia Police Force (police) and two divisions of the Department of Justice (Department) prepare reports for the coroner. Specifically, the Corrective Services Division (Corrective Services) and the Performance, Assurance and Risk Directorate, within the People, Culture and Standards Division, each prepare separate reports for the coroner (see Part 12 below). These reports outline their respective agencies' investigations and/or review of actions undertaken while the deceased was in custody. The Department's reports, in particular, address aspects of the supervision, treatment, or care of the deceased person while held in custody.

3.12. Once the investigations and reports to the coroner are completed, in consultation with the coroner, counsel assisting prepares the matter for inquest. This preparation involves compiling a brief of evidence, which includes written materials relevant to the inquiry (the coronial brief).

3.13. An inquest is a public legal inquiry held in the Coroner's Court, conducted by the coroner to investigate the circumstances surrounding a death, determine the cause and manner of death, and identify any contributing factors. During the inquest, counsel assisting presents the evidence, and the coroner examines this along with documentary materials, in order to make findings. These findings aim to provide answers for the bereaved. In addition, the coroner may make recommendations for preventing future deaths or improving systems and practices.

3.14. Throughout the coronial process, families are kept informed and may participate by providing information or witness testimonies to aid in the investigation, either through the legal practitioner representing them or directly to the Coroner's Court if they are not legally represented.

3.15. Once the inquest is complete, the coroner will review all of the evidence and write a report, that contains the findings as to cause and manner of death, outlines the circumstances surrounding the death, makes any required comments on the treatment, supervision and care provided to the deceased and may make recommendations aimed at preventing similar deaths in the future. This report is referred to as the "Inquest Finding" and is contained in the formal 'record of investigation into a death'.[12]

3.16. The coronial process emphasises transparency, accountability, and the protection of public safety.

4. Summary of Aboriginal support services

Counselling and Aboriginal liaison

4.1. Members of the CCIS, working together with the SALO, will use their best endeavours to provide culturally sensitive and culturally safe support to families before, during, and after the inquests into the deaths of their loved ones. This support includes:

1. Regularly updating the families on the progress of the coronial investigation, including any delays and the reasons for them;

2. Assisting police, where practicable, with considerations concerning the identification of the senior next of kin and, where requested by family members, explaining the contents of the brochure titled "When a Person Dies Suddenly.";

3. Liaising with the State Mortuary staff to make arrangements for next of kin family members who request to view and/or touch the deceased body at the Bereavement Centre;

4. Assisting with the negotiation and mediation of potential burial disputes when there are multiple requests for the release of a deceased's body or may advise family members about the Department's Aboriginal Mediation Service;[13] and

5. Inquiring with the family members as to any cultural considerations they would like the presiding coroner to consider during the conduct of the inquest (see 4.3 below).

4.2. Where any of the next of kin family members are represented by a legal practitioner, the counsel assisting the coroner will seek the legal practitioner's permission for the members of the CCIS and/or the SALO to provide support to their client. Permission is required before direct support may be provided.

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[12] *Coroners Act 1996* (WA), s 26(1); *Coroners Regulations 1997* (WA), r 6, Form 3.

[13] Aboriginal Mediation Service', *WA Government - Department of Justice* (Web Page, 31 October 2024) <https://www.wa.gov.au/organisation/department-of-justice/aboriginal-mediation-service>; If mediation is unsuccessful, the coroner will make a decision based on the evidence provided by the involved parties, with an opportunity for applications for review to the Supreme Court of Western Australia.

Culturally sensitive inquest

4.3. The coroner will as far as practicable ensure that an inquest is conducted in a culturally sensitive and safe manner. This includes taking account of any cultural considerations raised by the family of the deceased in discussions with counsel assisting and/or members of the CCIS and the SALO. These considerations may include:

1. The name the family wish to use for the deceased throughout the duration of the inquest hearing(s) and appropriate cautions about the use of the name;

2. The display in the Coroner's Court of a photograph of the deceased at certain stages during the inquest;

3. An appropriate acknowledgement of country; and

4. The display and use in the Coroner's Court of symbols and/or items of cultural significance to the deceased and their family during the inquest.

4.4. Counsel assisting, the members of the CCIS and/or the SALO will all take the opportunity to inquire with the family of the deceased with respect to these matters before the commencement of the inquest proceedings. If the family are represented by a legal practitioner, those inquiries will be made with their legal practitioner by the counsel assisting.

5. Application of Guideline

5.1. This Guideline applies to all coronial investigations of Aboriginal Deaths in Custody under the Coroners Act.[14]

5.2. Upon application being made, with reasons, the State Coroner may direct that this Guideline applies only in part. This may occur after counsel assisting or the SALO or a member of the CCIS consults with the family of the deceased.

6. Coroner's duty to investigate

6.1. Coroners only investigate "reportable deaths".[15]

6.2. The definition of "*reportable death*" in the Coroners Act includes a person whom immediately before their death was a person "*held in care*", which is relevantly defined as being held in, escaping from or being transported to and 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*".

6.3. All deaths in custody in Western Australia are subject to a mandatory inquest.[16] A mandatory inquest is a legal requirement imposed by the Coroners Act, compelling the coroner to conduct a formal hearing to determine how the death occurred, its cause and manner, and to make comments on matters connected with the death including public safety and the administration of justice.

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[14] *Coroners Act 1996* (WA), s 22(1)(a) – (c).
[15] *Coroners Act 1996* (WA), s 3 (definition of 'reportable death'), s 19(1).
[16] *Coroners Act 1996* (WA), s 22(1) (a) - (c).

6.4. The requirement to hold an inquest where there has been a death in custody reflects the community's concerns about the treatment of those who are deprived of their liberty, and who were in custody immediately before death. They are unable to make their own independent choices concerning access to medical care, and are dependant on the care provided to them.

6.5. When there is a death in custody, the coroner who holds the inquest must comment on the quality of supervision, treatment and care of the person while in that care.[17]

7. Deaths in custody or police presence

7.1. This part of the Guideline aims to enhance understanding and compliance with reporting obligations under the Coroners Act for investigative agencies.

Deaths in prison custody

7.2. Generally, deaths in custody refer to a death that occurred in a prison whether by natural causes, or whether the death was unnatural (such as by suicide), violent, or resulting from injury. In addition to a prison, there are various other settings in which a death will be considered a death in custody for the purpose of the Coroners Act. These include deaths of persons under the care of Corrective Services outside a prison and young persons in juvenile detention. Each of these settings is further elaborated on below.

7.3. Deaths in custody encompass situations where:

1. Individuals are detained in prison for various reasons, including serving a sentence, awaiting trial, contempt of court or Parliament, or as otherwise mandated by law. It includes any other case where an individual remains in lawful custody;[18]

2. People who are in the care of Corrective Services outside a prison. For example, people who are in custody at a Court, in a lock-up, in a hospital for medical treatment, and people being moved between custodial places;[19]

3. Young persons held in juvenile detention,[20] which may include, where relevant, the contexts above in which the young person is detained for the purpose of the administration of criminal justice.

Deaths involving police

7.4. Deaths in custody can also occur, as previously stated, where the person is under, or escaping from, the control, care or custody of police, or a person whose death "*appears to have been caused or contributed to by any action of a member of the Police Force*".[21]

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[17] *Coroners Act 1996* (WA), s 25(3).
[18] *Prisons Act 1981* (WA), s 3 (definition of 'prisoner').
[19] *Coroners Act 1996* (WA), s 3 (definition of 'person held in care' para (aa)); *Court Security and Custodial Services Act 1999* (WA), ss 10, 13, 15 - 16.
[20] *Coroners Act 1996* (WA), s 3 (definition of 'person held in care' para (d)).
[21] *Coroners Act 1996* (WA), s 3 (definition of 'person held in care' para (a)(iii) and definition of "reportable death" para (g)).

7.5. Common types of cases that involve members of the police are:[22]

1. Deaths in the course of police pursuit of vehicles, also known as evade police intercept driving;

2. Deaths of arrested people in police custody, for example a person who dies of natural causes or by suicide while in police custody;

3. Deaths that raise questions of excessive use of force, for example a person who dies in the course of being restrained by police or as a result of the deliberate infliction of lethal force;[23] and

4. Deaths that raise issues concerning standards of care, for example the police's treatment of a vulnerable person or their failure to seek medical treatment.[24]

7.6. Some of these deaths are referred to as "deaths in police presence". Whether a death comes within the scope of a death in police presence requiring an inquest will be determined by the State Coroner with reference to the particular circumstances of each case.

8. Notification to the coroner

8.1. A death in custody must be reported immediately to the coroner by the person under whose care the deceased was held, in accordance with the requirements of section 17(5) of the Coroners Act.

8.2. The Commissioner of Corrective Services[25] or the member of the police in charge has a statutory duty to report deaths in their custody immediately to the coroner.[26]

9. A death in custody has occurred

9.1. When a death in custody or in police presence occurs, police and paramedics attend. Paramedics will attempt resuscitation, if possible. If it is clear that the person is already deceased or cannot be revived, paramedics will pronounce the person life extinct.

9.2. Once death is confirmed, police secure the scene to preserve evidence, restrict access to authorised personnel, and initiate their investigation. Details about the management of the scene, police powers, and the investigation process are detailed in the *Police investigation and report* section below.

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[22] Hugh Dillon and Marie Hadley, *The Australasian Coroner's Manual* (Federation Press, 2015) 24 [2].
[23] These include the deaths of persons being forcibly restrained and deaths of persons due to police use of weapons.
[24] Such as deaths due to alleged drunkenness or drug intoxication, or poor medical care while in police custody.
[25] The Director General of the Department of Justice has delegated the responsibility for managing the security, control, and welfare of all prisoners, both inside and outside prison, to the Commissioner of Corrective Services. The Commissioner has further delegated the responsibility for immediately reporting a death in custody to the coroner to their Operations Centre. The Superintendent or Officer in Charge directly notifies the police, who notify the Coronial Investigation Squad, which must promptly report the death in custody to the coroner.
[26] The Commissioner of Police has delegated the responsibility for immediately reporting a death in custody to the coroner that involves police to the relevant Officer in Charge of the investigation, who must promptly report the death to the coroner.

10. Identifying and notifying the senior next of kin

10.1. The senior next of kin is an important concept in the Coroners Act and governs who in the deceased person's family may exercise certain substantive rights with respect to the deceased's body. However, it does not mean that the person is more "senior" or important in relation to the rest of the deceased's loved ones, and it does not necessarily mean that the deceased's body will be released to that person by the coroner for burial or cremation.

10.2. The term "senior next of kin" as defined in the Coroners Act refers to the first available individual from the deceased person's family, prioritised in the following order: a spouse or partner living with the deceased, a legally married spouse not living with the deceased, adult children of the deceased, parents of the deceased, adult siblings, an executor named in the deceased's will or personal representative, or an emergency contact nominated by the deceased.[27]

10.3. Aboriginal people have an extended family structure and an important family kinship system which defines where a person fits into their family and community. These family structures and kinship systems are a cohesive force which bind Aboriginal people together, providing support which is essential to their wellbeing. This support is critical throughout the coronial process.

10.4. In recognition of this, references to family and/or next of kin throughout this Guideline should be interpreted flexibly and with respect to these structures and systems. So far as possible, arrangements will be made by members of police to have due regard to the deceased's extended family and community, as is appropriate in the circumstances of each case. Therefore, members of the police will use best endeavours to identify the senior next of kin in the family taking this into account. Where practicable,[28] police may consult with the SALO or, in appropriate cases, seek the input of senior members of the deceased's community to assist with considerations regarding the identification of the senior next of kin, as outlined in section 37(5) of the Coroner's Act.

10.5. As soon as practicable after the coroner takes jurisdiction to investigate the death in custody, the coroner must notify the senior next of kin that a post mortem examination is likely to be performed on the body and that there is a right to object to the examination or to have an independent doctor present at the examination.[29]

10.6. In practice, this legislative requirement is met by a member of police serving a brochure on the senior next of kin titled, "*When a Person Dies Suddenly*". The brochure provides basic information about the role of the coroner and the rights of the senior next of kin. Further, it provides the contact details of the CCIS and other support services available for families and friends of the deceased. In the case of Aboriginal families, the member of police will also serve a culturally relevant version of the brochure, together with the generic brochure referred to above. If requested by family members, the SALO may assist in explaining the brochure's contents.

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[27] *Coroners Act 1996* (WA), s37(5).
[28] Police requests for assistance from the SALO must be made during operational hours, namely, from 8:30am to 4:30pm.
[29] *Coroners Act 1996* (WA), ss 20(d) – (g), 35

11. Dealing with the body

Control of the body

11.1. Once a death becomes a coronial case the coroner investigating the death has control over the body of the deceased.[30]

11.2. At the earliest opportunity police will contact the designated coronial body transport contractor to collect the body and transfer it to the State Mortuary. In Perth, the body will be transferred directly to the State Mortuary. In regional areas the body may need to remain at the local hospital morgue until transportation to the State Mortuary is able to be arranged.

11.3. The body is secured and a P98 (Mortuary Admission) form is completed by a member of police. The form details the known circumstances of the death, including where the body was found and who certified life extinct (meaning who pronounced the person to be deceased).

Touching and viewing the body

11.4. While the body is under the control of the coroner investigating the death, the family of the deceased have a statutory right to view and touch the body, unless the coroner determines that it is undesirable or dangerous to do so.[31]

11.5. The coroner carefully considers whether to make an order directing that the deceased's body may not be touched. Such an order will be made to prevent the potential for evidence to be tainted, to protect the family members from the risk of infection, or to shield them from the distress of witnessing the deceased when their bodily integrity is in a compromised state (for example in the case of severe burns).

11.6. The Coroner's Court CCIS can offer advice to family members planning to attend the State Mortuary to view the body of a loved one. The SALO may be available to assist with making the arrangements for the family to contact the State Mortuary, to view their loved one.

11.7. Upon request, the Aboriginal Family Liaison Officer at the State Mortuary may be able to assist the deceased's family to view a loved one's body in a culturally appropriate manner at the Bereavement Centre. The timing and manner in which the viewing will occur will be determined by the coroner in consultation with family members, the CCIS, the SALO, and State Mortuary staff. Where the body is at a regional hospital morgue, arrangements may be made to view the body in that location. If a coroner orders that the deceased's body cannot be touched, and the post mortem examination has not yet occurred, the family is usually permitted, depending upon the mortuary facility, to see the body through the mortuary glass window or behind a barrier.

11.8. Despite the senior next of kin having specific rights with respect to the deceased's body, they do not have a right under the Coroners Act to refuse certain other family members of the deceased from viewing or touching the body. All the family members listed in the hierarchical structure in section 37(5) of the Coroners Act have a statutory

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[30] *Coroners Act 1996* (WA), s 30(1).
[31] *Coroners Act 1996* (WA), s 20(1)(c), s 30(2).

right to view and touch the body, unless the coroner orders otherwise. Appointments are required in order for family members to view the body. Where possible, the coroner can arrange separate viewings for different family members in consultation with the family and the individuals mentioned above.

Post mortem

11.9. In Western Australia the post mortem examinations are performed by the forensic pathologists at the State Mortuary. They are highly specialised medical procedures. A post mortem examination of the body may involve an external examination only, or the external examination may be followed by an internal examination.

11.10. An external post mortem examination involves an examination of the deceased's body externally by a forensic pathologist to determine any visible signs of injury or disease, the taking of tissue samples for analysis (for example the taking of a blood sample for toxicological analysis), a review of the CT scan of the body and a review of the deceased's medical notes, if available. It is important to note that there will invariably be some form of external post mortem examination of the deceased's body by a forensic pathologist. This examination is typically conducted soon after death and does not involve a dissection of the deceased's body.

11.11. An internal post mortem examination, on the other hand, involves a more detailed examination where, after the external examination, the body is dissected, and internal organs are examined to determine the cause of death. It may involve the taking of further tissue samples for analysis, and/or the retention of organs for analysis (such as the retention of the brain for neuropathological examination).

Post mortem objection process

11.12. The senior next of kin has a statutory right to object to a post mortem examination being performed on the deceased.[32] This objection must be made by the senior next of kin within 24 hours of the report of death to the coroner (except that for deaths in the Kimberley and Pilbara Regions, a period of 72 hours is allowed for an objection, to account for time taken to contact persons in more remote areas).

11.13. If the senior next of kin requests that a coroner refrain from directing a post mortem examination, and, if the coroner deems a post-mortem examination necessary despite the objection, the coroner must notify the senior next of kin in writing and provide a copy to the State Coroner.[33]

11.14. If no objection to a post mortem examination has been made, unless there is an immediate necessity, the post mortem examination does not proceed until one clear working day at least after the senior next of kin has been served with the coronial brochure.[34]

11.15. An example of an immediate necessity to perform a post mortem examination is in the case of a suspected homicide.

11.16. When an objection has been made, the coroner must make a determination whether to direct a post mortem, taking into account the views of any person who asked the

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[32] *Coroners Act 1996* (WA), s 37.
[33] *Coroners Act 1996* (WA), s 37(1).
[34] *Coroners Act 1996* (WA), s 37(2).

coroner to perform the post mortem on the body, and the views of the senior next of kin of the deceased if that person has asked the coroner not to direct a post mortem examination.[35]

11.17. When an objection has been made, unless the coroner believes that a post mortem examination needs to be performed immediately, it must not be performed until two clear working days after the senior next of kin has been given notice of the coroner overruling the objection, or until after any extension of time granted by the Supreme Court of Western Australia (Supreme Court).[36]

11.18. The senior next of kin can also withdraw their objection, allowing the coroner to proceed with directing the post mortem examination.[37] If the senior next of kin maintains their objection, they have the right to apply to the Supreme Court within the specified timeframe to request an order prohibiting the post mortem examination.[38] The Supreme Court may grant an extension of time under exceptional circumstances if deemed necessary in the interests of justice.[39]

11.19. Ultimately, if an application is made to the Supreme Court, the Supreme Court holds the authority to make an order prohibiting the post mortem examination if it deems it desirable given the circumstances.[40]

11.20. In practice, when a person makes a formal objection to a post mortem examination a coronial counsellor will contact the senior next of kin to discuss the objection and ascertain the reason for the objection. They will explain the process above but also how a post mortem examination can benefit the family by providing a more precise answer about the cause of death. The SALO may be involved in discussions explaining the purpose of the post mortem examination to the family.

Release of the body

11.21. Once the forensic pathologist has completed their post mortem examination, and taken any required tissue samples for further testing, the body of the deceased is released from the State Mortuary. In practice the coroner, or their delegate, issues a certificate[41] authorising the disposal of the body for burial or cremation and the body is released to the funeral director nominated by the applicant.

11.22. A coroner investigating a death cannot issue a certificate of release if:

1. a funeral director has not been appointed;

2. there are any pending objections to a post mortem examination, or a request for time extensions to the Supreme Court for a post mortem objection; or

3. there is an application before the Supreme Court regarding the release of the body or the Supreme Court has ordered that the body must not be released.[42]

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[35] *Coroners Act 1996* (WA), ss 36, 37.
[36] *Coroners Act 1996* (WA), s 37(2).
[37] *Coroners Act 1996* (WA), s 37(2a).
[38] *Coroners Act 1996* (WA), s 37(3).
[39] *Coroners Act 1996* (WA), s 37(3a).
[40] *Coroners Act 1996* (WA), s 37(4).
[41] *Coroners Act 1996* (WA), s 29.
[42] *Coroners Act 1996* (WA), s 29(2) – (3).

11.23. The function of issuing of the certificate permitting the disposal of the body by burial or cremation is delegated to the coroner's registrars who may consult with the coroner, as required. The certificate permitting burial, cremation or other disposal is made in the form of Form 4.[43]

11.24. In practice, to release a body from the State Mortuary following a coronial investigation a funeral director must send a "request for removal" of the body on behalf of the person authorising the funeral to the Office of the State Coroner.

11.25. The Office of the State Coroner encourages Aboriginal families to appoint a funeral director to ensure the release of the body at the earliest opportunity. If a funeral director has not been appointed due to financial hardship, the Registry, CCIS and/or SALO is able provide general information to Aboriginal families with respect to potential funding sources, such as bereavement assistance schemes.

Urgent post mortem and early release

11.26. There is a process in place for an application to be made to the coroner for an urgent post mortem examination, and therefore an early release of the body, if there are Aboriginal cultural matters that the family wishes to observe.

11.27. Family members of the deceased must submit a written request for an urgent post mortem examination with their reasons to the CCIS or directly with a member of police, or must provide a verbal account of the reasons for an urgent post mortem examination. Where a verbal account is provided, the person receiving the verbal account must take comprehensive notes.

11.28. The request for the urgent post mortem examination will be submitted to the coroner for decision. A member of the CCIS will communicate the coroner's decision to the applicant. The SALO may become involved in these discussions.

11.29. If the person who applied for the urgent post mortem examination is not the senior next of kin, the senior next of kin has the statutory right to object to the urgent post mortem as outlined above.

Dispute over right to arrange a funeral

11.30. A body dispute issue can arise when the coroner receives more than one request for release of a deceased's body.

11.31. In cases where there is disagreement among family members regarding the release of a body under the control of the coroner, the coroner may intervene to help mediate a resolution.

11.32. The Office of the State Coroner offers assistance through the CCIS to ascertain whether the parties are willing to negotiate to reach an agreement. The Department's Aboriginal Mediation Service may also assist Aboriginal people to resolve potential conflicts with respect to burial disputes.[44] The SALO may become involved in these discussions.

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[43] *Coroners Regulations 1997* (WA), r 7.

[44] 'Aboriginal Mediation Service', *WA Government - Department of Justice* (Web Page, 31 October 2024) <https://www.wa.gov.au/organisation/department-of-justice/aboriginal-mediation-service>.

11.33. If the parties are unable to agree, the coroner may consider evidence provided by the parties to make a decision. The parties will be advised of a timeframe by which to make submissions to the coroner and that submissions should detail the following:

1. Any evidence of the deceased's wishes as expressed in their will or as otherwise identified by the deceased's executor;

2. The reasons each party says the body should be released to them;

3. The requesting party's connection to the deceased; and

4. Confirmation that the requesting party have the financial means or the ability to dispose of the body in an appropriate way, with supporting details.

11.34. If intervention by the coroner is unsuccessful, and the parties are not able to reach agreement, the coroner will make a decision as to whom the body will be released to, but will refrain from executing it for a number of days, so that the aggrieved party has an opportunity to apply to the Supreme Court for an order as to whom the body will be released to and the manner and place of the deceased's burial.

12. Investigation process

Post mortem examination and report

12.1. If a coroner reasonably believes that it is necessary for an investigation of a death, the coroner may direct a pathologist or a doctor to perform a post mortem examination on the body.[45]

12.2. The purpose of the post mortem examination is to assist the coroner in making findings on the cause and/or manner of death.

12.3. Post mortem examinations on the bodies of persons who have died in custody are performed by the forensic pathologists at the State Mortuary, which is part of PathWest Laboratory Medicine WA (PathWest). Forensic pathologists are highly specialised doctors. They are supported by specialist staff who are able to assist them with the examinations.

12.4. PathWest also utilises the services of specialist clinicians in the areas of neuropathology, toxicology, radiology and/or anthropology, when further testing or analysis is required.

12.5. Following the post mortem examination of the body of a deceased, the forensic pathologist provides an interim post mortem report to the coroner in writing. This generally occurs within 48 hours of the post mortem examination. The interim post mortem report may contain a preliminary opinion as to cause of death or the cause may be classified as 'undetermined' and subject to the receipt of toxicological analysis, neuropathology examination or other tests that a forensic pathologist may require. Upon receipt of this interim information, the coroner provides an update to the deceased's next of kin. It is not the final outcome regarding the cause of death.

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[45] *Coroners Act 1996* (WA), s 34.

12.6. A completed and final post mortem examination report (sometimes referred to as a supplementary post mortem report) can take some time to be submitted to the coroner by the forensic pathologist. The time taken may be affected by the type and number of tests that the forensic pathologist awaits, from specialist clinicians. For example, a post mortem report that awaits the analysis of results of complex toxicological analysis and/or neuropathological examinations will require more time to finalise due to the specialised nature of the tests involved.

12.7. In the case of deaths in custody, PathWest is to use its best endeavours to provide the full post mortem report (including the supplementary post mortem report) to the coroner within 6 to 9 months after receiving the coroner's authorisation to perform the post mortem examination.

Police investigation and report

12.8. Under the Coroners Act, members of the police are contemporaneously coroner's investigators,[46] and in every coronial case, a police investigation will occur. The police investigation into a death in custody is directed towards ascertaining the circumstances surrounding the death, including whether there are any suspicious circumstances. The investigation begins immediately upon confirmation that the person is deceased.

12.9. Death in custody investigations on behalf of the coroner are conducted by experienced police officers ordinarily from the Major Crime Division.[47] The Major Crime Division encompasses five units (Homicide, Coronial, Cold Case, Major Crash and Arson) each specialising in the investigation of reportable deaths. In particular, the Homicide Squad and Coronial Investigation Squad provide specialist support to the coroner investigating a death in custody and assist one another in the investigation when required.

12.10. The Homicide Squad is a dedicated unit that specialises in the investigation of homicides, suspicious and unexplained deaths, deaths in custody, and critical incidents involving police. The Coronial Investigation Squad is a dedicated police unit responsible for investigating the majority of reportable deaths. They focus on gathering evidence to assist the coroner in determining the cause and circumstances of death, particularly when the cause is not immediately clear.

12.11. In instances where a death occurs in police custody, or where a death occurs in the custody of another agency and is contributed to by criminal conduct, the investigation will be conducted by Homicide Squad, and a report will be prepared for the coroner. Officers from the Homicide Squad will be notified of the death and will attend the scene, accompanied by forensic crime scene investigators and/or members of the Coronial Investigation Squad, if required. In cases of deaths in police custody or in the presence of police, the police Internal Affairs Unit will also investigate and prepare a report for the coroner.

12.12. For investigations into deaths in non-police custody, officers from the Coronial Investigation Squad will be notified of the death and will attend the scene, accompanied by forensic crime scene investigators and/or members of the Homicide Squad, where appropriate. In particular, if the death in custody is suspected to be a suicide, drug overdose, death caused by injury, or a sudden or unexplained death, the

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[46] *Coroners Act 1996* (WA), s 14(2).

[47] This is in line with recommendation 34 of the Royal Commission into Aboriginal Deaths in Custody Final Report, which required that the most qualified death investigators be responsible for death in custody investigations.

Coronial Investigation Squad will assist the Homicide Squad in the investigation by providing specialised support and evidence gathering.

12.13. If there is reasonable suspicion of criminality, police are able to secure the crime scene by establishing a protected forensic area, allowing evidence to be preserved while restricting access.[48] Once secured, police are empowered to prevent evidence from being concealed or disturbed, restrict unauthorised entry, and remove unauthorised persons from the area. If there is no reasonable suspicion of criminality, police have the authority to enter and inspect the area (see below)[49] and may continue to restrict access,[50] subject to the coroner's approval within six hours.[51] The coroner must ensure that the restriction is not kept for longer than is necessary.[52]

12.14. The police gather evidence for the coroner and have powers to enter[53] and inspect places,[54] make copies of relevant documents with the coroner's authorisation,[55] or take possession of anything relevant to the investigation.[56] Depending on the circumstances, this may include copying of custodial and medical records, staff - related documents (e.g., training and rosters), and taking possession of the CCTV footage relevant to the death (if available), ligatures, weapons, drugs, drug paraphernalia, and/or suicide notes.

12.15. Police in every investigation identify witnesses, and where possible, seek witness statements or an account of the circumstances from those involved and follow up on relevant lines of inquiry. Police are able to finalise their report for the coroner once they receive all of the evidentiary material, including the post mortem examination report.

12.16. Police are to use their best endeavours to provide the Police Investigation Report within 6 to 8 weeks of receipt of the final or supplementary post mortem report.

Corrective Services procedures

12.17. Prisons and youth detention centres are governed and managed by rules, standards, guidelines and operational instruments published by the Commissioner of Corrective Services, a number of which are available to the public on the Western Australian Government website.[57]

12.18. When a death in custody occurs, custodial officers follow detailed procedures outlined in several of the Commissioner's Operating Policy and Procedures (COPP), which govern how prison officers undertake their duties when a death occurs in a prison or a detention centre.

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[48] *Criminal Investigation Act 2006* (WA), pt 5 div 4.
[49] *Coroners Act 1996* (WA), s 33.
[50] *Coroners Act 1996* (WA), s 32(1).
[51] *Coroners Act 1996* (WA), s 32(2) – (3).
[52] *Coroners Act 1996* (WA), s 32(6).
[53] *Coroners Act 1996* (WA), s 33 (2a)(a).
[54] *Coroners Act 1996* (WA), s 33 (2a)(b).
[55] *Coroners Act 1996* (WA), s 33 (3)(c).
[56] *Coroners Act 1996* (WA), s 33 (2a)(c).
[57] Department of Justice, Corrective Services Division, *Custodial Policies and Procedures* (20 April 2024) <https://www.wa.gov.au/organisation/department-of-justice/corrective-services/custodial-policies-and-procedures>.

12.19. When custodial medical staff or a paramedic at the scene confirm that a prisoner or detainee has died, the custodial officers follow the procedures set out in the COPPs titled the "Death of a Prisoner"[58] and the "Death of a Detainee".[59]

12.20. The Superintendent is responsible for the management of the deceased and the scene until authority is handed over to the Coronial Investigation Squad or the Homicide Squad.

12.21. The scene of a death is treated as a crime scene to preserve evidence. At all times officers are required to respect the dignity of the deceased. To the extent that it is possible, they should have regard to cultural or religious requirements.

12.22. In accordance with the COPPs:

1. The Operations Centre immediately notify the coroner of the death in custody by notifying the coroner's registrar;

2. The Superintendent or Officer in Charge take immediate steps to notify the relevant authorities of the death, including, the Coronial Investigation Squad, the police officer in charge in the nearest police station, the Operations Centre, the Commissioner and Deputy Commissioner of Corrective Services, and the Custodial Contract Manager (if applicable); and

3. Internal notifications are made to various departments within the prison, including, Health Services, Employee Welfare Services, and the Aboriginal Visitors Scheme. The Department's Performance Assurance and Risk Directorate (PAR) is also notified (see below).

12.23. Custodial officers are responsible for tasks such as managing the crime scene log, screening the area from public view, and identifying potential suspects or witnesses among the prison detention population.

Department of Justice reports to the coroner

12.24. All prisoners are in the custody of the Chief Executive Officer of the Department.[60]

12.25. PAR coordinates two reports to assist the coroner in fulfilling their duty under the Coroners Act to comment on the quality of supervision, treatment, and care provided to prisoners or detainees while in the Department's custody.[61]

12.26. PAR conducts independent reviews of all prisoner and detainee deaths and prepares a Death in Custody Report for the coroner. This report focuses on the individual's custodial history and the circumstances surrounding the death. It may also provide a broad overview of the health services the individual received during their time in custody.

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[58] Department of Justice, Corrective Services Division,'COPP 13.2 Death of a Prisoner', *Commissioner's Operating Policies and Procedures: Prisons* (30 April 2024) < https://www.wa.gov.au/organisation/department-of-justice/corrective-services/commissioners-operating-policies-and-procedures-prisons>.

[59] Department of Justice, Corrective Services Division,'COPP 8.3 Death of a Detainee', Commissioner's Operating Policies and Procedures: Youth Detention Centres (12 April 2024)< https://www.wa.gov.au/organisation/department-of-justice/corrective-services/commissioners-operating-policies-and-procedures-youth-detention-centres>.

[60] *Prisons Act 1981* (WA), s 16.

[61] *Coroners Act 1996* (WA), s 25(3).

12.27. Corrective Services prepares a Health Services Summary Report for the coroner. This report outlines the specific health services provided to the prisoner or detainee, including details of medical care, medication, treatments, and mental health care. At Acacia Prison, the Health Services Manager is responsible for preparing this report, while the Director of Medical Services prepares this report for other custodial facilities.

12.28. These reports collectively detail the Department's custodial management, supervision, care and health services provided to the prisoner or detainee while in custody. They also identify any deficiencies and detail actions the Department has taken or will take to address these issues.

12.29. The Death in Custody and Health Services Summary reports are to be prepared independently of, but alongside, the Police Investigation Report.

12.30. PAR and Corrective Services are to use their best endeavours to provide the Death in Custody Review Report and Health Services Summary Report to the coroner within 6 to 8 weeks of receipt of the final or supplementary post mortem report, or within 12 months from the date of death, whichever is the earlier.

13. Inquest – key concepts and principles

What is an inquest?

13.1. An inquest is a formal hearing by the Coroner's Court[62] and is a public inquiry into a particular death or deaths. All deaths in custody are subject to a mandatory public inquest.[63] It serves as a vital fact-finding process presided over by the coroner and aimed at making findings about the circumstances surrounding a person's death and the cause of their death.[64]

13.2. The inquest is that portion of the coroner's entire investigation into the death, that occurs in the Coroner's Court. The coroner leads the direction of an inquest and is supported by counsel assisting[65] and a coronial team (see below).

Inquest, an inquiry not a trial

13.3. Despite some similarities, such as the presentation of evidence and examination of witnesses, the objectives and legal frameworks of inquests and criminal trials differ significantly. Unlike a criminal trial, which seeks to establish guilt or innocence and impose legal consequences, the primary function of an inquest is to uncover the cause and circumstances of a death. As part of their ancillary function, the coroner may make recommendations directed towards preventing similar deaths in the future. Importantly, coroners must not frame findings or comments in a way that suggests any person's guilt, appears to determine civil or criminal liability, or is inconsistent with the results of any earlier criminal proceeding where the question of whether the accused person caused the death is at issue. [66]

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[62] *Coroners Act 1996* (WA), s 3 (definition of 'inquest').
[63] *Coroners Act 1996* (WA), s 22.
[64] *Coroners Act 1996* (WA), s 25(1).
[65] *Coroners Act 1996* (WA), s 46(2).
[66] *Coroners Act 1996* (WA), ss 25(5), 53(2).

13.4. A coroner is not bound by the rules of evidence and may be informed and conduct an inquest in any manner the coroner reasonably thinks fit.[67] As a matter of practice the Coroner's Court aligns itself to the rules of evidence and departs from them where necessary or desirable and to the extent needed in order to assist in making the findings under section 25(1) of the Coroners Act. It is important to note that while not bound by the rules of evidence, coroners will focus on whether any proposed evidence is relevant or reliable.

13.5. Coroners do not engage in wide-ranging inquiries that stray far from the fundamental issues of the cause and circumstances of the death in question, the appropriateness of treatment, supervision, and care where required, and any related recommendations.[68]

Who is an interested person?

13.6. An "interested person" in the context of a coronial inquest is an individual or entity recognised by the coroner as having a direct interest in the proceedings. In inquests, the senior next of kin and other family members are considered interested persons.[69]

13.7. Other individuals or entities may also qualify if it is likely they will be subject to adverse comment. Adverse comment may arise if the coroner believes the actions or omissions of an individual or entity contributed to the death or if there was non-compliance with procedures or policies, even if those actions were not directly causal. In such cases, adverse comment could negatively affect their interests, making it essential to ensure procedural fairness for all involved (see below).[70]

13.8. Insurers and beneficiaries, persons who may have caused, or contributed to the death, a union employee (in the case of a workplace death), and the Commissioner of Police are also interested persons.[71]

Rights of an interested person

13.9. An 'interested person' is entitled to appear at a coronial inquest, either personally or by their legal representative, and examine or cross-examine witnesses,[72] and make submissions with respect to their own interests.[73]

13.10. Interested persons may suggest witnesses for examination at the inquest or identify issues they wish the coroner to consider. These proposals should be communicated to the counsel assisting the coroner as soon as is practicable to enable the coroner to consider their relevance. The final decision on the scope of the inquest, and the relevance of the evidence being proposed lies with the coroner.

13.11. In support of the rights to examine or cross examine witnesses and make submissions, interested persons have the right to access statements the coroner intends to consider

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[67] *Coroners Act 1996* (WA), s 41.
[68] *Harmsworth v State Coroner* [1989] VR 989; *Domadgee v Deputy State Coroner Clements* [2005] QSC 357.
[69] *Coroners Regulations 1997* (WA), r 17 (a) – (b).
[70] *Annetts v McCann* (1990) 170 CLR 596; *Muscemi v Attorney General* (NSW) [2003] NSWCA 77.
[71] *Coroners Act 1996* (WA), s 37(5) and s 44(3); *Coroners Regulations 1997* (WA), r 17 (c) – (g).
[72] *Coroners Act 1996* (WA), s 44(1).
[73] *Coroners Act 1996* (WA), s 44(2)

during an inquest.[74] This is done by providing access to the coronial brief to interested persons (see below).

13.12. To ensure procedural fairness, before a coroner makes a finding or comment adverse to the interests of an interested person, the coroner must give that person an opportunity to make submissions against any finding or comment being made adverse to their interests.[75]

The role of the Coroner, Counsel Assisting, legal practitioners and police investigators at inquest.

13.13. The coroner is a judicial officer responsible for holding the inquest, directing the conduct of inquest proceedings, making determinations on the scope of the inquiry, and ensuring that all relevant issues in the inquiry are addressed. The coroner oversees the examination of witnesses, evaluates the evidence presented, and formulates findings regarding the cause and manner of the death and is under a statutory obligation to comment on the quality of supervision, treatment, and care of the person while they were in custody.

13.14. Counsel assisting manages the conduct of the inquest by presenting evidence, questioning witnesses, and facilitating proceedings. They assist the coroner by ensuring that all relevant evidence is brought before the court and that the inquest is conducted in an orderly and efficient manner.

13.15. During the inquest, police investigators may be called upon to give evidence in court, providing crucial insights into the investigation and responding to questions from the coroner, counsel assisting, and the legal representatives of interested persons. Their testimony is essential in helping the court understand the circumstances surrounding the death and ensuring that all relevant facts are considered.

13.16. Legal practitioners representing interested persons have the duty to advocate for their client's interests, ensuring that their perspectives and concerns are adequately presented and considered during the inquest. They may question witnesses and make submissions on issues relevant to their client's interests.

13.17. Legal practitioners appearing for family members at an inquest into the death of the deceased play an important role, focusing on bringing to the coroner's attention, the family's concerns. They can suggest witnesses or issues for consideration and propose findings, comments, and recommendations to the coroner through counsel assisting. Additionally, they guide the family through the inquest process, helping them understand the proceedings and outcomes.

13.18. Coroners recognise the special position of next of kin in an inquest. Where family members are not legally represented, coroners will consider investigating issues or questions raised by them having regard to whether it is materially relevant to the inquest. Coroners may request that counsel assisting ask family members if they have any questions to be asked of witnesses before counsel assisting concludes their examination.

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[74] *Coroner's Act 1996* (WA), s 42.
[75] *Coroners Act 1996* (WA), s 44(2); *Annetts v McCann* (1990) 170 CLR 596; *Muscemi v Attorney General* (NSW) [2003] NSWCA 77.

13.19. The coroner strives to make proceedings during an inquest understandable and accessible to the interested persons and bereaved family members. Members of the media may attend the inquest and report upon the proceedings, subject to any non-publication order made by the coroner.[76]

14. Pre-inquest preparation

Allocation of coroner

14.1. As soon as the death in custody is reported to the coroner, the State Coroner will allocate a coroner to that investigation (which may be the State Coroner or another coroner). As far as practicable, the allocated coroner will be the presiding coroner at the inquest.

14.2. The allocated coroner will lead the investigation and is to be consulted by counsel assisting regarding the scope of the inquest, the evidentiary material required for the inquest, and the witnesses to be called at the inquest, as outlined below.

Preparing for inquest

14.3. Preparing for an inquest involves the coroner conferring with counsel assisting about the available evidentiary material, in order to direct the inquiry. This includes identifying the scope of the inquest, identifying the key issues, monitoring the gathering of any further relevant evidence and considering relevant expert opinions to ensure a comprehensive analysis of the cause of, and circumstances of, the death is able to be undertaken at the inquest.

14.4. With the guidance of the coroner, counsel assisting reviews all the evidence, compiles the coronial brief, identifies and selects the necessary witnesses[77] to resolve the issues under inquiry, and remains open to pursuing further lines of inquiry as the matter develops.

14.5. Before an inquest commences, the coroner identifies individuals with relevant information concerning the death who may be called as witnesses, as well as those who may face criticism for their acts or omissions related to the death in custody. Those facing potential criticism are given an opportunity to be represented and make submissions to ensure procedural fairness.

15. Pre-inquest procedure

Request leave to appear

15.1. Legal practitioners must seek leave to appear on behalf of an interested person at an inquest. This is done by submitting a letter to the State Coroner or emailing the letter

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[76] *Coroners Act 1996* (WA), s 49.
[77] *Coroners Act 1996* (WA), s 46(1)(a).

to the Listings Manager,[78] clearly identifying the interested person(s) they wish to represent.

15.2. A coroner must be satisfied that a person whose legal representative is seeking leave to appear for has a 'sufficient interest' or standing,[79] which is a question of fact based on the circumstances of the death.[80] A person has a sufficient interest if there is a reasonable chance that the coroner will make a finding that affects their interests, especially if it may be an adverse comment.[81] The class of persons to whom the coroner may grant leave to appear is wider than those whom the coroner may consider criticising.[82] Leave to appear may be restricted to those issues that are relevant to that party's interests.

Coronial brief

15.3. The coronial brief is a comprehensive bundle of documents prepared by the Coroner's Court that contains the evidentiary material proposed to be tendered at the inquest. It typically includes information about the deceased person's identity, the certification of their death, and a range of reports and witness statements addressing the circumstances surrounding their death. It includes the results from autopsies or other examinations, medical records, forensic evidence and any other relevant information collected during the investigation. The coronial brief serves as a crucial reference for the coroner when conducting an inquest and helps to ensure that all relevant information is considered during the proceedings.

15.4. The documents that form the coronial brief are those deemed relevant by the coroner to the inquest. For example, not all evidentiary material obtained during a police investigation may be relevant to the scope of the coroner's inquest.

Access to the coronial brief

15.5. Electronic copies of the coronial brief will be made available via USB key to legal practitioners representing interested persons who have been granted leave to appear at the inquest and made an application for the coronial brief. Legal practitioners should be aware that copies of the coronial brief cannot be directly provided to their client (see below).

15.6. The Coroner's Court does not provide copies of the coronial brief directly to unrepresented interested persons.

15.7. For represented interested persons, access to the coronial brief is ordinarily managed through their legal representation. It is important for legal practitioners to be aware that the State Coroner issues a Direction,[83] placed on the coronial brief in each inquest directing that the contents of the brief are only used for the purpose of preparing for the inquest. Failure to obey a coroner's direction may constitute a crime.[84]

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[78] coronerslistings@justice.wa.gov.au
[79] *Coroners Act 1996* (WA), s 42.
[80] *Barci v Heffey* (unreported, Vic Sup Ct, 10 February 1995), per Beach J.
[81] Ibid.
[82] *Annetts v McCann* (1990) 170 CLR 596 at 609 per Brennan J.
[83] *Coroners Act 1996* (WA), s 46(1) (e).
[84] *Coroners Act 1996* (WA), s 46A.

15.8. Unrepresented interested persons may be granted access to the coronial brief at the coroner's discretion. These individuals may be permitted to view the coronial brief and take notes; however, they are not permitted to take photos, copy, remove, or possess any documents. When considering a request for access, the presiding coroner will have regard to section 44 of the Coroners Act.[85] If the request for access is approved by the presiding coroner, the Coroner's Court will assist in facilitating the viewing of the coronial brief, in whole or in part, at the Coroner's Court or another courthouse. Access requests from unrepresented individuals should be directed to the Listings Manager who will submit the request to the presiding coroner and subsequently relay the presiding coroner's decision. [86]

15.9. If a coroner has concerns that a witness may tailor their evidence to give unreliable or untruthful evidence if forewarned of the contents of the brief, the coroner may consider withholding some or all of the coronial brief until the witness has given their version of events. Before the inquest is concluded, however, such witnesses must, as a matter of procedural fairness, be given the opportunity to consider and respond to adverse evidence.[87]

Late evidentiary material

15.10. Any evidentiary material sought to be relied on by interested persons must be submitted to the Coroner's Court at least two weeks prior to the inquest for the presiding coroner to make a determination as to whether it is relevant to the inquest. Any evidentiary material provided less than two weeks prior to the inquest is considered late. Legal practitioners should take all reasonable steps to avoid the late submission of evidentiary material sought to be relied upon by their clients.

15.11. Parties submitting late material must immediately provide electronic copies to counsel assisting and all interested persons, acknowledging that the coroner has not yet decided on its relevance to the inquest. They should seek to tender the material on the inquest's first day, be ready to summarise its content and purpose, identify key passages, and explain the delay if requested by the coroner. At the commencement of the inquest, they must supply hard copies to counsel assisting, legal practitioners for the interested persons and two copies for the Coroner's Court.

15.12. If the coroner determines that the late material is relevant to the inquest and it is appropriate and fair to all parties to include it, the coroner will receive it into evidence, and an exhibit number will be allocated.

Request to stream proceedings from the courtroom

15.13. Streaming Coroner's Court proceedings to other locations can enhance open justice and allow bereaved families who cannot attend the courthouse to observe the proceedings from another location. However, it must be balanced against limitations such as technological reliability, space, and workloads. For example, streaming proceedings to a more remote location is subject to the technological reliability in that location, and availability of a courthouse or other facility.

15.14. Requests for streaming to a regional courthouse or other regional facility via Microsoft Teams should be submitted to the Listing Manager of the Coroner's Court at least four

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[85] *Coroners Act 1996* (WA), s 44(1) - (2).
[86] Coronerslistings@justice.wa.gov.au.
[87] *Annetts v McCann* (1990) 170 CLR 596 at [4], [35] - [40] per Ipp JA.

weeks before the inquest is scheduled to commence. Streaming is not a routine part of the Coroner's Court process and is subject to the presiding coroner's approval. The Listing Manager will submit the request to the presiding coroner and relay the presiding coroner's decision.

15.15. Streaming to the personal device of a next of kin (e.g. a laptop) is considered only in exceptional circumstances, for example where the next of kin resides overseas or interstate or where there is no available and suitably located regional courthouse or other regional facility. Detailed reasons must be provided, and it is subject to technological capacity and the presiding coroner's approval.

15.16. Streaming to the personal devices of legal practitioners and journalists will not be approved; they must attend court in person.

15.17. If the deceased's identity (or any other information) is suppressed pursuant to a non-publication order made by a coroner, streaming is only permitted to another regional courthouse, with the presiding coroner's approval and with proper display of the Suppression Order.[88]

The call-over procedure

15.18. The Coroner's Court uses a call-over procedure in order to list an inquest for the first time, and to re-confirm the dates for the inquests already listed. The aim of the call-over procedure is to embed certainty in the inquest listing process, so that the next of kin have clarity as to the inquest dates, and legal practitioners who have been granted leave to appear, are able to adequately prepare for the inquest.

15.19. The call-over also involves reviewing case progress, considering family views on proposed dates, and addressing outstanding evidentiary issues.

15.20. The State Coroner presides at the call-over.

Call-over scheduling

15.21. Call-over hearings are scheduled monthly. Their location and time[89] is advertised on the Coroner's Court website and interested persons who have made themselves known to the Coroner's Court are also notified individually.

15.22. New matters are called on first at a call-over and after inquest dates have been set for those (or other determinations made), the matters from the previous call-over are called, for the purpose of re-confirming those inquest dates.

15.23. An inquest is typically listed no sooner than three months after its first call-over, to allow for preparation time. Results of the call-over are published on the Coroner's Court's website after each session.

Before call-over

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[88] *Coroners Act 1996* (WA), s 49.

[89] Unless otherwise directed, call-overs will be held in Court 51 on Level 5 of the Central Law Courts building at 9:30am, on the second Friday of every month, except for January.

15.24. Legal practitioners for interested persons are not required to attend call-overs. However, their absence may result in the listing of an inquest and issuance of directions without their input. Therefore, parties wishing to address concerns about listing dates or evidence are encouraged to attend. Legal practitioners intending to appear at the call-over must notify the Listings Manager in advance.

15.25. Legal practitioners for interested persons who would like a copy of the coronial brief should email their request to the Listings Manager. A copy of the coronial brief will ordinarily be available before or at the time of the first call-over date.

15.26. Family members are contacted in advance of call-over (by letter and by telephone) to ascertain whether the proposed inquest dates are suitable to them. The Coroner's Court uses its best endeavours to list inquests for dates that are suitable to the family members where possible.

15.27. Legal practitioners representing interested persons can email the Listings Manager[90] to communicate unavailable dates for the next six months, and the Coroner's Court will endeavour to accommodate these dates. Matters such as the location of the inquest, anticipated length of the inquest, and submissions to include additional witnesses (including experts) will be addressed at the call-over.

At call-over

15.28. During the call-over, case progress is reviewed, the State Coroner is informed as to the family's views regarding the proposed inquest dates, outstanding issues are considered, and timeframes for the provision of outstanding information may be set. If the case is ready to proceed to inquest, the counsel assisting will distribute the proposed witness list to the legal practitioner(s) for the interested person(s), and the State Coroner will allocate the date(s) for the inquest, at that call-over.

15.29. Where a substantive evidentiary issue arises at the call-over, the State Coroner, may determine that matter would be more effectively addressed by the presiding coroner. In such cases, a Directions Hearing before the presiding coroner will be listed.

16. Conduct of inquest

Prior to commencement

16.1. Prior to the inquest, the counsel assisting the coroner will use best endeavours to contact the deceased's family members, or their legal practitioner if represented, to ascertain:

1. whether they wish the coroner to make a culturally appropriate acknowledgement of country, and if so, whether there are specific matters relating to that acknowledgment that they wish to draw to the coroner's attention;

[90] Coronerslistings@justice.wa.gov.au.

2. how they wish the coroner to refer to their loved one. Coroners will ordinarily adopt the family's preferred reference to their loved one;

3. whether the family wishes for a photograph of the deceased to be displayed in the Coroner's Court at certain stages during the inquest. If so, an electronic version of the photograph should be provided to the presiding coroner two business days before the inquest. The presiding coroner will determine when the photograph can be displayed, such as during the counsel assisting's opening address. Ordinarily, photographs will not be prominently displayed while other witnesses are giving evidence; and/or

4. whether the family wishes to display or use symbols and items of cultural significance to the deceased and their family during the inquest.

16.2. The coroner aims to balance the needs of the grieving family with maintaining a non-adversarial, welcoming courtroom environment for all witnesses. Images of the deceased on clothing, such as T-shirts, are discouraged in the courtroom. These should be covered by a cardigan, jacket, or another T-shirt while the wearer is in the courtroom.

16.3. Counsel assisting the coroner may request that the CCIS and/or the SALO be involved in the above discussions where the next of kin are unrepresented or may seek guidance from the CCIS and/or the SALO on contacting the unrepresented next of kin about these matters.

Acknowledgement of country

16.4. Where the next of kin have indicated their agreement, the presiding coroner will ordinarily commence the inquest with a culturally appropriate acknowledgement of country. After that the case will be announced: *"This is an inquest into the death of…".*

16.5. The full name of the deceased will be used when the case is first called. Immediately afterwards, the presiding coroner will direct that from then, the deceased will be referred to in accordance with the family's preferred reference.

Appearances

16.6. Appearances are taken, beginning with counsel assisting or the police officer assisting the coroner, followed by those of legal practitioners for the interested persons, who have been granted leave to appear. It is usual for the family members of the deceased person, who are in attendance at the Coroner's Court, to be identified by their legal practitioner or counsel assisting may do so, after ascertaining whether they wish to be identified in the Coroner's Court. The presiding coroner will ordinarily acknowledge them and offer the condolences of the court.

Introductory remarks by coroner

16.7. The presiding coroner may make brief, general introductory remarks explaining what the inquest is about and the format it will follow. The presiding coroner may, where appropriate, outline the role of the coroner, the nature of the inquest, and explain the process to interested persons and the public. Additionally, the presiding coroner will usually explain to legally unrepresented next of kin their right to ask relevant questions of the witnesses, in consultation with, and through, the counsel assisting.

Counsel Assisting's opening address

16.8. Counsel assisting the coroner will then deliver an opening address, outlining the background to the case, the issues to be investigated, the statutory questions the inquest aims to answer (identity of the deceased, date, place, cause and circumstances of the death, coroner's duty to comment on the quality of the supervision, treatment and care of the deceased), and any key features of the anticipated evidence.

Coronial brief

16.9. After the opening address, the counsel assisting will tender the coronial brief into evidence, and the coroner will allocate an exhibit number(s). If a legal practitioner proposes to tender late evidentiary material, this will occur after the counsel assisting has tendered the coronial brief, and in accordance with the process described previously. If the coroner accepts any additional evidentiary material, an exhibit number(s) will be allocated.

Investigator overview

16.10. The police investigator may be called first to give an overview of the investigation. In some circumstances, the investigator may offer opinions within their expertise concerning the circumstances surrounding the death. Opinion evidence is admissible in inquests, but the coroner must decide its weight. Counsel assisting will ordinarily ask questions of the police investigator that are directed to significant features in their statement or report.

Examination of witnesses

16.11. Counsel assisting then calls the remainder of the witnesses identified on the witness list. As witnesses will usually have given written statements or prepared reports beforehand, counsel assisting will focus on key features related to the salient issues, clarifying or expanding on written statements as necessary. Counsel assisting will have regard to the importance of members of the public gallery (including next of kin) becoming aware of the salient issues and will frame their questions accordingly, so that the witness can tell their story, or if the witness is an expert, explain their evidence in a manner that makes its import readily ascertainable. Regard is to be had to the inquest being understandable and accessible to members of the public gallery (including next of kin).

16.12. After counsel assisting completes their questioning of a witness, the coroner may ask follow up questions. After that, if there are unrepresented next of kin, the coroner may ask counsel assisting to confer with them, and if desired and appropriate, ask questions of the witness on their behalf. The coroner will consider whether such questions are relevant to the inquest.

16.13. After that, the coroner will call upon the other legal practitioners to ask questions of the witness, if desired. Cross-examination by other legal practitioners is ordinarily permitted only in respect of their client's specific interest. General and/or repetitive cross-examination is not ordinarily permitted. If necessary, it should be emphasised

that inquests are not trials. A coroner may disallow any question which in the coroner's opinion is not relevant or otherwise a proper question.[91]

16.14. After the other legal practitioners have questioned the witness, the coroner will ask the counsel assisting whether any matter arises for re-examination. The coroner may then choose to ask any further questions that might be required for clarity. After that the coroner will excuse the witness, and counsel assisting will call the next witness.

16.15. A coroner has the statutory power to compel a witness at an inquest to answer a question which they have objected to on the basis of self-incrimination, provided that the coroner is satisfied that it is expedient for the ends of justice. Where the witness answers the question(s) to the satisfaction of the coroner, the coroner will issue them with a certificate.[92] The certificate has the legal effect of making their compelled testimonial evidence in the inquest inadmissible in a criminal proceeding (other than a prosecution for perjury).[93] A legal practitioner representing a witness under these circumstances must inform their clients of this right and seek the certificate at the appropriate time (before their client commences to give the evidence that they object to giving). If the person is unrepresented and objects to answering a questions on the bases of self-incrimination, the coroner will explain to that person their rights in relation to the seeking of, and grant of a certificate.

Next of kin's personal statement

16.16. At the beginning or conclusion of the formal evidence, but before final addresses, a member or members of the deceased person's family may be invited to make a statement about their loved one: about who the deceased was as a person, and how their death has impacted them. This may be done orally, in person or through a spokesperson, or in writing, read out by them, their legal representative, a spokesperson or the counsel assisting. This helps the coroner in better understanding the life of the deceased person, and the impact of their death. It should be noted that such testimonials are not for the purpose of making submissions concerning findings the coroner should make nor for indicating any desired consequences for any particular individual.

Counsel's submissions

16.17. At the conclusion of the evidence, counsel assisting may address the coroner, making submissions regarding findings that are open to the coroner and may propose adverse comments and/or recommendations to the coroner, if appropriate.

16.18. In more complex inquests, where substantial adverse findings or comments may be considered by the coroner, it may be appropriate for counsel assisting to prepare a written outline of these potential adverse comments. Whether such an outline is required is at the discretion of the coroner. If the coroner requests a written outline, it is to be initially provided to the coroner for their consideration, who may instruct that it be provided to the other legal practitioners appearing at the inquest. The purpose of the written outline is to ensure that any individual or entity who may be subject to multiple or significant adverse finding(s) or comment(s) has an appropriate opportunity for procedural fairness.[94]

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[91] *Coroners Act 1996* (WA), s 44(4).
[92] *Coroners Act 1996* (WA), s 47(1), (2).
[93] *Coroners Act 1996* (WA), s 47(3).
[94] *Coroners Act 1996*, s 44(2).

16.19. In the case of proposed recommendations, prior consultation should take place, where possible, between counsel assisting and the legal practitioners representing any entity that may be affected by the recommendation. For more complex inquests, where substantial recommendations may be considered by the coroner, it may appropriate for counsel assisting to prepare a written outline of the potential recommendations for the coroner and the other legal practitioners appearing at the inquest, allowing for thorough consideration.

Submissions of interested person

16.20. The legal practitioner for an interested person may respond to proposed adverse comments or findings at the conclusion of the inquest or may seek the coroner's leave to provide written submissions in response at a later date. Where the coroner is considering making an adverse finding or comment against an individual or entity, the coroner will ordinarily grant the leave to provide subsequent written submissions, if requested, in order to afford an appropriate opportunity for procedural fairness. Otherwise, if not requested, the legal practitioner for the interested person may be invited to make their oral submissions at the conclusion of the inquest.[95]

16.21. Interested persons do not have a general right to address the whole of the evidence but can make submissions relevant to the protection of their own interests.[96]

16.22. A legally represented family member may make oral or written submissions to the coroner, at the conclusion of an inquest, requesting consideration of a particular finding, comment, or recommendation. An unrepresented family member may make such submissions in writing.

16.23. In formulating their findings and comments, the coroner will have regard to submissions made by an interested person against the making of an adverse finding or comment[97] and will have regard to responses provided by affected entities in respect of proposed recommendations.

16.24. The coroner may seek submissions on other aspects of the evidence, or possible recommendations, in appropriate cases.

17. Findings, comments and recommendations

17.1. An inquest concludes with the coroner making written findings of fact (if possible), in respect of the identity of the deceased person, the date, place, cause and circumstances of that death. These written findings comprise the coroner's record of investigation.[98]

17.2. Findings, including comments and/or or recommendations (the Inquest Findings) are usually provided to all relevant persons and organisations at least seven (7) days before being published on the Coroner's Court website.

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[95] *Coroners Act 1996*, s 44(2).
[96] *Annetts v McCann* (1990) 170 CLR 596 at 601 [08]; *Coroners Act 1996* (WA), s 44 (2).
[97] *Coroners Act 1996*, s 44(2).
[98] *Coroners Act 1996* (WA), s 26(1); *Coroners Regulations 1997* (WA), r 6, Form 3.

17.3. In the case of Aboriginal families in more remote areas best endeavours will be used to provide the Inquest Findings fourteen (14) days before being published on the Coroner's Court website.

17.4. The SALO may become involved in discussions with next of kin concerning the process for receiving the finding, and its subsequent publication.

17.5. Any Inquest Findings provided to parties prior to being made public are final. The primary purpose of providing the findings to family members at an early stage is to ensure they have time to read and understand the findings before they are made public.

17.6. Responses from Ministerial Offices concerning recommendations made by the coroner are published on the Coroner's Court website, upon receipt, next to the Inquest Finding.

17.7. The State Coroner provides specific reports to the Attorney General on an annual basis regarding the investigation of each death of a person held in care, [99] which includes information about the quality of supervision, treatment, and care of individuals who died in custody.

RVC Fogliani
STATE CORONER

4 December 2024

[99] *Coroners Act 1996* (WA), s 27(1).