OFFICE

of the

STATE CORONER

for

WESTERN AUSTRALIA

ANNUAL REPORT

2019-2020

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Our ref: Annual Report

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Dear Attorney

ANNUAL REPORT 2019-2020

In accordance with section 27(1) of the Coroners Act 1996 I submit my report on the operations of the Office of the State Coroner for the year ended 30 June, 2020.

Yours sincerely

R V C FOGLIANI
STATE CORONER

2 October 2020

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State Coroner's Overview

Executive Summary of Outcomes

Under section 8 of the *Coroners Act 1996* (Coroners Act) one of my functions is to ensure that the State Coronial system is administered and operates efficiently. The outcomes for the Office of the State Coroner for 2019/20 are outlined below:

- Backlog of cases increased from 458 as at 30 June 2019 to 483 as at 30 June 2020.
    - Of those 483 backlog cases:
        - 105 were backlog inquest cases.
        - 297 were cases where no further finalisations were possible as at 30 June 2020 because the coroner was awaiting completion of aspects of the coronial investigation by external entities.
        - 36 cases were pending analysis before finalisation.
        - 45 cases were awaiting finalisation.
    - By continuing to list the oldest cases for inquest wherever possible, the statistics show a greater than usual time to hearing; however, this also reflects that, appropriately, the older matters are being progressed as a priority.
    - A total of 2737 investigations were finalised in 2019/20:
        - 2637 finalised by administrative finding of which 706 (27%) were backlog cases.
        - 100 finalised by inquest of which 100 (100%) were backlog cases at the time of completion and 75 were mandated inquests.
        - 1931 (70%) of the cases finalised were under 12 months old.
        - 806 (29%) of the cases finalised were over 12 months old.
    - The number of inquests finalised increased significantly from 61 in 2018/19 to 100 in 2019/20. This was due to additional resources being allocated for a coroner (0.5 FTE) to investigate and finalise by inquest a concentrated referral of 44 Long Term Missing Persons cases.
    - The total number of administrative findings finalised increased significantly from 2231 in 2018/19 to 2637 in 2019/20; this is compared to 2259 in 2017/18 compared to 2366 in 2016/17 compared to 1991 in 2015/16. This was due to the temporary suspension of inquests during COVID-19, resulting in the court vacating a number of inquests. The additional time available to the officers of the court was applied to the focused completion of administrative findings.
    - The number of total cases on hand over 24 months old increased to 7.9% in 2019/20 compared to 7.19% in 2018/19, compared to 6.6% in 2017/18, compared to 6.4% in 2016/17, compared to 6.7% in 2015/16.

- Reports of deaths to the coroner increased to 2573 in 2019/20 compared to 2452 in 2018/19, compared to 2291 in 2017/18, compared to 2422 in 2016/17 and 2214 in 2015/16. The number of deaths reported remains high with an increase of 121 from 2018/19.
- The number of cases on hand was 2067 at 30 June 2020 compared to 2280 at 30 June 2019 compared to 2127 at 30 June 2018, compared to 2173 at 30 June 2017 compared to 2178 at 30 June 2016.

- The number of death certificates received in 2019/20 was 1129 compared to 1458 in 2018/19 compared to 1280 in 2017/18 compared to 1174 in 2016/17 compared to 1198 in 2015/16. These are cases where the coroner has determined that the reported death does not require further investigation and the doctor's death certificate is accepted.

- Counselling Service contacts and referrals increased slightly from the previous reporting year, however they still remain high at 10304 in 2019/20, compared to 10239 in 2018/19, compared to 10781 in 2017/18, compared to 11241 in 2016/17, compared to 10106 in 2015/16.

- The number of objections received to the performance of post mortem examinations for the purpose of investigating deaths increased to 447 for 2019/20 compared to 386 for 2018/19 compared to 320 in 2017/18 compared to 319 in 2016/17 compared to 246 in 2015/16.

- A procedure for non-invasive post mortem examinations was piloted and introduced in the 2016/17 financial year and continued thereafter with 247 non-invasive post mortem examinations conducted in 2019/20, compared to 273 in 2018/19, compared to 261 for 2017/18 and 227 in 2016/17.

- Law Reform Commission recommendations 55 and 56 were enacted on 21 September 2018, resulting in s 19A enabling a coroner to make an early determination to discontinue an investigation into certain natural cause deaths, and s 25(1A) enabling a coroner to issue early non-narrative findings subject to public interest considerations. With the benefit of a full financial year, this has resulted in 647 findings being completed under s 19A in 2019/20, compared with 88 findings completed in 2018/19. There were 267 findings completed under s 25(1A) in 2019/20, compared with 51 findings in 2018/19.

Structure of the Report

The first part of this Report provides statistical and other information on the operations of the Office of the State Coroner in the past financial year ended 30 June 2020 (2019/20).

The second part of this Report contains the specific reports that I am required to provide on the death of each person held in care under section 27(1) of the Coroners Act.

The legislative requirement to provide a specific report on the death of each person held in care reflects the community's concern with the quality of the supervision, treatment and care of persons who have been taken into care and/or persons whose freedoms have been removed by operation of law. They include children the subject of protection orders, persons under the custody of police, prisoners and involuntary mental health patients.

Investigations that have not been finalised are not the subject of a specific report. An investigation is finalised when the coroner has made the findings required, if possible, to be made under section 25(1) of the Coroners Act. Generally, in approximately 96% of cases, an investigation is finalised without holding an inquest. An inquest is part of an investigation.

The Coroner's Court of Western Australia – information available to the public

It is said that the role of the Coroner's Court is to speak for the dead and to protect the living. This two fold role is a vital component of a civil society.

As an independent judicial officer, the coroner investigates a reportable death to find how the deceased died and what the cause of death was. It is a fact finding exercise, aimed not at apportioning blame, but at establishing the circumstances attending the manner of the death. It is in the public interest for there to be a careful and thorough review of the information so that a sudden, unnatural or unexplained death is properly investigated and the cause and manner of that death is properly found and recorded.

A significant function of the Coroner's Court is to provide an opportunity for grieving relatives and friends of the deceased to witness the proceedings involving their loved ones at a public inquest, in open court. For people who are emotionally distraught and suffering intense feelings of loss, the Coroner's Court can provide much needed answers about how their loved one died and in some cases, whether isolated or systemic changes may be introduced so as to avoid a death in similar circumstances in the future. It may be a comfort to know what happened to their loved one; it has the possibility of allaying rumours or suspicion; it may show that no other person caused or contributed to the death; it may show otherwise; it may explain complex medical procedures that had previously not been understood or known by the family; it may shed light on the quality of medical care afforded to the deceased; it may increase medical knowledge and awareness. It provides much needed information.

In these cases the principles of open justice serve the grieving family and friends of the deceased as well as the witnesses, persons involved in the care of the deceased and the wider community who has an interest in the proceedings.

When an investigation is finalised other than by inquest, the coroner's record of investigation is referred to as an administrative finding.

There were 2637 administrative findings finalised by coroners in the 2019/20 year comprising 96.3% of all reportable deaths investigated for this year. For these matters the coroner makes findings on the evidence before him or her, in chambers. They are not public proceedings. These findings are provided to the deceased's next of kin and they are not published on the Coroner's Court website.

There were 100 inquests finalised by coroners in the 2019/20 year comprising approximately 3.7% of all reportable deaths investigated for this year. As Inquests are public proceedings, the coroner takes evidence in open court (unless otherwise ordered). The coroner's written findings are published on the Coroner's Court website. Where the coroner has made a recommendation, the written response by the Minister or responsible entity is also published on the website.

The focus over the 2019/20 year: The Backlog of coronial cases, Coronial Case Management System, Reform, Restructure and CT Scanner.

Backlog

As with the previous reporting years, much of the effort across all levels at the Office of State Coroner has been aimed towards addressing the accumulated backlog of cases. The backlog cases are determined by reference to the date that a reportable death is reported to the coroner. When the date of that report is more than 12 months old, that case enters into backlog and becomes a priority.

The backlog is a dynamic figure because cases are constantly being finalised and equally, at the 12 month anniversary, cases are also coming into backlog, on a daily basis. As outlined in the Executive Summary, as at 30 June 2020 the backlog stood at 483.

That does not mean that all reportable deaths are able to be investigated by a coroner in the order of the date of the report of the death. Other factors impact upon the prioritisation of cases, most significantly the complexity of the investigation and/or the availability of witnesses or other evidence. Another factor that may result in prioritisation is where a matter connected with a death raises an issue of concern in the area of public health or safety.

Coronial Case Management System

On 10 February 2020, the Integrated Court Management System (ICMS) was implemented at the Coroner's Court replacing the previous case management system (MUNCCI). With the implementation of ICMS there has been a progressive transition to an electronic case management file that will provide greater flexibility to judicial and administrative staff within the Court.

Staff are becoming proficient with ICMS and there is a continual effort to maximise the benefits that the system can deliver. Processes and practices have been and are being streamlined to ultimately ensure that the Coroner's Court strives towards a timely and efficient completion of coronial investigations.

This is part of a process of continual improvement. The ICMS allows for a broader access to file records, so that multiple functions may be carried out on the one matter. It also enhances search capabilities to assist with retrieval of records and responses to queries.

Reform

On 21 September 2018, recommendations 55 and 56 made by the Law Reform Commission of Western Australia in its *Review of Coronial Practice in Western Australia, project no. 100*, January 2012 were enacted. The Coroners Act was amended to include s 19A, enabling a coroner to make an early determination to discontinue an investigation into certain natural cause deaths and s 25(1A) enabling a coroner to issue early non-narrative findings subject to public interest considerations. The enactment of sections 19A and 25(1A) has increased efficiency, reduced unnecessary delays and delivered more timely responses and outcomes to the families of the deceased. This process commenced in the Perth Coroner's Court 10 December 2018, and after

being trialled, it was extended to the Regional Courts on 5 March 2019. With the benefit of a full financial year, this has resulted in 647 findings being completed under s 19A and 267 findings under s 25 (1A).

Further amendments to the Coroners Act are being drafted in accordance with the recommendations made by the Law Reform Commission of Western Australia.

Internal Restructure

An internal review into the structure of the Coroner's Court was completed in 2019 and resulted in an adapted structure being implemented in 2020. The adapted structure aims to ensure that there is better utilisation of existing resources and reduction in the duplication of functions and will lead to officers undertaking duties that are comparable with their classification level.

CT Scanner

On 5 June 2019 the Attorney General, Hon Mr John Quigley MLA attended the official inauguration of the long awaited CT scanner at the State Mortuary. Installation of the CT scanner fulfils recommendation 102 of the *Review of Coronial Practice in Western Australia, project no.100*, by lessening the need for full invasive post mortem examinations in certain cases. The CT scanner greatly enhances the scope of forensic pathology, thereby improving the quality of services to the community and I thank the Attorney General for his support.

The range of cases that may be more efficaciously progressed under the reform process has been expanded now the dedicated CT scanner is available to the forensic pathologists at the State Mortuary, due to the depth and quality of information afforded by this medium at an early stage.

I acknowledge the efforts of PathWest in supporting the usage of the CT scanner, developing processes and their continued expertise in this area.

The number of CT scans performed over the course of the financial year gradually increased from 94 for the month of July 2019 through to 240 scans being performed for the month of June 2020. For the financial year ended 30 June 2020, a total of 2141 CT scans were performed.

Report on inquests that are required by law to be held (mandated inquests)

Under section 22(1) of the Coroners Act, a coroner who has jurisdiction to investigate a death must hold an inquest under the circumstances specified in that section.

Where the Coroners Act mandates the holding of an inquest, the inquests are sometimes referred to as "mandated inquests" although that term is not used in the legislation.

Overall there were 100 investigations finalised by inquest in the past financial year and of those, a total of 87, being 87%, comprised investigations where an inquest was mandated by law.

The 87 mandated inquests were finalised by coroners in the following categories and these are described below:

- 24 mandated inquests in relation to persons held in care immediately before death;
- 7 mandated inquests in relation to the suspected deaths of missing persons;
- 44 mandated inquests in relation to the suspected deaths of missing persons held by Coroner Vicker as part of the Long Term Missing Persons project; and
- 12 mandated inquests where it appeared that the death was caused, or contributed to, by an action of the police force.

(a) Mandated inquests - persons held in care immediately before death

A deceased will have been a "person held in care" under the circumstances specified in section 3 of the Coroners Act. They include children the subject of a protection order under the *Children and Community Services Act* 2004, persons under the control, care or custody of a member of the Police Force, persons in custody under the *Prisons Act* 1981 and involuntary patients under the *Mental Health Act 2014*.

Under section 3 of the Coroners Act, all Western Australian deaths of persons held in care are reportable deaths.

In the past financial year there were 24 investigations of deaths of persons held in care finalised by mandated inquest. Of those:

- Fourteen investigations were finalised by inquest in respect of deaths of persons held in custody under the *Prisons Act* 1981;
- Four investigation was finalised by inquest in respect of a child who was the subject of a protection order under the *Children and Community Services Act 2004*; and
- Six investigations were finalised by inquest in respect of the death of an involuntary patient within the meaning of the *Mental Health Act* 1996.

In respect of all of the 24 investigations of deaths of persons held in care finalised by mandated inquest this past reporting year, the coroner was required under section 25(3) of the Coroners Act to comment on the quality of the supervision, treatment and care of the person while in that care. In five cases, the coroner expressed concern about aspects of supervision, treatment and/or (Bolton, J; Capper, B; Rice, D; Child SH and Reilly, N).

Under section 27(1) of the Coroners Act, my annual report is required to include a specific report on the death of each person held in care. A Table of the 24 investigations into deaths of persons held in care that were finalised by inquest in the past financial year appears at pages 42 to 43 of this report. Following that Table, at pages 44 to 77 are the specific reports on the deaths of each person held in care, arranged in the order in which they appear on the Table.

(b) Mandated inquests – where it appeared the death was caused, or contributed to, by any action of a member of the police force.

Twelve investigations were finalised by mandated inquest where it appeared that the death was caused, or contributed to, by any action of a member of the police force.

In ten instances, the coroner found that the police did not cause or contribute to the death. In the other two instances, the coroner found the police were carrying out a legitimate law enforcement activity, or their actions were justified by the circumstances.

A Table of the twelve investigations appears at page 35 of this Report.

(c) Mandated inquests – suspected deaths

Seven investigations into the suspected deaths of missing persons were finalised by mandated inquest.

Where a person is missing and the State Coroner has reasonable cause to suspect that the person has died and that it is a reportable death, the State Coroner may direct that the suspected death of the person be investigated. Where such a direction has been given, under section 23(2) a coroner must hold an inquest into the circumstances of the suspected death.

In each instance, the coroner found that the death of the missing person had been established beyond all reasonable doubt.

A Table of the seven investigations appears at page 36 of this Report.

Long Term Missing Persons Project

This project commenced in the 2019 calendar year, and concerns the assessment by the coroner of the concentrated referral by police of a number of long term missing person's cases, ranging from as far back as the 1960's, for investigation and if possible, finalisation.

For this purpose, the Department of Justice provided funding for a part-time coroner (0.5 FTE) for a period of 12 months and this role was filled by Coroner Evelyn Vicker (formerly the Deputy State Coroner) commencing as from 9 June 2019 and concluding on 8 June 2020.

Coroner Vicker exercised the functions under section 23(1) of the Coroners Act, by assignment, and where she had reasonable cause to suspect that the person had died and that the death was a reportable death, directed that the suspected death be investigated. This first such inquest was heard by Coroner Vicker on 5 August 2019. A total of 44 inquests were held and finalised by 30 June 2020.

In all but one instance, the coroner found that the death of the long term missing person had been established beyond all reasonable doubt.

A Table of the 44 investigations appears at page 37 to 40 of this Report.

I thank Coroner Vicker for her careful and thoughtful progression of these matters.

Report on inquests that are held pursuant to an exercise of discretion by the coroner (discretionary inquests)

Under section 22(2) of the Coroners Act, a coroner who has jurisdiction to investigate a death may hold an inquest if the coroner believes it is desirable. These inquests are sometimes referred to as "discretionary inquests," although that term is not used in the legislation.

In exercising the discretion under this statutory function the coroner will have regard to whether an inquest will assist in reaching the findings required to be made, if possible, under section 25(1) of the Coroners Act and/or whether there are reasons for highlighting issues of public health or safety in connection with the death. The coroner will also take account of the reasons provided by any person who makes a request for an inquest under section 24(1) of the Coroners Act. Of the 100 investigations finalised by inquest in the past financial year, a total of 13, being 13%, comprised investigations where the inquest was discretionary.

A Table of all of the investigations that were finalised by inquest appears at pages 29 to 34 of this Report. The mandated inquests are marked as such, leaving the remainder on that Table, a total of 13, as the discretionary inquests.

The Coronial Counselling Service

Under section 16 of the Coroners Act, the State Coroner is to ensure that a counselling service is attached to the Coroners Court of Western Australia. Any person coming into contact with the coronial system may seek the assistance of the counselling service and, as far as practicable, that service is to be made available to them.

Over this reporting year, the Coronial Counselling Service has focussed on its core function which is to ensure, as far as practicable, that persons coming into contact with the coronial system are able to speak with an experienced counsellor who will endeavour to address their questions and concerns and explain the coronial process to them.

The range of services provided by the Coronial Counselling Service and statistical information on work output is set out at page 23 to 24 of this Report.

The Death Prevention Role and the Coronial Ethics Committee

Over the course of a coronial investigation important information is gathered about the cause and manner of death, including the circumstances attending the manner of death. This is reflected in the findings of the coroners, though not exclusively so. The material gathered, including in the form of statistics where that is amenable, can provide vital information about matters such as the prevalence of disease, it may reflect upon the state of mental health within the community, and can be of invaluable assistance in identifying where resources could usefully be applied to provide the most effective assistance, with the ultimate aim of preventing deaths in the future in similar circumstances.

Only the coronial findings on inquest are made public, and they comprise less than 4% of all investigations. Following an inquest a coroner may make specific recommendations in connection with the death that may result in practices being changed, for example at hospitals or at workplaces, to assist in preventing similar deaths in the future. This is part of the death prevention role of the coroner.

The Office of the State Coroner has a working relationship with the Department of Health, the Patient Safety Surveillance Unit (PSSU). Their specialist medical consultant reviews coronial findings and related information. The salient points are de-identified and where necessary summaries are published in the booklet "From Death We Learn" which is then distributed to relevant clinical areas.

The Office of the State Coroner has also entered into a working relationship with the Therapeutic Goods Administration (TGA) in recognition of the importance of identifying any reportable deaths that may have been associated with the use of medicines, vaccines or medical devices. To assist the TGA with monitoring the safety of therapeutic products, the Office of the State Coroner has developed a notification system whereby relevant information is de-identified and provided to the TGA. There were 121 such notifications to the TGA this financial year.

The working relationships with the PSSU and the TGA are also in furtherance of the coroner's death prevention role.

For reasons of confidentiality, a considerable amount of coronial information that may potentially assist in the prevention of future deaths is not accessible to the public, nor generally to persons conducting research.

There are occasions where, under strict guidelines, access to specific types of information may be made available to persons conducting research connected with the death prevention role. This is done through the Coronial Ethics Committee attached to the Coroner's Court of Western Australia. The Coronial Ethics Committee considers incoming requests for coronial data and makes recommendations to me on the ethical considerations involved in proposed research projects or matters touching on the use of coronial information.

Pursuant to paragraph 8 of the Guidelines for the Coronial Ethics Committee, I am required to report annually on the operations of the Coronial Ethics Committee, including a specific report on any recommendation of the Coronial Ethics Committee which I have rejected. The report on the operations of the Coronial Ethics Committee during the past reporting year appears at page 25 to 26 of this Report.

Acknowledgements

I wish to acknowledge the ongoing and assiduous efforts to finalise investigations and reduce the backlog on the part of Deputy State Coroner Barry King, Coroner Evelyn Vicker (who worked part-time on a special project concerning long term missing persons), Coroner Sarah Linton and Coroner Michael Jenkin. Their application and dedication reflects their strong commitment to their important service to the community through the coronial system.

This reporting year saw the retirement of Coroner Vicker after 19 years. I thank her for her dedicated service to the Western Australian coronial system. Over almost all of this period, Ms Vicker discharged the functions in her capacity as the Deputy State Coroner.

Every Magistrate in Western Australia is contemporaneously a coroner and I acknowledge their considerable efforts in the area of coronial work.

All of the staff members at the Coroner's Court of Western Australia have been exceptionally dedicated to one of the central tasks of the court, which is to try and find answers for grieving family members and to communicate that with accuracy and sensitivity. They have shown an unwavering and attentive commitment to this task and I acknowledge their ongoing efforts.

Every member of the police force of Western Australia is contemporaneously a coroner's investigator. The Coroner's Court of Western Australia continued to be well supported by all of the coroner's investigators, including those at the Coronial Investigation Squad, by the forensic pathologists and other PathWest staff, and the toxicologists and other ChemCentre staff. I use this opportunity to express my gratitude to these officers and staff members in all of these agencies that ably assist the Coroner's Court on a daily basis. I am grateful for the assistance of a number of officers from the Department of Justice over the past year in connection with the continued progression of the reform proposals. These initiatives take time and energy and the Coroner's Court has been well served by their efforts.

I am pleased to present the 2019/20 Annual Report of the Office of the State Coroner.

R V C FOGLIANI
STATE CORONER

Office Structure

An internal review into the structure of the Coroner's Court was completed in 2019 and resulted in an adapted structure being implemented in 2020. The new structure continues to operate with 23 full time employees. The restructure aims to ensure that there is better utilisation of existing resources, reduction of duplication of functions and will lead to officers undertaking duties that are comparable with their classification level.

The Coroner's Court of WA comprises the State Coroner, Deputy State Coroner, two Coroners and as from 9 June 2019, one part-time Coroner (12 month appointment), and 23 FTE.

Table A – Office Structure

Coroners and Inquest staff	*Management and Registry Staff*	*Counselling Service*
State Coroner	Principal Registrar	Senior Counsellor
Deputy State Coroner	Office Manager	Counsellor x 2
Coroner x 2.5	Registry Manager	
Counsel Assisting x 3	Assistant Registry Officer	
Listings Manager	Resource and Administration Officer	
Chambers Administrator	Findings Clerk x 2	
Customer Service Officer x 3	Customer Service Officer x 5	

Registry and Statistics

The Registry is the repository of the statistical information concerning the work of the Coroner's Court of Western Australia. Registry staff members record the salient details of the coroner's findings, including the deceased's name, date of death, the cause and manner of death and date of the coroner's finding.

The legal requirements to report a death that is or may be a reportable death to the coroner are set out in section 17 of the Coroners Act. Under section 19 of the Coroners Act, a coroner has jurisdiction to investigate a death if it appears to the coroner that it is or may be a reportable death. One of the functions of the State Coroner is to ensure that all reportable deaths reported to a coroner are investigated.

A reportable death is a Western Australian death that occurs in the circumstances set out in section 3 of the Coroners Act and includes a death that appears to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from injury; that occurs during an anaesthetic, or as a result of an anaesthetic (and is not due to natural causes); of a person who immediately before death was a person held in care; that appears to have been caused or contributed to while the person was held in care; that appears to have been caused or contributed to by any action of a member of the Police Force; of a person whose identity is unknown; and/or

where the cause of death has not been certified by a doctor in accordance with the *Births, Deaths and Marriages Registration Act* 1998.

Under section 14 of the Coroners Act every member of the Police Force of Western Australia is contemporaneously a coroner's investigator. They investigate the reportable deaths and prepare a report for the coroner.

The coroners investigate the reportable deaths and if possible, make findings in relation to the cause and manner of death.

With capable guidance from Registry Manager and Coroner's Registrar, the Registry has been responsible for the administration of the coronial files upon the initial report of the occurrence of a reportable death and upon finalisation of the coroner's investigation, either by administrative finding or by inquest.

At all levels in the Coroner's Court, the main focus in the past financial year continued to be on clearing the backlog of coronial cases (that is cases where the death was reported to the coroner 12 months ago, or more). Staff members within the Registry close the coronial files after the coroner has finalised the investigation.

The number of cases about to enter into backlog in any given month is calculated; and the Coroner's Court endeavours to finalise more than that number in an effort to prevent the backlog from increasing. A total of 2573 reportable deaths were reported to the coroner for full investigation in the past financial year and 2737 cases were completed representing a clearance rate of 106%.

With regard to the 2737 cases completed in the past reporting year the breakdown is as follows:

- 2637 – the number of investigations finalised by administrative finding, of which 706 (27%) were backlog cases, and

- 100 - the number of investigations finalised by inquest, of which 100 (100%) were backlog cases.

At the conclusion of the reporting year, the cases on hand referred to the Coroner's Court of Western Australia for investigation by a coroner amounted to 2067, of which 483 were backlog cases (over 12 months old).

The backlog increased from 458 in 2018/19 to 483 in 2019/20. The number of cases where no further finalisations were possible as at 30 June 2020 because the coroner was awaiting completion of aspects of the coronial investigation by external entities decreased from 338 in 2018/19 to 297 in 2019/20.

Of the 483 backlog cases, 105 were inquest cases waiting to be heard or pending finalisation by a coroner.

The following Tables provide an overview of the work of the Coroner's Court in the 2019/20 year.

Table B – Overview of Work

CASES RECEIVED	*PERTH*	*COUNTRY*	*TOTAL*
Full Investigation	**1919**	**654**	**2573**
Death Certificates	**1129**	**n/a**	**1129**

CASES COMPLETED	*PERTH*	*COUNTRY*	*TOTAL*
Finalised by Inquiry	**1726**	**911**	**2637**
Finalised by Inquest	**94**	**6**	**100**
TOTALS	**1820**	**917**	**2737**

BACKLOG	*PERTH*	*COUNTRY*	*TOTAL*
	360	**123**	**483**

CASES ON HAND	*PERTH*	*COUNTRY*	*TOTAL*
	1583	**484**	**2067**

FINALISATION RATIO		
Finalised by Inquiry	**96.3%**	**2637**
Finalised by Inquest	**3.7%**	**100**

Table C – Cases Closed

Table C below shows the age of a coronial file when closed calculated from the date of death. It will be seen that 71% (1931) of files were closed in under 12 months and 29% (806) of files were over 12 months old at closure (i.e. backlog files).

	INQUIRY		INQUEST	
TIMELINES	***PERTH***	***COUNTRY***	***PERTH***	***COUNTRY***
< 3 mths	**318**	**136**	**0**	**0**
3-6 mths	**338**	**168**	**1**	**0**
6-12 mths	**714**	**243**	**13**	**0**
12-18 mths	**383**	**127**	**19**	**0**
18-24 mths	**86**	**37**	**17**	**0**
>24 mths	**57**	**30**	**44**	**6**
TOTALS	**1896**	**741**	**94**	**6**

Table D – Deaths reported and cases completed

Table D below shows the total number of deaths reported and cases completed during the 2018/19 year for Perth and Regional WA.

TOTAL NUMBER OF DEATHS REPORTED TO THE CORONER			
Death certificates			1129
Metropolitan deaths	1919		
Regional deaths	654		
• **Albany**		98	
• **Broome**		30	
• **Bunbury**		204	
• **Carnarvon**		36	
• **Islands**		0	
• **Geraldton**		70	
• **Kalgoorlie**		77	
• **Kununurra**		29	
• **Northam**		56	
• **Port Hedland**		54	
TOTAL NUMBER OF REPORTABLE DEATHS	2573		
CASES COMPLETED	**PERTH**	**COUNTRY**	**TOTAL**
Finalised by Inquiry	1896	741	2637
Finalised by Inquest	94	6	100
TOTALS	1990	747	2737

Table E – Findings on manner of death

Table E below shows the statistics relating to coroners' findings on the manner of death for the past five financial years. They represent investigations that were finalised by a coroner in those financial years, either by administrative finding or by inquest.

MANNER OF DEATH	*2015-2016*	*2016-2017*	*2017-2018*	*2018-2019*	*2019-2020*
Accident	635	700	811	830	663
Misadventure	44	61	40	25	33
Natural Causes	851	1039	908	868	506
No Jurisdiction	3	7	4	5	6
Open Finding	105	139	116	81	124
Self Defence	1	3	3	2	2
Suicide	322	420	392	421	434
Unlawful Homicide	88	53	48	61	55
Section 19A (Natural Causes)	N/A	N/A	N/A	N/A	647(a)
Section 25 (1A)	N/A	N/A	N/A	N/A	267(b)
TOTALS	**2049**	**2422**	**2322**	**2293**	**2737**

Section 19A and Section 25 (1A) findings were only in effect for a full financial year in 2019/20, and are therefore separately accounted for in 2019/2020.

(a) These are findings where the coroner determines under Section 19A that the death is due to natural causes and therefore is not required to continue to investigate.

(b) These are findings where the coroner determines under Section 25(1A) that there is no public interest in finding how death occurred.

Post Mortem Examinations

Under section 25(1)(c) of the Coroners Act a coroner investigating a death must find, if possible, the cause of death.

Under section 34(1) 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. A post mortem examination is a detailed medical examination of the body of a person who has died, undertaken for the purpose of investigating the death.

Post mortem examinations for the Coroner's Court of Western Australia are performed at the direction of the coroner by experienced forensic pathologists. They prepare a confidential report for the coroner and provide an opinion on the cause of death. The post mortem report may also provide information that is relevant to manner of death. The coroner takes this information into account when making a finding.

Under section 36 of the Coroners Act, any person can ask the coroner who has jurisdiction to investigate a death to direct that a post mortem examination be performed on the body. If the coroner refuses the request an application may be made to the Supreme Court for an order that a post mortem be performed. Applicants have two clear working days after receiving the coroner's notice of refusal to apply to the Supreme Court unless an extension of time has been granted by the Supreme Court.

Objections to Post Mortem Examinations

Under section 37 of the Coroners Act, except where the coroner decides that a post mortem examination must be performed immediately, the senior next of kin may object to the conduct of a post mortem examination.

The senior next of kin in relation to the deceased means the first person who is available from the categories of persons referred to in section 37(5) of the Coroners Act, in the order of priority listed in that sub section.

A Coroner's brochure entitled "When a person dies suddenly" is served upon the senior next of kin by attending police officers as soon as possible following a death. That brochure explains the procedure for making an objection to the conduct of a post mortem examination. The senior next of kin may give notice of an objection to a post mortem examination to the Coronial Investigation Squad of the Western Australia Police, seven days a week from 7 am to midnight, or directly with the Coroner's Court of Western Australia during office hours.

The reasons for objections to a post mortem examination by a senior next of kin vary from person to person. In the normal course they are discussed with a member of the coronial counselling service who will convey them to the coroner. In a number of cases the coroner, after considering the other evidence that could assist in determining the likely cause of the death, will accept the objection and no post mortem examination will be performed.

In other cases, the coroner after carefully considering the reasons for the objection may nonetheless decide that a full internal post mortem examination is necessary and will overrule the objection. The coronial counsellor communicates the coroner's decision and reasons for over-ruling the objection to the senior next of kin. Also, under section 37(1) of the Coroners Act, the coroner must immediately give notice in writing of that decision to the senior next of kin and to the State Coroner. Within two clear working days of receiving notice of the coroner's decision (or before the end of any extension of time granted) the senior next of kin may apply to the Supreme Court for an order that no post mortem examination be performed. The Supreme Court may make an order to that effect if it is satisfied that it is desirable in the circumstances.

With the availability of the dedicated CT scanner at the State Mortuary as from 5 June 2019, the range of cases that are able to be considered for this process is expanded, thereby helping to alleviate some of the stress and anxiety for families who wish to object to full internal post mortem examinations. In the 2019/20 year, 2141 CT scans were performed.

The discussions between the senior next of kin and the members of the coronial counselling service are a vital component of the process for objections. The counsellors have experience in dealing compassionately with sensitive matters and are cognisant of cultural issues that may impact upon decision making in this area. The work of the coronial counselling service is further addressed at pages 23 to 24 of this Report.

Table F – Reported deaths and outcomes of objections

Table F below shows the number of post mortem examinations and the number of objections received in the 2019/20 year and the outcomes:

REPORTED DEATHS	
Immediate post mortem	**37**
No objection to post mortem	**2022**
Objection to post mortem	**447**
No post mortem conducted (missing person, death certificate originally issued or by order of coroner etc)	**67**
NUMBER OF REPORTED DEATHS	**2573**

OBJECTIONS TO POST MORTEMS	
Objection accepted	**388**
Objection withdrawn	**58**
Objection Overruled	**1**
TOTAL OBJECTIONS TO POST MORTEMS	**447**

Pathologist Recommended External Post Mortem Examinations

Consistent with the Law Reform Commission of Western Australia's recommendations 100 to 103 in its *Review of Coronial Practice in Western Australia, project no. 100* and pending external review of this component of the recommendations, the State Coroner has implemented the scheme to support the forensic pathologist's use of the least invasive procedures that are available and appropriate in the conduct of post mortem examinations.

The process involves forensic pathologists recommending to the coroner, where considered appropriate, that an external post mortem examination together with a review of available medical records and/or toxicological information is sufficient to enable them to form an opinion on cause of death. In each instance the senior next of kin are consulted, and the coroner makes a decision as to whether to approve the forensic pathologist's recommendation.

Before the availability of the CT scanner, the types of cases that were able to be considered for this external examination process were more limited to instances of obvious trauma and cases where the deceased had died in hospital, with well documented medical records including pre-mortem imaging. With the availability of the dedicated CT scanner at the State Mortuary as from 5 June 2019, the range of cases that are able to be considered for this process is significantly expanded. They can now include a greater range of trauma cases, and also cases where the deceased has died in circumstances that appear to be natural causes.

Table G below shows the number of pathologist recommended external post mortem examinations approved by the coroner, and the number of instances where the coroner has directed a full internal post mortem examination.

Table G - Outcomes in PRE (Pathologists Recommended External Post Mortem Examinations)

PATHOLOGIST RECOMMENDED EXTERNAL (PRE)	
PRE recommended by Pathologist	**254**
PRE approved by Coroner	**247**
PRE not approved by Coroner - Full PM	**0**
PRE rejected by next of kin - Full PM	**7**
PRE approved – Partial PM	**0**
TOTAL PATHOLOGIST RECOMMENDED EXTERNAL	**254**

Coronial Counselling Service Functions

The State Coroner's obligation under section 16 of the Coroners Act is to ensure that a counselling service is attached to the court. This is met through the Coronial Counselling Service (CCS). Any person coming into contact with the coronial system may seek the assistance of the CCS and, as far as practicable, that service is to be made available to them.

The CCS provides information, counselling, and liaison to those affected by sudden death and to numerous government and non-government agencies. The CCS is available from 7 am to 6 pm every day of the year including public holidays.

During the 2019/20 year, CCS was staffed by a Senior Coronial Counsellor and two counsellors. There were some staffing changes during the year with the Senior Coronial Counsellor seconded to another position in the Department in August 2019 for 12 months, that position being backfilled by one of the counsellors, and another counsellor announcing his retirement (effective August 2020). Whilst backfilling opportunities were explored to ensure full coverage, this was not always achieved and resulted in the need to focus on priority work at times.

In the latter part of the 2019/20 year, CCS was transferred to the Court Counselling and Support Services directorate with the Senior Coronial Counsellor reporting to the Director Court Counselling and Support Services. Previously, CCS was located within the Magistrates Court and Tribunals directorate with the Senior Coronial Counsellor reporting to an administrative role who was not tasked with providing this professional supervision. CCS's new line management includes the provision of professional supervision as all CCS positions require a four year Psychology or Social Work qualification with eligibility for professional membership. In addition, it aligns CCS with all other court based support services which have a social and behavioural science requirement.

Over the past reporting year, the coronial counsellors have spent many hours communicating with people who come into contact with the Coroner's Court. They aim to impart clear and accurate information, with compassion and they have a deep understanding of grief and loss.

Coronial counsellors provide information to the next of kin about the progress through the coronial system of the investigation into their family member's death. They explain the process and the timelines involved when a senior next of kin objects to a post mortem examination, discuss tissue retention issues, provide advice on body release dates, and facilitate connections to agencies that may assist with other aspects of the process.

Coronial counsellors are able to facilitate the viewing of selected case material from the coronial files to assist next of kin to better understand what happened to their family member. This process involves supporting the next of kin during the viewing as appropriate and being available to answer questions. Coronial counsellors are able to attend at the State Mortuary to support next of kin if they require that support when viewing their loved one.

The Perth based CCS provides its services in a variety of ways including in person and telephone. In addition it has continued to maintain productive links with counselling services available in regional and/or remote areas to ensure locally based services are available. From March to June 2020, CCS's in person services were suspended due to COVID-19, and the majority of work was undertaken by telephone contact.

Table H – Counselling Statistics and referral types

Table H below shows the number and types of referrals dealt with by the Coronial Counselling Service for the past five reporting years.

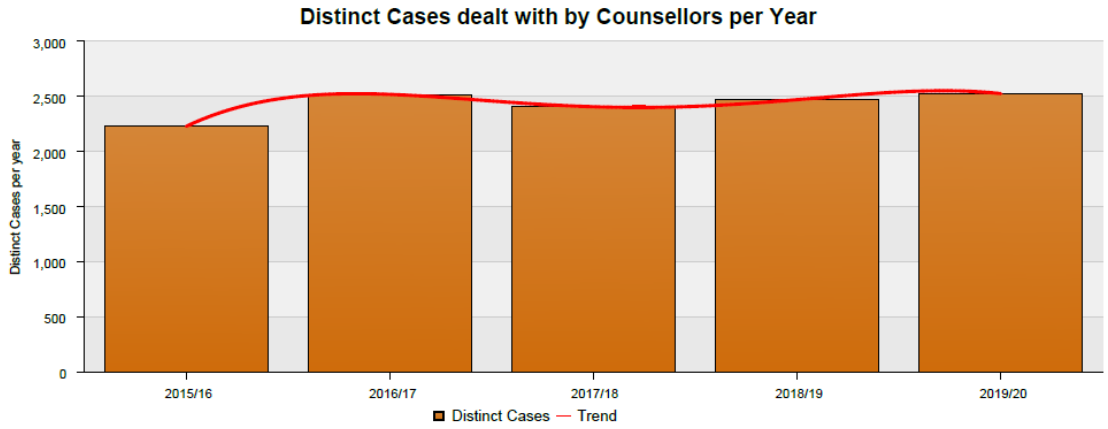
TYPE OF SERVICE	*2015-2016*	*2016-2017*	*2017-2018*	*2018-2019*	*2019-20*
Phone, Office/Home Visits	**6993**	**7274**	**6885**	**6993**	**7977**
Offers of Service	**547**	**577**	**701**	**652**	**150**
Mortuary/file viewings	**2566**	**3390**	**3195**	**2594**	**1815**
TOTAL CONTACTS	**10106**	**11241**	**10781**	**10239**	**9942**

For the 2019/20 year the above categories are explained as follows:

- Phone, Office/Home visits refers to all telephone calls (7741) visits to home addresses (6) and attendances at other offices or attendances by others at the Court (230);
- Offers of Service refers to letters offering counselling (150). It needs to be noted that offers of service as a proactive offer of counselling was suspended in January 2020; and
- Mortuary/file viewings refers to emails (954), interoffice liaison (858) and mortuary contact (3).

For this reporting year, given the new ICMS system and new reporting structure, further analyses are provided.

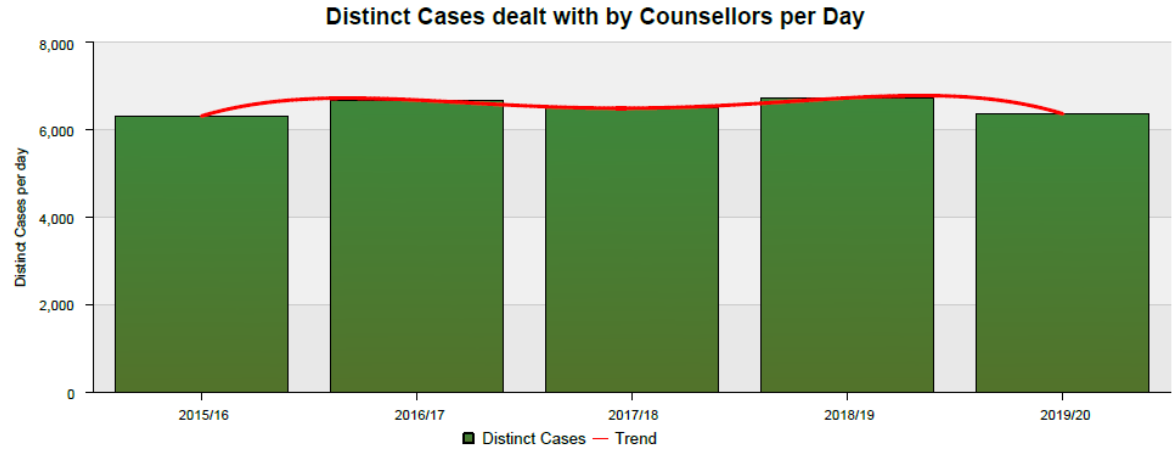
The following table shows the total number of individual cases that CCS has been involved in where the number of cases worked on per year has been counted only once over the entire year.



Cases dealt with by Counsellors

	2015/16	2016/17	2017/18	2018/19	2019/20	% Change
Distinct cases dealt with by counsellors per year	2,230	2,519	2,407	2,471	2,526	2.2%

As CCS service delivery would usually involve contact with a case more than once, the following table demonstrates the total number of cases when each case is counted per working day.



	2015/16	2016/17	2017/18	2018/19	2019/20	% Change
Distinct cases dealt with by counsellors per day	6,309	6,675	6,489	6,724	6,361	-5.4%

Coronial Ethics Committee Functions

The Coronial Ethics Committee was established pursuant to section 58 of the Coroners Act and operates in compliance with the National Health and Medical Research Council's National Statement on Ethical Conduct in Human Research and its associated guidelines.

Coronial data is confidential. An application for the provision of coronial data must be accompanied by a detailed written submission to the Coronial Ethics Committee. Applications are primarily made for research purposes. As the level of business for the Committee has increased over time, so have the number of meetings the Committee holds. On average, this past reporting year, the Coronial Ethics Committee has met bi-monthly to consider applications. In decision-making, the Committee members attempt to strike a balance between family concerns (including privacy, confidentiality, and consent issues), and the benefits of research to the community at large. Once an application has been considered, the Coronial Ethics Committee makes its recommendation to the State Coroner about whether the coronial data sought should be released, and under what conditions.

The membership of the Coronial Ethics Committee is drawn from a range of representative categories to allow for a broad cross section of views to be considered during discussions. The Coroner's Court of Western Australia is well served by the considerable work done by Coronial Ethics Committee members, who volunteer their time. The subject matter is sensitive and the Committee makes a vital contribution to the coroner's death prevention role.

The members of the Coronial Ethics Committee for the 2019/20 year are as follows:

Dr Jodi White	Chairperson, Forensic Pathologist, PathWest
Mr Michael Jenkin	Coroner
Associate Professor Jennet Harvey	Member with relevant research experience
Ms Simone Brand	Member with counselling background
Ms Christine Pitt	Legal Member
Ms Natalie Gately	Lay member
Dr Thomas Hitchcock	Member with relevant research experience
Dr Rosemary Coates	Lay member
Ms Kim Farmer	Indigenous member

Upon rotation, one of the counsel assisting acts as Secretary to the Committee.

Owing to the effects of COVID-19, the April and June 2020 meetings were conducted electronically via email so the work of the Committee was not interrupted.

This past reporting year, the Coronial Ethics Committee met four times in person and twice electronically and addressed the following number of projects, as indicated in Table I below. The State Coroner did not reject any of the Ethics Committee's recommendations.

Table I – Projects and recommendations

Number of Projects Considered	**Number of projects approved**	**Number of projects not approved**	**Deferred**
13	11	0	2
Number of Requests for renewal Considered	**Number of Requests for renewal Approved**	**Number of Requests for renewal Not approved**	**Deferred**
8	8	0	0
Number of Amendments	**Number of amendments approved**	**Number of amendments not approved**	
35	34	0	1

Principal Registrar and Coroner's Registrars

Coroner's registrars are appointed under section 12 of the Coroners Act and one of the registrars performs the functions of the Principal Registrar. All registrars have statutory functions under section 13 of the Coroners Act and they exercise the powers or duties of a coroner that are delegated to them by the State Coroner in writing under section 10 of the Coroners Act. In the 2019/20 year there have been six coroner's registrars at the Coroner's Court in Perth, four of whom exercise delegated functions under section 10 of the Coroners Act. They exercise their delegations contemporaneously with their other functions.

In addition, registrars of Magistrates Courts may act as coroner's registrars if an investigation is held at a courthouse where the Magistrates Court sits.

A coroner's registrar's delegated functions under section 10 and statutory functions under section 13 include, but are not limited to, receiving information about a death which a coroner is investigating other than at an inquest, issuing summonses, requiring witnesses to attend at inquests, directing that a pathologist or a doctor perform a post mortem examination, authorising the release of the body following the post mortem examination and authorising tissue donations under the *Human Tissue and Transplant Act* 1982.

The coroner's registrars also have specific delegated functions empowering them to restrict access to a place where the death occurred, or where the event which caused or contributed to the death occurred. Of necessity, arrangements are in place so that a coroner's registrar is contactable at any time of the day or night, every day of the year.

The Principal Registrar is the coroner's registrar who deals with incoming notifications and requests to the Coroner's Court and assesses those incoming matters for referral to the State Coroner where they involve complexities and/or the exercise of non-delegated statutory functions.

The Principal Registrar executes the State Coroner's directions in relation to the conduct of coronial investigations. The Principal Registrar represents the State Coroner at a variety of internal and external forums/meetings. On behalf of the State Coroner, the Principal Registrar liaises with members of the Western Australia Police Force, officers from the Department of Health, the Western Australian Ombudsman, and numerous other government and non-government agencies. The Principal Registrar also provides education and information sessions to health and legal professionals and other organisations as part of a community education strategy.

Counsel Assisting the Coroner

The Coroner's Court has three counsel who assist the coroners in the conduct of their inquests. They are legal practitioners, and they appear in court as counsel assisting the coroner. They present the evidence and examine and cross examine witnesses. They prepare the matters for inquest, compile the coroner's brief, and they liaise with family members and interested persons in the lead up to the inquest, to ensure that all relevant material is placed before the coroner at

the inquest, in order to assist the coroner in making the findings under s 25(1) of the Coroners Act. They also assist the coroner in formulating recommendations to prevent deaths arising in similar circumstances. Where necessary or desirable, they are involved in the gathering of further evidence for the coroner.

The counsel assisting also provide advice and recommendation to the State Coroner upon statutory requests for inquests, that may be made by any person. On rotation, one of the counsel assisting acts as the Secretary to the Ethics Committee.

Police Assisting the Coroner

The four police officers attached to the Coroner's Court serve as a critical link between the Coroner's Court and the Coronial Investigation Squad of the Western Australia Police Force. They provide assistance to the coroners in the preparation of matters for inquest, including the gathering of evidence where necessary and serving of summonses.

There is one sergeant, who carries out the dual roles of appearing as sergeant assisting the coroner at inquests in court, and supervising the three senior constables attached to the court. During this reporting year, one of the senior constables also appeared in court to assist the coroner for the inquests into the suspected deaths of the long term missing persons.

Together the police officers attached to the court assist the coroners in the exercise of the statutory functions under the Coroners Act, including the gathering of further evidence (including under compulsion), the provision of supplemental information from governmental departments and medical and technical experts, assistance to coroners in other jurisdiction at the direction of the State Coroner, liaison with inquest witnesses, and quality assurance on the more complicated reports to the coroner. They provide assistance to all police officers state-wide, in relation to advice and guidance on matters of coronial procedure, jurisdiction and authority, to generate consistency in approach to coronial investigations.

Over the past reporting year, under the guidance of the sergeant, two of the senior constables have been involved in the implementation and progression of the triage system, that supports the making of determinations by the coroner under s 19A and s 25(1A) of the Coroners Act. This system seeks to fast track certain types of cases, in order to bring about an early resolution for the families. It is noted that a total of 914 such findings were completed by the coroners over this reporting year.

Table J – Total number of inquests

Table J below shows the total number of inquests **(100)** finalised in the 2019/20. An inquest is finalised when the coroner signs the inquest finding.

Name of Deceased	*Date of Death*	*Inquest Date*	*Finding*	*Date of finding*
***CONLEY** Troy Michael	21/1/2016	15/2/2019	Natural Causes	9/7/2019
***NICOL** Annabel	15/6/2015	12/2/2019	Suicide	11/7/2019
***FLEURY** Mark Quenton	14/2/2016	20-21/5/2019	Suicide	17/7/2019
***BONNEY** Arthur James	5/8/2015	25-26/2/2019	Natural Causes	22/7/2019
#WATSON Andrew Michael	On or about 11/5/2013	11/4/2019	Suicide	23/7/2019
***OXLEY** Stephen Thomas	9/12/2017	16/7/2019	Natural Causes	23/7/2019
***CHILD KT**	23/11/2016	29/7/2019	Natural Causes	30/7/2019
^McALPINE Rhett Samuel	14/9/2016	16/5/2019	Misadventure	31/7/2019
#BALE Matthew James	On or about 21/3/2016	19/6/2019	Misadventure	1/8/2019
***CHANDLER** Timothy James	25/12/2017	26/7/2019	Natural Causes	2/8/2019
BOARD Anita Jade	12/11/2017	18-20/2/2019	Misadventure	14/8/2019
^ROGERS Clinton Edward	18/11/2016	8/8/2019	Accident	15/8/2019
^HILDER Daniel Paul	8/7/2016	15/8/2019	Accident	20/8/2019
***BOLTON** Judy Sonia	10/12/2016	24-25/6/2019	Natural Causes	20/8/2019
***CHI** James Ronald	26/6/2017	2-3/7/2019	Natural Causes	30/8/2019
^PIETRALA David John	11/2/2016	27/8/2019	Accident	3/9/2019

Name of Deceased	*Date of Death*	*Inquest Date*	*Finding*	*Date of finding*
+CLARKE James	18/5/1966	12/8/2019	Open Finding	5/9/2019
+SETTREE Peter John Edward	19/9/1979	28/8/2019	Misadventure	5/9/2019
+CULLEN David	14/1/1972	6/8/2019	Open Finding	5/9/2019
+MAHER John Patrick	24/4/1980	13/8/2019	Accident	5/9/2019
+NEWBY Francis Joseph	1/4/1978	7/8/2019	Misadventure	5/9/2019
RILEY Dylan James	1/8/2015	29/8/2019	Natural Causes	23/9/2019
MORGAN-SMITH Sean	24/6/2015	27/5/2019	Accident	23/9/2019
STRANGE Paul	9/12/2016	4-6/2019	Suicide	27/9/2019
HANSEN Lorraine Jane	29/6/2019	24-25/9/2019	Open Finding	23/10/2019
^LINDSAY Brendan John	8/11/2014	10-13/9/2018	Homicide by way of self defence	7/11/2019
^FORBES Glenys Joy and **^FORBES** Kevin Hugh	17/9/2017	24/7/2019	Unlawful Homicide	17/10/2019
***CAPPER** Bret Lindsay	14/1/2016	8-10/10/2019	Suicide	13/11/2019
+HIGGS Joseph Wellard	Between 20-28/5/1986	5/9/2019	Open Finding	13/11/2019
+BATEMAN Clarence Benningfield	25/9/1977	6/9/2019	Open Finding	14/11/2020
+CARTER John (Jack) Edward	10/12/1965	1/10/2019	Misadventure	14/11/2020
***RICE** David Anthony	14/10/2015	14/10/2019	Accident	14/11/2020
+JAMES Gordon	On or about 27/7/1987	15/10/2019	Suicide	15/11/2019

Name of Deceased	*Date of Death*	*Inquest Date*	*Finding*	*Date of finding*
+DUFFY Brian Anthony	On or about 26/2/1993	2/10/2019	Open Finding	15/11/2019
+MOEN Sigurd	On or about 24/9/1967	2/10/2019	Open Finding	15/11/2019
***CHILD SH**	1/9/2018	14/5/2019	Natural Causes	21/11/2019
CURNOW Kym Brett **BUTCHER** Thomas Leslie **KOHRS-LICHTE** Julie **WINTHER** Anna Sushchova	17/11/2015	25-29/3/2019	Accident	22/11/2019
#GAUNT Nathan James	On or about 22/10/2018	5/11/2019	Suicide	27/11/2019
^MARSH Aaron Stephen	24/8/2018	17/10/2019	Accident	22/11/2019
+NUNN Derrick Charles Walter	23/12/1973	16/10/2019 and 11/12/2019	Misadventure	11/12/2019
+PATTERSON Joseph Leon	On or about 26/7/1974	27/8/2019	Open Finding	16/12/2019
^SCRIVENER Ryan Philip	28/2/2016	11-12/9/2019	Suicide	17/12/2019
***CHILD AC**	10/8/2017	19/11/2019	Natural Causes	19/12/2019
***MALLETT** Jason James Sutherland	3/3/2017	26/11/2019	Natural Causes	20/12/2019
***CHILD TJW**	12/7/2018	18/12/2019	Natural Causes	20/12/2019
PHAM Uock **O'NEILL** Justin Michael **PHAM** Jacob Tuan **#PHAM** Tuan	4/10/2018	6/12/2019	Misadventure	30/12/2019
^HEADLAND Zaraiyah-Lily **^ HEADLAND** Andreas Hohaia	26/9/2016	29-30/10/2019	Unlawful Homicide	16/1/2020

Name of Deceased	*Date of Death*	*Inquest Date*	*Finding*	*Date of finding*
#DA SILVA Jose	30/4/2017	24/1/2020	Open Finding	3/2/2020
***HODGKINSON** Tania Marie	23/3/2017	3-4/12/2019	Suicide	5/2/2020
***WUMBIE** Eric	13/4/2016	12/2/2020	Natural Causes	20/2/2020
+MOZES Arthur Edwin	6/10/2017	25/11/2019	Open Finding	25/2/2020
+McCARTHY Gloria Anne	17/11/1972	9/12/2019	Misadventure	25/2/2020
+COLLEY Gordon	7/12/1977	26/11/2019	Open Finding	4/3/2020
+PALMER Jackie	4/1/1995	12/2/2020	Natural Causes	4/3/2020
+BIBROU Whisky	21//10/1976	5/8/2019	Open Finding	4/3/2020
+RODRIGUES Andrew Inez	18/12/1993	27/11/2019	Open Finding	4/3/2019
+O'NEILL Charles	Not deceased	7/1/2019	Not Deceased	4/3/2020
***HAZELGROVE** Norman Alexander	18/9/2017	18/2/2020	Natural Causes	20/3/2020
#ZHANG Qianfang	On or about 16/9/2017	27/2/2020	Open Finding	9/3/2020
+RYALL Richard Lakeman	On or about 16/11/1986	10/12/2019	Suicide	31/3/2020
+CARPENTER Malcolm Andrew	25/5/1975	11/12/2019	Misadventure	31/3/2020
+NAGAI Hajime	11/3/1995	10/12/2019	Misadventure	31/3/2020
+BATES Charles Donald	28/7/1977	29/8/2019	Misadventure	31/3/2020
***CANDY** Benedict Chifley David	1/9/2017	19/3/2020	Natural Causes	2/4/2020
***KELLY** Valerie	24/9/2016	9/3/2020	Natural Causes	2/4/2020

Name of Deceased	*Date of Death*	*Inquest Date*	*Finding*	*Date of finding*
***BECHARA** Hassan	6/7/2017	7/4/2020	Natural Causes	24/4/2020
THOMPSON Brendan John	6/3/2016	5/2/2019	Accident	15/5/2020
+HIYOMORI Tatao	On or about 8/1/1986	21/1/2020	Open Finding	4/5/2020
+WATTS Derek Spencer	30/1/1977	8/1/2020	Misadventure	4/5/2020
+NANCE Paddy	On or about 30/9/199	28/1/2020	Open Finding	13/5/2020
+HATAKEYAMA Toshiyuki	6/8/1979	29-30/1/2020	Misadventure	13/5/2020
+WALLABY Ngoolbu	During February 1977	29/1/2020	Open Finding	13/5/2020
+WANDARAGAH Tojo	Between 27/3 and 30/4/1991	19/11/2019	Open Finding	4/5/2020
+WELLINGTON Bryon Harold	On or about 16/11/1994	28/1/2020	Open Finding	13/5/2020
#RAE Thomas Dominic	7/7/2019	7/5/2020	Accident	14/5/2020
***REILLY** Nualla Christine	9/6/2017	24-25/2/2020	Suicide	26/5/2020
+JACKAMORA Fred	After 9/11/1983	28-29//1/2020	Open Finding	26/5/2020
+UMBUL Yilmut	Between March and April 1982	2/12/2019	Open Finding	26/5/2020
+TARI Sylvina	Late 1981 early 1982	3/12/2019	Open Finding	26/5/2020
+GIBBARD Edward John	On or following 23/12/1976	14 and 28/10/2020	Open Finding	27/5/2020
+PEACE Winifred Mary	After 22/10/1959	4/3/2020	Open Finding	27/5/2020
+MARBIN Simon	After 12/12/1992	30/1/2020	Open Finding	28/5/2020
+PETA Michael	On or about 16/1/1975	30/1/2020	Open Finding	28/5/2020

Name of Deceased	*Date of Death*	*Inquest Date*	*Finding*	*Date of finding*
+FOGARTY Christen Lee	25/7/2002	24/3/2020	Open Finding	2/6/2020
+JESSEN Barry Jay	17/8/2006	6/4/2020	Misadventure	2/6/2020
+HAYTHORNTHWAITE Kate Campbell	On or about 26/1/1968	18/2/2020	Open Finding	2/6/2020
+NGURRAKATA Wombat	On or about 17/1/1988	29/1/2020	Open Finding	2/6/2020
+BARRETT Wilfred Arthur	Sometime in May 1984	19/2/2020	Open Finding	3/6/2020
+JOHNSTONE Anthony	During November December 1996	17/3/2020 and 13/5/2020	Open Finding	3/6/2020
***DYBALL** Michael Warren	1/5/2016	22/5/2020	Natural Causes	3/6/2020
***ATWELL** Brian Vincent	13/7/2017	22/5/2020	Natural Causes	3/6/2020
^NIELSEN Thorvald Anthony	13/4/2017	16-18/3/2020	Homicide by way of self defence	15/6/2020

 # = Missing person (7)

+ = Long Term Missing Persons (44)

*** = Person held in care (24)**

^ = Death that appeared to be caused or contributed to by any action of a member of the police force (12)

The balance of the matters listed (13) were discretionary inquests

Total Inquests : 100

I acknowledge the considerable assistance rendered by the Coroner's Court's Listing Manager and my Administrator in their management of the court's listing requirements, their preparation of matters for hearing and all of the guidance they provide to staff members for the preparation of inquest briefs.

The Tables appearing after Table J (Tables K, L and M) are subsets of the information contained in Table J, and the following Tables all relate to mandated inquests.

DEATHS THAT APPEARED TO BE CAUSED, OR CONTRIBUTED TO, BY ANY ACTION OF A MEMBER OF THE POLICE FORCE

Under section 22(1)(b) of the Coroners Act, a coroner who has jurisdiction to investigate a death must hold an inquest if the death appears to be a Western Australian death and it appears that the death was caused, or contributed to, by any action of a member of the Police Force.

Table K – Deaths caused or contributed to by any action of a member of the police force

Table K below shows the number of inquests **(12)** finalised in 2019/20 year into deaths that appeared to be caused, or contributed to, by any action of a member of the Police Force.

Name of Deceased	*Date of Death*	*Inquest Date*	*Finding*	*Date of finding*
McALPINE Rhett Samuel	14/9/2016	16/5/2019	Misadventure [Police Pursuit]	31/7/2019
ROGERS Clinton Edward	18/11/2016	8/8/2019	Accident [Police Pursuit]	15/8/2019
HILDER Daniel Paul	8/7/2016	15/8/2019	Accident [Police Pursuit]	20/8/2019
PIETRALA David John	11/2/2016	27/8/2019	Accident [Police Pursuit]	3/9/2019
LINDSAY Brendan John	8/11/2014	10-13/9/2018	Homicide by way of self defence [Police Shooting]	7/11/2019
FORBES Glenys Joy **FORBES** Kevin Hugh	17/9/2017	24/7/2019	Unlawful Homicide [Police Pursuit]	17/10/2019
MARSH Aaron Stephen	24/8/2018	17/10/2019	Accident [Police Pursuit]	22/11/2019
SCRIVENER Ryan Philip	28/2/2016	11-12/9/2019	Suicide [Police Attendance]	17/12/2019
HEADLAND Zaraiyah-Lily **HEADLAND** Andreas Hohaia	26/9/2016	29-30/10/2019	Unlawful Homicide [Police Response]	16/1/2020
NIELSEN Thorvald Anthony	13/4/2017	16-18/3/2020	Homicide by way of self defence [Police Shooting]	15/6/2020

In ten instances, the coroner found that the police did not cause or contribute to the death. In the other two instances, the coroner found the police were carrying out a legitimate law enforcement activity, or their actions were justified by the circumstances.

The coroners' findings and the responses appear on the website of the Coroner's Court of Western Australia.

SUSPECTED DEATHS

Under section 23 of the Coroners Act 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 the State Coroner has given such a direction a coroner must hold an inquest into the circumstances of the suspected death of the person, and if the coroner finds that the death of the person has been established beyond all reasonable doubt, into how the death occurred and the cause of the death.

Table L – Missing Persons

Table L below shows the number of inquests (7) finalised in 2019/20 year into suspected deaths (this is separate to the reporting on the long term missing person project).

Name of Deceased	*Date of Death*	*Inquest Date*	*Finding*	*Date of finding*
WATSON Andrew Michael	On or about 11/5/2013	11/4/2019	Suicide	23/7/2019
BALE Matthew James	On or about 21/3/2016	19/6/2019	Misadventure	1/8/2019
GAUNT Nathan James	On or about 22/10/2018	5/11/2019	Suicide	27/11/2019
DA SILVA Jose	30/4/2017	24/1/2020	Open Finding	3/2/2020
ZHANG Qianfang	On or about 16/9/2017	27/2/2020	Open Finding	9/3/2020
RAE Thomas Dominic	7/7/2019	7/5/2020	Accident	14/5/2020
PHAM Tuan	On or about 4/10/2018	6/12/2019	Misadventure	30/12/2019

In all of the cases the coroner found that the death of the person had been established beyond all reasonable doubt.

The coroners' findings and the responses appear on the website of the Coroner's Court of Western Australia.

Table M – Long Term Missing Persons Project

In addition to the Missing Persons inquests that were conducted in the ordinary course of coronial investigations, Coroner Evelyn Vicker was engaged to investigate 44 long term missing persons cases over the course of the 2019/20 financial year.

Table M below shows the number of inquests (44) finalised in 2019/20 year into the suspected deaths of the long term mssing persons.

Name of Deceased	*Date of Death*	*Inquest Date*	*Finding*	*Date of finding*
CLARKE James	18/5/1966	12/8/2019	Open Finding	5/9/2019
SETTREE Peter John Edward	19/9/1979	28/8/2019	Misadventure	5/9/2019
CULLEN David	14/1/1972	6/8/2019	Open Finding	5/9/2019
MAHER John Patrick	24/4/1980	13/8/2019	Accident	5/9/2019
NEWBY Francis Joseph	1/4/1978	7/8/2019	Misadventure	5/9/2019
HIGGS Joseph Wellard	Between 20-28/5/1986	5/9/2019	Open Finding	13/11/2019
BATEMAN Clarence Benningfield	25/9/1977	6/9/2019	Open Finding	14/11/2020
CARTER John (Jack) Edward	10/12/1965	1/10/2019	Misadventure	14/11/2020
JAMES Gordon	On or about 27/7/1987	15/10/2019	Suicide	15/11/2019
DUFFY Brian Anthony	On or about 26/2/1993	2/10/2019	Open Finding	15/11/2019
MOEN Sigurd	On or about 24/9/1967	2/10/2019	Open Finding	15/11/2019
NUNN Derrick Charles Walter	23/12/1973	16/10/2019 and 11/12/2019	Misadventure	11/12/2019

Name of Deceased	*Date of Death*	*Inquest Date*	*Finding*	*Date of finding*
PATTERSON Joseph Leon	On or about 26/7/1974	27/8/2019	Open Finding	16/12/2019
MOZES Arthur Edwin	6/10/2017	25/11/2019	Open Finding	25/2/2020
McCARTHY Gloria Anne	17/11/1972	9/12/2019	Misadventure	25/2/2020
COLLEY Gordon	7/12/1977	26/11/2019	Open Finding	4/3/2020
PALMER Jackie	4/1/1995	12/2/2020	Natural Causes	4/3/2020
BIBROU Whisky	21//10/1976	5/8/2019	Open Finding	4/3/2020
RODRIGUES Andrew Inez	18/12/1993	27/11/2019	Open Finding	4/3/2019
O'NEILL Charles	Not deceased	7/1/2019	Not Deceased	4/3/2020
RYALL Richard Lakeman	On or about 16/11/1986	10/12/2019	Suicide	31/3/2020
CARPENTER Malcolm Andrew	25/5/1975	11/12/2019	Misadventure	31/3/2020
NAGAI Hajime	11/3/1995	10/12/2019	Misadventure	31/3/2020
BATES Charles Donald	28/7/1977	29/8/2019	Misadventure	31/3/2020
HIYOMORI Tatao	On or about 8/1/1986	21/1/2020	Open Finding	4/5/2020
WATTS Derek Spencer	30/1/1977	8/1/2020	Misadventure	4/5/2020

Name of Deceased	*Date of Death*	*Inquest Date*	*Finding*	*Date of finding*
NANCE Paddy	On or about 30/9/199	28/1/2020	Open Finding	13/5/2020
HATAKEYAMA Toshiyuki	6/8/1979	29-30/1/2020	Misadventure	13/5/2020
WALLABY Ngoolbu	During February 1977	29/1/2020	Open Finding	13/5/2020
WANDARAGAH Tojo	Between 27/3 and 30/4/1991	19/11/2019	Open Finding	4/5/2020
WELLINGTON Bryon Harold	On or about 16/11/1994	28/1/2020	Open Finding	13/5/2020
JACKAMORA Fred	After 9/11/1983	28-29//1/2020	Open Finding	26/5/2020
UMBUL Yilmut	Between March and April 1982	2/12/2019	Open Finding	26/5/2020
TARI Sylvina	Late 1981 early 1982	3/12/2019	Open Finding	26/5/2020
GIBBARD Edward John	On or following 23/12/1976	14 and 28/10/2020	Open Finding	27/5/2020
PEACE Winifred Mary	After 22/10/1959	4/3/2020	Open Finding	27/5/2020
MARBIN Simon	After 12/12/1992	30/1/2020	Open Finding	28/5/2020
PETA Michael	On or about 16/1/1975	30/1/2020	Open Finding	28/5/2020
FOGARTY Christen Lee	25/7/2002	24/3/2020	Open Finding	2/6/2020
JESSEN Barry Jay	17/8/2006	6/4/2020	Misadventure	2/6/2020

Name of Deceased	*Date of Death*	*Inquest Date*	*Finding*	*Date of finding*
HAYTHORNTHWAITE Kate Campbell	On or about 26/1/1968	18/2/2020	Open Finding	2/6/2020
NGURRAKATA Wombat	On or about 17/1/1988	29/1/2020	Open Finding	2/6/2020
BARRETT Wilfred Arthur	Sometime in May 1984	19/2/2020	Open Finding	3/6/2020
JOHNSTONE Anthony	During November December 1996	17/3/2020 and 13/5/2020	Open Finding	3/6/2020

In all of the cases except for the investigation into the suspected death of Charles O'Neill the coroner found that the death of the person had been established beyond all reasonable doubt.

The coroners' findings and the responses appear on the website of the Coroner's Court of Western Australia.

PERSONS HELD IN CARE

Under section 3 of the Coroners Act a "person held in care" means:

(a) a person under, or escaping from, the control, care or custody of –

(i) the CEO as defined in section 3 of the *Children and Community Services Act* 2004; or
(ii) the Chief Executive Officer of the department of the Public Service principally assisting the Minister administering the *Prisons Act* 1981 in its administration; or
(iii) a member of the Police Force;

or

(aa) a person for whom the CEO as defined in the *Court Security and Custodial Services Act* 1999 is responsible under section 10, 13, 15 or 16 of that Act, whether that person is at a custodial place as defined in that Act, is being moved between custodial places or escapes, or becomes absent, from a custodial place or during movement between custodial places; or

(b) a person admitted to a centre under the *Alcohol and Other Drugs Act 1974*; or

(ca) a resident as defined in the *Declared Places (Mentally Impaired Accused) Act 2015* section 3;

(c) a person

(i) who is an involuntary patient under the *Mental Health Act 2014*; or
(ii) who is apprehended or detained under that Act; or
(iii) who is absent without leave from a hospital or other place under section 97 of that Act; or

(d) a person detained under the *Young Offenders Act 1994*;

Table N overleaf shows the number of inquests **(24)** finalised in 2018/19 into deaths of persons held in care.

In accordance with section 27(1) of the Coroners Act, the specific report on the death of each person held in care appears after Table N.

Table N – Persons held in care

Table N below shows the number of inquests (24) finalised in 2019/20 year into Deaths of persons held in care.

Name of Deceased	*Date of Death*	*Inquest Date*	*Finding*	*Date of finding*
CONLEY Troy Michael	21/1/2016	15/2/2019	Natural Causes	9/7/2019
NICOL Annabel	15/6/2015	12/2/2019	Suicide	11/7/2019
FLEURY Mark Quenton	14/2/2016	20-21/5/2019	Suicide	17/7/2019
BONNEY Arthur James	5/8/2015	25-26/2/2019	Natural Causes	22/7/2019
OXLEY Stephen Thomas	9/12/2017	16/7/2019	Natural Causes	23/7/2019
CHILD KT	23/11/2016	29/7/2019	Natural Causes	30/7/2019
CHANDLER Timothy James	25/12/2017	26/7/2019	Natural Causes	2/8/2019
BOLTON Judy Sonia	10/12/2016	24-25/6/2019	Natural Causes	20/8/2019
CHI James Ronald	26/6/2017	2-3/7/2019	Natural Causes	30/8/2019
CAPPER Bret Lindsay	14/1/2016	8-10/10/2019	Suicide	13/11/2019
RICE David Anthony	14/10/2015	14/10/2019	Accident	14/11/2020
CHILD SH	1/9/2018	14/5/2019	Natural Causes	21/11/2019
CHILD AC	10/8/2017	19/11/2019	Natural Causes	19/12/2019
MALLETT Jason James Sutherland	3/3/2017	26/11/2019	Natural Causes	20/12/2019

Name of Deceased	*Date of Death*	*Inquest Date*	*Finding*	*Date of finding*
CHILD TJW	12/7/2018	18/12/2019	Natural Causes	20/12/2019
HODGKINSON Tania Marie	23/3/2017	3-4/12/2019	Suicide	5/2/2020
WUMBIE Eric	13/4/2016	12/2/2020	Natural Causes	20/2/2020
HAZELGROVE Norman Alexander	18/9/2017	18/2/2020	Natural Causes	20/3/2020
CANDY Benedict Chifley David	1/9/2017	19/3/2020	Natural Causes	2/4/2020
KELLY Valerie	24/9/2016	9/3/2020	Natural Causes	2/4/2020
BECHARA Hassan	6/7/2017	7/4/2020	Natural Causes	24/4/2020
REILLY Nualla Christine	9/6/2017	24-25/2/2020	Suicide	26/5/2020
DYBALL Michael Warren	1/5/2016	22/5/2020	Natural Causes	3/6/2020
ATWELL Brian Vincent	13/7/2017	22/5/2020	Natural Causes	3/6/2020

In five cases, the coroner expressed concern about aspects of supervision, treatment and/or care (Bolton, J; Capper, B; Rice, D; Child SH and Reilly, N).

The coroners' findings and the responses appear on the website of the Coroner's Court of Western Australia.

The individual cases summaries follow.

PERSONS HELD IN CARE – specific reports

Troy Michael CONLEY
Inquest held in Perth 15 February 2019, investigation finalised 9 July 2019

Mr Troy Michael Conley (Mr Conley) died on 21 January 2016 at Sir Charles Gairdner Hospital. He was 45 years old. The Deputy State Coroner found that the cause of death was severe chronic obstructive pulmonary disease, and that death occurred by way of natural causes.

Immediately before death, Mr Conley was a 'person held in care', under section 3 of the *Coroners Act 1996* because he was a sentenced prisoner and, under the *Prisons Act 1981,* Mr Conley was in the custody of the Chief Executive Officer of the Department of Corrective Services. Mr Conley was serving his sentence at Bunbury Prison.

Mr Conley was a gyprock worker who had used drugs from an early age. By 2010 he was addicted to intravenous amphetamine and heroin. Mr Conley had an extensive and varied criminal history which included traffic offences, burglary and stealing, and drug offences. Mr Conley was a smoker.

Mr Conley entered prison on remand in April 2012. On 15 June 2012, he saw a medical officer in Hakea Prison with a cough and wheeze. On 16 October 2012, he was sentenced to four years imprisonment. In December 2012, he was diagnosed with chronic obstructive pulmonary disease.

Over the next two years, Mr Conley's condition was managed by the prison doctor. In late 2014 and early 2015, he saw a physician at the South West Health Campus who diagnosed significant emphysema from smoking and progressive massive fibrosis from occupational exposure and fibrosing venulitis from intravenous drug use. The physician referred him to a respiratory specialist at Sir Charles Gairdner Hospital, who continued to see him from that time. Mr Conley continued to smoke.

On 7 January 2016, Mr Conley was admitted to the emergency department at Bunbury Hospital for infective exacerbation of chronic lung disease. On 12 January 2016, he was transferred to Sir Charles Gairdner Hospital and was diagnosed with likely foreign body granulomatosis (talcosis) secondary to intravenous drug use, causing progressive upper lobe fibrosis, likely upper lobe emphysema, central progressive massive fibrosis and pulmonary hypertension. Mr Conley was advised that a lung transplant would be particularly onerous, and that the only other treatment option was palliation.

On 13 January 2016, Mr Conley advised that he wanted palliation. On 21 January 2016, he died with his family present. Six hours before he died, Mr Conley was released from custody under the Royal Prerogative of Mercy, but he was too unwell to leave hospital.

The Deputy State Coroner found that the care provided to Mr Conley was reasonable and appropriate while he was incarcerated.

The Deputy State Coroner did not make any recommendations.

The Finding is on the website of the Coroner's Court of Western Australia..

Annabel NICOL
Inquest held in Perth 12 February 2019, investigation finalised 11 July 2019

Ms Annabel Nicol (Ms Nicol) died on 15 June 2015 at Bandyp Women's Prison. The cause of death was ligature compression of the neck (hanging). The Coroner found the manner of death was by suicide. She was 50 years old.

Immediately before death Ms Nicol was a "person held in care" under section 3 of the *Coroners Act 1996* because she was a sentenced prisoner, and pursuant to the *Prisons Act 1981* she was in the custody of the Chief Executive Officer of the Department of Corrective Services. Ms Nicol was serving her sentence at Bandyup Women's Prison.

On 13 March 2015 Ms Nicol was placed on remand at the Bandyup Women's Prison having breached her existing CBO. Ms Nicol was also said to be a Schedule 2 offender under the *Bail Act 1982* (WA), allegedly having committed a serious offence whilst on bail for a serious offence. Ms Nicol's release on bail was opposed by police prosecutors at her first court appearance and she was refused bail.

Ms Nicol started using alcohol at a young age, which developed into chronic alcoholism during her marriage. Ms Nicol had suffered with depression and alcohol addiction for many years. Ms Nicol had hospital admissions on at least three occasions after being found collapsed in the street due to acute alcohol intoxication. She had convictions in 2012 and 2013 for driving under the influence of alcohol.

After being imprisoned, Ms Nicol became profoundly depressed and suicidal.

On 5 April 2015, approximately three weeks after being incarcerated, Ms Nicol, was taken by ambulance to the Swan Hospital Emergency Department. Ms Nicol provided hospital staff with a four day history of ingesting multiple cleaning products as well as a metal paperclip two weeks previously. A recommendation was made by the hospital that Ms Nicol have a psychiatric assessment at the prison.

On 8 April 2015 Ms Nicol underwent a medical officer review for her new admission and was referred for psychiatric assessment. On 10 April 2015 Ms Nicol was seen by a mental health nurse and assessed. Ms Nicol did not appear to have any psychiatric history and the conclusion was that she did not need to be seen by mental health staff. After exhibiting distress and behavioural issues, on 28 April 2015 Ms Nicol had her first psychiatric review. Ms Nicol had regular contact within the health services of the prison thereafter. She spent a significant period of time in the Crisis Care Unit but was eventually returned to the mainstream population, at her request as she wanted more freedom to socialise and to smoke. Ms Nicol initially appeared to be settling well in the mainstream unit.

On the afternoon of 15 June 2015 Ms Nicol approached another prisoner asking for some cleaning product. Ms Nicol appeared to look lost and out of sorts. Ms Nicol was given some cleaning products and shortly after entered the prison shower block. The same prisoner who had provided Ms Nicol with the cleaning product earlier, went to the shower

block around the same time as Ms Nicol. That prisoner heard noises and became concerned for Ms Nicol's welfare. Prison staff were alerted and attended the shower block.

Ms Nicol was located inside a shower cubicle hanging with a cloth ligature around her neck. Prison and medical staff attempted resuscitation but were unsuccessful and Ms Nicol was declared life extinct.

The Coroner found Ms Nicol's monitoring and mental health treatment was to a high standard, despite the pressures on the staff and the limited facilities available to meet her needs.

The Coroner made three recommendations. The Coroner made two recommendations relating to improving the mental health resources at Bandyup Women's Prison. The third recommendation was made to allow medical and nursing staff who are treating remand and sentenced prisoners access to court ordered reports, which will assist them to provide a better level of care and treatment.

The Finding is on the website of the Coroner's Court of Western Australia..

Mark Quenton FLEURY
Inquest held in Perth 20-21 May 2019, investigation finalised 17 July 2019

Mr Mark Quenton Fleury (Mr Fleury) died on 14 February 2016 at a house in Usher. The cause of death was from ligature compression of the neck (hanging). The Coroner found the manner of death was suicide. Mr Fleury was 38 years old.

Immediately before his death Mr Fleury was a "person held in care" under the *Coroners Act 1996* because he was subject to a Community Treatment Order made under sections 76 and 79 of the *Mental Health Act 1996.* He had been diagnosed with paranoid schizophrenia with a lack of insight to his illness.

After finishing school, Mr Fleury qualified a glazier and for a time he ran his own business servicing the Bunbury area. Mr Fleury married in 2010 and had a daughter but he and his wife subsequently separated in 2012 and she relocated overseas with their daughter in November 2015.

Mr Fleury's first recorded contact with the South West Mental Health Service (Service) was in 2002, when he was said to be experiencing paranoid, persecutory delusions. These delusions were a consistent theme of his illness and although they responded to treatment, they never entirely remitted.

In 2013 Mr Fleury's family were concerned that he had become unwell after ceasing his antipsychotic medication. They contacted the Service and he was admitted on an involuntary basis to the Acute Psychiatric Unit at Bunbury Hospital (APU) on 8 July 2013. Mr Fleury was discharged home on 30 July 2013, and made the subject of a CTO.

In January 2014, Mr Fleury's compliance with his medication and his attendance at the Service became more erratic. Mr Fleury CTO was allowed to expire and he refused to take medication or attend the clinic. On 9 October 2014, he was admitted to the APU, after his family contacted the Service when his mental health deteriorated. Mr Fleury was discharged home on a CTO on 24 October 2014 and he remained subject to a CTO until his death.

On 7 February 2016, Mr Fleury and his mother presented to the Bunbury Hospital. Mr Fleury was seen by the Psychiatric Liaison Nurse and discharged to be followed up by the Service the next day. During the following week, members of Mr Fleury's family contacted the Service and other agencies to report their concerns about Mr Fleury's mental health. Mr Fleury was assessed by a doctor on 10 February 2016, but did not meet the criteria for involuntary admission to the APU. A similar assessment was made during a phone call between Mr Fleury and his caseworker on 12 February 2016.

On 14 February 2016, Mr Fleury had dinner at his mother's house. Mr Fleury said he was feeling unwell and had a brief lie down. Mr Fleury left his mother's home at about 9.30 pm saying he would sleep better in his own bed. Before he left, he and his mother talked about what they could do the following weekend. At about 9.50 pm, Mr Fleury sent his brother a text message saying goodbye. Mr Fleury's mother and brother became

concerned and drove separately to Mr Fleury's house. They broke in and found one of the bedroom doors was locked.

Police and ambulance officers arrived and forced their way into the bedroom. They found Mr Fleury sitting on the floor of a bedroom with a ligature around his neck, clearly deceased.

The Coroner noted that since Mr Fleury's death there have been improvements to the Service's record keeping systems. In addition, emergency action plans had been introduced and peer workers had been employed to support mental health consumers and their carers and families.

The Coroner considered that the supervision, treatment and care provided to Mr Fleury in the period prior to his death was adequate.

The Coroner did not make any recommendations.

The Finding is on the website of the Coroner's Court of Western Australia.

Arthur James BONNEY
Inquest held in Perth 25 February 2019, investigation finalised 22 July 2019

Mr Arthur James Bonney (Mr Bonney) died on 5 August 2015 at Fiona Stanley Hospital. He was 59 years old. The Deputy State Coroner found that the cause of death was ischaemic heart disease in the context of acute-on-chronic kidney failure in association with contrast-induced nephropathy, and that death occurred by way of natural causes.

Immediately before death, Mr Bonney was a 'person held in care' under section 3 of the *Coroners Act 1996* because he was a sentenced prisoner, and under the *Prisons Act 1981* he was in the custody of the Chief Executive Officer of the Department of Corrective Services. Mr Bonney was serving his sentence at Casuarina Prison.

On 20 June 2013, Mr Bonney was sentenced to seven and a half years imprisonment. He was initially placed in Hakea Prison.

Two days after Mr Bonney arrived at Hakea Prison, he experienced sudden cardiac arrest. Mr Bonney was taken to Royal Perth Hospital, where he was admitted for eight days. Mr Bonney was returned to Hakea Prison and was then transferred to Casuarina Prison, where he remained until his death. He resided primarily in the infirmary under a standard privileged regime and was employed as an infirmary worker. Over the next two years he was taken to Royal Perth Hospital and Fiona Stanley Hospital approximately 40 times, and for five of those times he was admitted as an emergency patient for heart-related episodes.

On 30 July 2015 Mr Bonney attended Fiona Stanley Hospital and underwent an upper abdomen CT scan with contrast. Following the CT scan, he was transferred back to Casuarina Prison. Despite having several risk factors for contrast induced nephropathy, including the use of nephrotoxic medications, neither his serum creatinine nor his eGFR level was checked within 48 hours of the CT scan.

On the morning of 3 August 2015, Mr Bonney presented to the diabetic parade at Casuarina Prison. Mr Bonney complained of generalised body aches for two days and abdominal pain, nausea, loose stools and reduced appetite. Mr Bonney was diagnosed as suffering acute viral gastroenteritis and was prescribed paracetamol and metoclopramide. Later that day, he informed the prison nurse that he was still not feeling well. After being seen by the prison doctor, he was transferred to the emergency department at Fiona Stanley Hospital for further assessment.

At Fiona Stanley Hospital Mr Bonney presented as hyperkalaemic and acidotic. Mr Bonney was transferred from the emergency department to the ICU in the early hours of 4 August 2015 and was diagnosed with acute-on-chronic renal failure requiring dialysis, possibly precipitated by recent contrast CT and compounded by continuing to take nephrotoxic medications. Mr Bonney was placed on continuous venovenous haemodiafiltration, but his cardiac condition fluctuated. Mr Bonney developed increasing inotropic requirements and, at about 7.30 pm on 5 August 2015, he went into spontaneous cardiac arrest and died.

The Deputy State Coroner was satisfied that Mr Bonney's supervision, treatment and care while in custody was timely and appropriate.

As to Mr Bonney's care at Fiona Stanley Hospital, the Deputy State Coroner found that the administration of contrast for the CT scan contributed to Mr Bonney's heart failure, but that his time in the ICU reduced the level of kidney failure. To the extent that the nephrotoxic drugs led to kidney failure and contributed to heart failure, they were necessary to ensure that heart failure did not occur.

The Deputy State Coroner did not make any recommendations.

The Finding is on the website of the Coroner's Court of Western Australia.

Stephen Thomas OXLEY
Inquest held in Perth 17 July 2019, investigation finalised 23 July 2019

Mr Stephen Thomas Oxley (Mr Oxley) died on or about 9 December 2017 at Nedlands. The cause of death was artherosclerotic and hypertensive heart disease. The coroner found the manner of death was natural causes. He was 52 years old.

Immediately before his death Mr Oxley was a "person held in care" under the *Coroners Act 1996* because he was subject to a Community Treatment Order made under the *Mental Health Act 2014* (WA). He had been diagnosed with bipolar affective disorder and had little insight into, and impaired judgment with respect to, his mental illness. Mr Oxley also lacked the capacity to make sound treatment decisions with respect to his mental health.

Mr Oxley's first contact with mental health services was in 1989 and his mental health condition was managed by the Subiaco Adult Community Mental Health Clinic (Subiaco Clinic) for many years. When Mr Oxley was compliant with his medication, his mental health was generally stable. Mr Oxley's last admission to a mental health facility as an in-patient occurred in 2014.

Mr Oxley's CTO was last extended on 25 October 2017 and was due to expire on 24 January 2018. Mr Oxley had a number of risk factors for cardiovascular disease but the terms of Mr Oxley's CTO did not authorise staff at Subiaco Clinic to compel him to undergo investigations such as blood tests and ECG's that might have detected any deterioration in the his cardio-vascular health.

On 7 December 2017, Mr Oxley's mother visited him at his home with some shopping and stayed for about 30 minutes. Mr Oxley did not mention any problems or issues and he seemed his normal self. On 9 December 2017, Mr Oxley's long-term neighbour saw him walking back to his house carrying some milk. Mr Oxley was walking slowly but there was nothing out of the ordinary about his appearance.

On the morning of 11 December 2017 Mr Oxley's mother received a call from one of his friends to say she had visited Mr Oxley on each of the previous two days and there had been no response when she knocked on his door. Mr Oxley's mother went to Mr Oxley's home and found him lying on the floor next to his bed. Emergency services were called and ambulance officers confirmed he had died.

The Coroner found the supervision, treatment and care that Mr Oxley received from Subiaco Clinic while he was the subject of a CTO was of a very good standard.

The Coroner concluded that Mr Oxley's lifestyle choices played a significant role in his unexpected and premature death and found he died of natural causes.

The Coroner did not make any recommendation.

The Finding is on the website of the Coroner's Court of Western Australia.

CHILD KT (Name Subject to Suppression Order)
Inquest held in Perth 29 July 2019, investigation finalised 30 July 2019

Child KT (Child KT) died on 23 November 2016 at Princess Margaret Hospital. The Coroner found the manner of death was as a result of cardiorespiratory failure in a child with cerebral palsy and epilepsy. The cause of death was natural causes.

Immediately before death Child KT was a "person held in care" under the *Coroners Act 1996* because he was placed in the provisional care of the CEO of the Department of Child Protection and Family Services, as it was then known, pursuant to the *Children and Community Services Act 2004*.

A few weeks after Child KT's birth he developed pneumonia and was transferred to Princess Margaret Hospital for treatment. Child KT was diagnosed with spastic quadriplegia, cerebral palsy and developmental delay. Child KT required a high level of care and medical management. On 25 November 2011 the Department of Child Protection was granted an order for parental responsibility which remained in place until his death. Child KT was initially placed into Lady Lawley Cottage. The organisation "Life Without Barriers" assisted the Department to locate suitable specialist foster carers for Child KT. When Child KT was not hospitalised he lived with his foster parents in Perth. Department staff regularly assessed his care and found his foster parents provided an exceptional level of care. Contact within his biological family was facilitated where possible.

Child KT suffered from chronic respiratory disease and throughout 2015 he suffered a number of acute respiratory events. Specialists concluded that further invasive treatment to prolong Child KT's life or improve his underlying condition might prolong his pain and discomfort and were likely to lead to secondary problems associated with treatment. A decision was made Child KT should not receive invasive treatment and should receive palliative care. Forms were signed authorising that he be "not for resuscitation" and for "termination of life support", if required.

Child KT had a period of good health, but then in late October 2016 he was admitted to hospital for the last time. Child KT's health deteriorated over the next month and in the early hours of 23 November 2016 Child KT died in hospital.

The Coroner found the Department provided a very high level of supervision, treatment and care to Child KT from the time he was taken into care until his death.

The Coroner did not make any recommendations.

The Finding is on the website of the Coroner's Court of Western Australia..

Timothy James CHANDLER
Inquest held in Perth 26 July 2019, investigation finalised 2 August 2019

Mr Timothy James Chandler (Mr Chandler) died on 25 December 2017 at Fiona Stanley Hospital. The cause of death was multiple organ failure and pulmonary thromboemboli complicating generalised sepsis in a man with cellulitis. The Coroner found the manner of death was natural causes. He was 52 years old.

Immediately before death Mr Chandler was a "person held in care" under the *Coroners Act 1996* because he was subject to an Inpatient Treatment Order under the *Mental Health Act 2014.*

On 13 December 2017, Mr Chandler was taken to the Hospital by ambulance. On admission, he complained of a decreasing mobility and increasing weight over the previous seven months and a three week history of testicular pain. Mr Chandler was initially thought to have Fournier's gangrene, a serious condition requiring antibiotics and surgery. Mr Chandler had an unconventional belief system and rejected western medicine. As a result, Mr Chandler refused certain medical treatment including CT scans and possible surgery. Given Mr Chandler's presentation, it was decided to have him assessed by a psychiatrist to determine if he had capacity to make treatment decisions.

Mr Chandler was reviewed by the Hospital's on-call psychiatrist on 14 December 2017. Mr Chandler was found to have a psychotic illness, likely to be delusional disorder or perhaps schizophrenia. On the basis that Mr Chandler did not have the capacity to make treatment decisions, he was placed on an Inpatient Treatment Order and became an involuntary patient.

On 14 December 2017, Mr Chandler was transferred to the acute medical unit at the Hospital. Mr Chandler was found to have heart failure which was thought to be related to fluid overload, rather than a heart attack. Mr Chandler was also diagnosed with long standing right-sided heart damage secondary to sleep apnoea, and cellulitis. Mr Chandler was given antibiotics and medications to reduce his fluid overload and prevent a pulmonary embolism.

By 16 December 2017, Mr Chandler's condition seemed to be improving and there was no evidence of pulmonary embolism. However, on 17 December 2017, his condition suddenly deteriorated and his blood pressure became dangerously low. The medical emergency team was called and Mr Chandler was transferred to the intensive care unit. Initially there was some improvement, but he remained in a critical condition and required extensive medical support. On 25 December 2017, Mr Chandler's blood pressure suddenly dropped and despite treatment, could not be stabilised. Mr Chandler subsequently had a cardiac arrest and attempts to resuscitate him were unsuccessful.

The Coroner was satisfied that the supervision, treatment and care provided to Mr Chandler while he was an involuntary patient at the Hospital was both reasonable and appropriate.

The Coroner did not make any recommendations.

The Finding is on the website of the Coroner's Court of Western Australia.

Judy Sonia BOLTON
Inquest held in Perth 24-25 June 2019 and 1 August 2019, investigation finalised 20 August 2019

Ms Judy Sonia Bolton (Ms Bolton) died on 10 December 2016 at Royal Perth Hospital. The cause of death was acute myocardial infarction in due to a coronary thrombosis. The Coroner found the manner of death was by natural causes. She was 44 years old.

Immediately before death Ms Bolton was a "person held in care" under section 3 of the *Coroners Act 1996* because she was on remand, and pursuant to the *Prisons Act 1981* she was in the custody of the Chief Executive Officer of the Department of Corrective Services. Ms Bolton was in custody at Bandyup Women's Prison.

At about 5.30 pm on 10 December 2016, Ms Bolton developed pain whilst eating dinner and tried to walk it off prior to seeking help. She rang her daughter and said she was having chest pains and was going to lie down for a moment. Ms Bolton rang her daughter a short time later to say she had indigestion and was feeling better. At 6.15 pm a fellow prisoner made a cell call alarm and advised that Ms Bolton was unwell. The unit 1 control officer called a 'Code Green" on the prison radio to indicate a non-emergency situation that required the attendance of a nurse. A short time later, a nurse accompanied by two custodial officers arrived at unit 1 to attend to Ms Bolton.

Ms Bolton told the nurse she had eaten some chilli tuna and noodles. Ms Bolton was calm and did not appear to be distressed. Ms Bolton walked across the unit 1 courtyard to the control room where she was placed into a wheelchair and taken to the Prison medical centre for further assessment. At the medical centre, Ms Bolton got out of the wheelchair, walked inside and got onto the examination bed unaided. She was given Mylanta for her reported indigestion as well as oxygen and aspirin. Ms Bolton's blood pressure and oxygen saturations were taken and an electrocardiogram (ECG) was performed. At about 6.35 pm, Ms Bolton suddenly reported severe chest pain and said she felt as if she was going to die. Ms Bolton was noted to be very clammy, cold and a bit grey and her ECG was noted to be abnormal. Nursing staff suspected Ms Bolton was having a heart attack and arranged to transfer Ms Bolton by ambulance to Royal Perth Hospital (RPH), the closest hospital with specialist cardiac facilities.

The Officer in Charge of the Prison facilitated the entry of the ambulance and arrange custodial officers to accompany Ms Bolton to hospital. Ambulance officers received a handover from the prison nurses and performed an ECG which they attempted to transmit to RPH. The transmission was not received and was successfully resent. Ms Bolton's ECG indicated she was having a heart attack and ambulance officers were instructed to give her anti-coagulant medication. As they were about to leave the Prison, Ms Bolton had a VF arrest. Ambulance officers successfully revived Ms Bolton and rushed her to RPH. Ms Bolton was critically unwell when she arrived at RPH. Ms Bolton was initially conscious when she arrived at RPH, but was critically unwell. Ms Bolton had further VF arrests and despite the considerable efforts of the cardiac catheter team, Ms Bolton could not be revived and she was declared deceased at 9.18 pm on 10 December 2016.

In general terms, the Coroner was satisfied that the quality of supervision, treatment and care provided to Ms Bolton during her incarceration was appropriate. However, the Coroner commented that changes made (and about to be made) to health service delivery by the Department were appropriate. Although not causative of Ms Bolton's death, the Coroner also noted that the Prison's medical centre, which has been described as '*not fit for purpose*' should be remedied.

The Coroner did not make any recommendations.

The Finding is on the website of the Coroner's Court of Western Australia.

James Ronald CHI
Inquest held in Broome 2-3 July 2019, investigation finalised 30 August 2019

Mr James Ronald Chi (Mr Chi) died on 26 June 2017 at Broome Hospital. He was 69 years old. The Deputy State Coroner found that cause of death was chronic obstructive pulmonary disease and coronary artery atherosclerosis and that death occurred by way of natural causes.

Immediately before his death Mr Chi was a "person held in care" under the *Coroners Act 1996* because he was on an involuntary treatment order under the *Mental Health Act 2014*.

Mr Chi was one of Australia's most celebrated playwrights and musicians.

Mr Chi was diagnosed with bipolar affective disorder in the 1970's. His mental illness became increasingly difficult to manage, and the bipolar cycles became more frequent and extreme. In late 2014, he was admitted as an involuntary patient to Mabu Liyan, the mental health unit at Broome Hospital, where he remained effectively until his death. The last order for continuation of Mr Chi's status as an involuntary patient under an inpatient treatment order was made on 19 June 2017.

Apart from his mental illness, Mr Chi's medical history included chronic obstructive pulmonary disease with emphysema from heavy cigarette smoking. Mr Chi also had coronary artery disease, type 2 diabetes, renal dysfunction, malnutrition, gastroesophageal reflux disease and pseudo bowel obstruction from chronic constipation. All these conditions were treated with medications and diet modification. Despite receiving repeated advice to quit smoking, he was unwilling to stop. From about 2013, he developed significantly disabling Parkinsonism, with tremor, bradykinesia and postural instability, in the context of long exposure to first generation antipsychotic depot medications.

In the week or so before his death Mr Chi appeared to be in high spirits. He was feeling physically stronger with an improved mood, and he was compliant with his medication. On the morning of 26 June 2017, he was reactive and elevated, but he was still pleasant and polite. Later in the afternoon, he became breathless after an outburst in which he was yelling. Mr Chi was administered salbutamol, and the medical emergency team was called.

The medical emergency team transferred Mr Chi to the emergency department. Mr Chi was displaying agonal breathing and worsening bradycardia, but there was a 'not for resuscitation' order, so the emergency medical team took no further steps to revive him. Mr Chi died a short time later.

The Deputy State Coroner made a recommendation relating to improving long term supported accommodation for mental health patients in the Kimberley.

The Finding is on the website of the Coroner's Court of Western Australia.

Bret Lindsay CAPPER
Inquest held in Perth 8-10 October 2019, investigation finalised 13 November 2019

Mr Bret Lindsay Capper (Mr Capper) died on 14 January 2016 at Fiona Stanley Hospital. The cause of death was from bronchopneumonia and brain swelling following ligature compression of the neck (hanging). The Coroner found the manner of death was by suicide. He was 43 years old.

Immediately before death Mr Capper was a "person held in care" under section 3 of the *Coroners Act 1996* because he was on remand, and pursuant to the *Prisons Act 1981* he was in the custody of the Chief Executive Officer of the Department of Corrective Services. Mr Capper was in custody at Hakea Prison.

On 12 January 2016, Mr Capper had barricaded himself into a communal area in the prison wing he was being housed in. Despite the efforts of prison officers, Mr Capper placed an improvised ligature around his neck and hanged himself. Mr Capper had told other prisoners and custodial staff that he could not face the long prison sentence he anticipated he would receive.

Officers for the Special Operations Group (SOG) were deployed to Hakea Prison and used specialist equipment to gain access to room where Mr Capper was located. Mr Capper was given first aid and transported to Fiona Stanley Hospital.

Mr Capper had sought counselling for his mental state on 30 October 2015, but because there were not enough counsellors at Hakea Prison at the time, he was seen on only one occasion. Mr Capper had previously been diagnosed with antisocial personality disorder and the evidence at the inquest was that he would have benefitted from long-term counselling, had this been available. The Coroner found that Mr Capper was not placed on the Prison's Support and Monitoring system after being removed from At Risk Management System on 20 October 2015. Had this occurred, Mr Capper would have been monitored more regularly by the Prison At Risk Management Group and may have been more likely to have received ongoing counselling.

Since Mr Capper's death, physical changes have been made at Hakea Prison to prevent other prisoners from barricading themselves into communal areas. The Coroner made six recommendations aimed at addressing the issues identified during the course of the inquest, including the provision of adequate counselling services and the deployment process for the SOG.

The Coroner found that from the perspective of physical needs, he was satisfied that the supervision, treatment and care provided to Mr Capper was reasonable. However, Mr Capper was not provided with the ongoing counselling it had been identified he required.

The Finding is on the website of the Coroner's Court of Western Australia.

David Anthony RICE
Inquest held in Perth 14 October 2019, investigation finalised 14 November 2019

Mr David Anthony Rice (Mr Rice) died on 19 August 2015 at Fiona Stanley Hospital. The cause of death was from multiple injuries. The Coroner found the manner of death was by accident. He was 49 years old.

Immediately before death Mr Rice was a "person held in care" under section 3 of the *Coroners Act 1996* because he was a remand prisoner, and pursuant to the *Prisons Act 1981* he was in the custody of the Chief Executive Officer of the Department of Corrective Services. Mr Rice was in custody at Hakea Prison.

On 19 August 2015, Mr Rice was a member of a work party tasked to clean units at Hakea Prison. Unwanted items from these units were loaded into a large truck and taken to the Prison's Industries Service Yard (Yard), where they were unloaded and placed into storage.

At about 12.30 pm, a Vocational Services Officer (VSO) was instructed to drive the truck back to the units to collect more unwanted gear and rubbish. The size of the truck meant that the VSO had to perform a three-point turn in order to drive it out of the Yard. The VSO was having difficulty reversing the truck into the loading dock and Mr Rice, who was in the Yard with two other prisoners, offered to help. Mr Rice walked to the rear of the truck to guide the VSO.

The VSO slowly reversed the truck and did not see Mr Rice in the vehicle's side mirror. After reversing a short distance, the VSO considered he had enough clearance to drive forward and complete the three-point turn. As the VSO moved the truck forward he turned the steering wheel to the left causing the rear of the truck to swing to the right. A spilt second before the truck moved forward, Mr Rice suddenly appeared at the back of the truck on the driver's side. He became pinned between the rear of the truck and the wall of a coolroom in the loading dock.

The VSO moved the truck out of the way and Mr Rice fell to the ground. Prison officers and medical staff gave Mr Rice first aid and he was taken to FSH by ambulance. Mr Rice died at FSH as a result of his injuries.

Since Mr Rice's death, a number of infrastructure and policy changes have been made at Hakea Prison. These changes are aimed at reducing the likelihood of a critical incident involving vehicles.

The Coroner found that Mr Rice should not have been permitted to assist the VSO as a spotter and should not have been allowed anywhere near the truck as it reversed. With the exception of this lapse in supervision, the Coroner found that the supervision, treatment and care provided to Mr Rice during his incarceration, was otherwise adequate.

The Coroner did not make any recommendations.

The Finding is on the website of the Coroner's Court of Western Australia.

CHILD SH (Name Subject to Suppression Order)
Inquest held in Perth 1 November 2019, investigation finalised 21 November 2019

Child SH (Child SH) died on 1 September 2018 at Perth Children's Hospital. The Coroner found the manner of death was from aspiration pneumonia, with terminal palliative care, in a male child with complex medical co-morbidities including congenital myopathy and arthrogryposis. The cause of death was natural causes. He was 5 years old.

Immediately before death Child SH was a "person held in care" under the *Coroners Act 1996* because he was placed in provisional care and protection care of the CEO of the Department of Communities, pursuant to section 37 of the *Children and Community Services Act 2004*.

Child SH was born with several serious congenital conditions, including undifferentiated congenital myopathy (a form of muscle weakness). As a result of these conditions, Child SH had very complex needs and was totally reliant on a carer for all activities of daily living. Child SH was unable to walk and used a wheelchair and had an unsafe swallow, meaning he was tube fed. Child SH had swallowing issues which led to numerous hospital admissions for aspiration pneumonia and respiratory tract infections. During these admission, Child SH usually required respiratory support by way of an airflow mask (BiPAP mask).

On 28 August 2018, the DG approved a care plan whereby, should Child SH's condition deteriorate, Child SH would be treated palliatively and not resuscitated. On that date Child SH became febrile and was treated with oral antibiotics. On 29 August 2018, Child SH became distressed and anxious due to breathing difficulties and the dosages of morphine and midazolam infusions were increased. During 30 August 2018, Child SH appeared to be distressed whilst wearing the BiPAP mask and the skin on Child SH face broke down in several areas. As a result, the mask was removed and a high-flow oxygen mask was placed near Child SH head instead.

Child SH's condition continued to deteriorate and antibiotics were ceased on 31 August 2018. Child SH died on 1 September 2018.

The Coroner did not express any concerns about Child SH's supervision, treatment and care.

The Department of Communities properly conceded that Child SH's mother should have been provided with more intensive support in March 2018. The Coroner observed that the Department had made a number of improvements to its service delivery aimed at enhancing its child safety response.

The Coroner did not make any recommendations.

The Finding is on the website of the Coroner's Court of Western Australia.

CHILD AC (Name Subject to Suppression Order)
Inquest held in Perth 19 November 2019, investigation finalised 19 December 2019

Child AC (Child AC) died on 10 August 2017 at a home in East Victoria Park. The Coroner found the manner of death was from renal failure due to focal segmental glomerulosclerosis. The cause of death was natural causes. She was 8 years old.

Immediately before death Child AC was a "person held in care" under the *Coroners Act 1996* because she was placed in the provisional care and protection of the CEO of the Department of Communities, pursuant to section 37 of the *Children and Community Services Act 2004*. Proceedings in the Children's Court of Western Australia for Provisional Protection and Care in August 2012 granted a Protection Order for Child AC until she turned 18 years of age. She was placed into foster care and remained living with the same foster carer until her death.

On 2016 Child AC developed a serious form of nephrotic syndrome and her prognosis was poor. On 17 October 2016 the Department of Communities accepted medical advice that further intrusive medical procedures should be ceased as they were not in the best interests of Child AC. A decision was made that Child AC be certified "not to be resuscitated" in the event of a major health event and not be subject to any invasive treatment.

On 8 August 2017 Child AC's renal failure had progressed to the stage where Child AC required end of life care. The paediatric palliative care team took over Child AC's care. Child AC was placed in the care of the Silver Chain Hospice Care service until Child AC died peacefully at home on 10 August 2017.

The Coroner was satisfied the Department of Communities provided a very high level of supervision, treatment and care to Child AC from the time Child AC was taken into care until Child AC's death. In particular, the Coroner noted Child AC's foster carer provided a loving, caring home environment for Child AC.

The Coroner did not make any recommendations.

The Finding is on the website of the Coroner's Court of Western Australia.

Jason James Sutherland MALLETT
Inquest held in Perth 26 November 2019, investigation finalised 20 December 2019

Mr Jason James Sutherland Mallett (Mr Mallett) died on 3 March 2017 at Sir Charles Gairdner Hospital. The cause of death was cardiac arrhythmia in a man with coronary arteriosclerosis and myocarditis. The Coroner found the manner of death was natural causes. He was 46 years old.

Immediately before death Mr Mallett was a "person held in care" under the *Coroners Act 1996* because he was an involuntary patient under the *Mental Health Act 2014.* Mr Mallett was diagnosed as suffering from Bipolar or Mood Affective Disorder, as well as Schizo-affective disorder and ADHD.

The inquest focussed primarily on Mr Mallett's medical treatment during his admission to Sir Charles Gairdner Hospital and whether his heart disease should have been identified, as well as whether his monitoring was adequate.

On 24 February 2017 Mr Mallett was admitted as a voluntary patient to the Sir Charles Gairdner Hospital Mental Unit. He was started on various medications to manage his illicit drug withdrawals and psychotic symptoms. He had a physical examination and an ECG was requested, which appeared normal.

On 27 February 2017 Mr Mallett was made an involuntary patient after being reviewed. Mr Mallett was increasingly distressed, manic and significantly psychotic and needed to be cared for in the secure area of the Mental Health Unit. The change from being a voluntary to involuntary patient was significant for Mr Mallett because, as an involuntary patient, he was no longer able to go outside the ward to smoke. Mr Mallett was a heavy chain smoker.

On 2 March 2017 Mr Mallett rang his mother and complained that he could not have a cigarette and was going to die in hospital. Mr Mallett was very agitated and abusive towards staff at this time. Mr Mallett was given medications to calm him, including intramuscular clonazepam. When he eventually agreed to take oral medications, Mr Mallett was provided with a dose of quetiapine, chloral hydrate and Phenergan and was taken to his bedroom. Mr Mallett was encouraged to stay in his room to allow the medications to take effect. Mr Mallett was then monitored by nursing staff. On the last observations, prior to handover on 3 March 2017, Mr Mallett was found to be unresponsive. CRP was immediately commenced. A bedside ultrasound showed no cardiac activity and his death was confirmed.

The Coroner found Mr Mallett's medical care was of a generally high standard.

The Coroner made one recommendation for additional measures to be implemented for patients to have pulse oximetry in a psychiatric setting, where a patient is cooperative to its use. This would assist staff to monitor patients who have recently been agitated and then sedated.

The Finding is on the website of the Coroner's Court of Western Australia.

CHILD TJW (Name Subject to Suppression Order)
Inquest held in Perth 18 December 2019, investigation finalised 20 December 2019

Child TJW (Child TJW) died on 12 July 2018 at Perth Children's Hospital. The Coroner found the cause of death was from aspiration pneumonia leading to multi-organ failure in a female child with a complex medical history including cerebral palsy, hypoxic ischaemic encephalopathy, microcephaly, seizure disorder and airway obstruction. The manner of death was natural causes. She was 7 years old.

Immediately before death Child TJW was a "person held in care" under the *Coroners Act 1996* because she was placed into Provisional Protection and Care of the CEO of the Department of Communities, pursuant to section 37 of the *Children and Community Services Act 2004*. On 1 March 2018 the Perth Children's Court granted a Protection Order for Child TJW until she turned 18 years.

Child TJW was diagnosed with a severe brain injury following a traumatic birth. Child TJW suffered from complex medical issues and had high care needs.

Child TJW was supported in the community with regular input from Ability Centre's physiotherapist, occupational therapist and speech pathologist and with dietitian input from PMH. Child TJW required a nasopharyngeal airway to support her breathing, supplementary oxygen and normal saline nebulisers and salivary gland Botox injections to improve her upper airways secretions. Despite these measures, Child TJW continued to suffer from recurrent respiratory distress, infections and multiple daily seizures. Child TJW's care was very difficult to manage, even in a specialised setting. It was difficult for her family to continue to care for her at home and in September 2016 the concerns were raised with the Department about family's ability to continue to manage her care. Child TJW had a prolonged hospital admission while she was taken into provisional care and on 10 January 2017 Child TJW was placed at Lady Lawley Cottage.

During 2017 Child TJW had numerous admissions to PMH, often due to increased secretions and vomiting and acute respiratory distress. After discussions with her parents and on medical advice the Department took steps for a "Not for Resuscitation" Order to be signed on 8 November 2017.

On 1 July 2018 Child TJW was taken to the Perth Children's Hospital with a fever, increased respiratory secretions, uncontrolled seizures and respiratory distress. Child TJW was diagnosed with a chest infection. Despite treatment Child TJW's clinical state continued to deteriorate and it became clear that she had reached the end of her life. Child TJW received palliative care and was treated with comfort measures and able to have family visits, including her siblings until she passed away surrounded by family on 12 July 2018.

The Coroner was satisfied the Department had provided a very high level of supervision, treatment and care to Child TJW from the time she was taken into care until her death.

The Coroner did not make any recommendations.

The Finding is on the website of the Coroner's Court of Western Australia.

Tania Marie HODGKINSON
Inquest held in Perth 3-4 December 2019, investigation finalised 5 February 2020

Ms Tania Marie Hodgkinson (Ms Hodgkinson) died on 23 March 2017 at Bandyup Women's Prison. The cause of death was ligature compression of the neck (hanging). The Coroner found the manner of death was by suicide. She was 48 years old.

Immediately before death Mr Hodgkinson was a "person held in care" under section 3 of the *Coroners Act 1996* because she was a prisoner, and pursuant to the *Prisons Act 1981* she was in the custody of the Chief Executive Officer of the Department of Corrective Services. Ms Hodgkinson was serving her sentence at Bandyup Women's Prison.

On arrival at Bandyup Women's Prison on 30 December 2016 Ms Hodgkinson was assessed by a clinical nurse. Ms Hodgkinson was recorded as having no history of medical or psychiatric conditions. However, Ms Hodgkinson was experiencing heroin withdrawal symptoms and she verbalised self-harm intent. Ms Hodgkinson also spoke of her grief at losing her partner from a heroin overdose. Ms Hodgkinson was initially placed into the Crisis Care unit and placed on a high level of the At-Risk Management System. Ms Hodgkinson withdrawal symptoms were managed with standard medical treatment and she was kept under close observations. Ms Hodgkinson was also referred to the prison Alcohol and Substance Team and the Prison Counselling Service. After a few days she was moved out of the CCU into the general prison population.

On 21 March 2017 Ms Hodgkinson expressed concern during a counselling session that she might face further charges, and spoke of her unresolved grief in relation to her partner's death. Prison staff were asked to monitor her.

On the morning of 23 March 2017 Ms Hodgkinson attended a counselling session, during which she denied having any current thoughts or plans to harm herself. Ms Hodgkinson did mention wanting to move to a different prison with her cellmate, and the counsellor was following up this request. However, before that could be done, Ms Hodgkinson was found hanging inside her cell. Ms Hodgkinson had used a torn sheet as a ligature. Despite CPR being performed and the attendance of medical staff and ambulance officers, she could not be revived.

During the inquest hearing concerns were raised in respect to the visits room at Bandyup Prison, and the possible effect it may have had on Ms Hodgkinson receiving visits and having contact with her family. The Coroner noted a recent report from the Inspector of Custodial Services who found the Bandyup Visits Centre unfit for purpose and did not meet the needs of officers, prisoners or visitors. The Coroner made a recommendation relating to improving and upgrading the facility.

The Coroner was satisfied that Ms Hodgkinson's care in prison was overall reasonable and appropriate. The Coroner concluded Ms Hodgkinson's decision to take her life appeared to have been impulsive.

The Coroner did not make any recommendation.

The Finding is on the website of the Coroner's Court of Western Australia.

Eric WUMBIE
Inquest held in Perth 12 February 2020, investigation finalised 20 February 2020

Mr Eric Wumbie (Mr Wumbie) died on 13 April 2016 at Fiona Stanley Hospital. The cause of death was from valvular and ischaemic heart disease. The Coroner found the manner of death was by of natural causes. He was 37 years old.

Immediately before death Mr Wumbie was a "person held in care" under section 3 of the *Coroners Act 1996* because he was a prisoner, and pursuant to the *Prisons Act 1981* he was in the custody of the Chief Executive Officer of the Department of Corrective Services. Mr Wumbie was serving his sentence at West Kimberley Regional Prison.

Mr Wumbie presented at the prison with no specific concerns and no health issues were identified. He was described as a quiet individual who complied with prison rules and who was polite and courteous.

On 17 February 2016, Mr Wumbie complained shortness of breath on exertion. This was the first occasion on which he had reported symptoms which may have related to his heart. On examination, his heart sounds were normal, but his abdomen was tender. Mr Wumbie was given medication for possible gastro-oesophageal reflux. On 12 March 2016 he reported pains in his chest and abdomen and shortness of breath. Mr Wumbie's pulse was slightly elevated but his blood pressure and oxygen saturations were normal. Mr Wumbie was seen again on 20 March 2016 and although his chest was clear, his face and ankles were swollen and a trace of protein was noted in his urine. When he was reviewed by the prison medical officer on 21 March 2016, his swelling and protein levels had become worse. As a result he was transferred to Derby Hospital where he was diagnosed with heart failure. Mr Wumbie was subsequently transferred to Broome Regional Hospital, where he was given intravenous antibiotics and transferred to Fiona Stanley Hospital on 24 March 2016, by Royal Flying Doctor Service.

On 2 April 2016, Mr Wumbie was discharged from Fiona Stanley Hospital to the infirmary at Casuarina Prison to await surgery. The plan was that he would undergo procedures to replace his aortic valve and address his blocked coronary arteries. Whilst in the infirmary, Mr Wumbie received full-time nursing care.

On the evening of 3 April 2016, Mr Wumbie's cellmate found him coughing up blood and complaining of chest pain. Mr Wumbie was taken to Fiona Stanley Hospital by ambulance and scheduled for surgery on 13 April 2016.

On 13 April 2016, Mr Wumbie was taken to theatre and after he was anaesthetised, but before the procedure began, he developed a life-threatening heart rhythm. Mr Wumbie was successfully defibrillated and a normal rhythm was achieved, but tragically, the life-threatening heart rhythm returned, he developed other complications and he died during surgery.

The Coroner was satisfied that Mr Wumbie received a high standard of care at Fiona Stanley Hospital and that the standard of supervision, treatment and care he received, whilst in custody, was reasonable.

The Coroner did not make any recommendations.

The Finding is on the website of the Coroner's Court of Western Australia.

Norman Alexander HAZELGROVE
Inquest held in Perth 18 February 2020, investigation finalised 20 March 2020

Mr Norman Alexander Hazelgrove (Mr Hazelgrove) died on 18 September 2017 at Bethesda Hospital. The cause of death was from metastatic carcinoma of the lung with palliation. The Coroner found the manner of death was by of natural causes. He was 73 years old.

Immediately before death Mr Hazelgrove was a "person held in care" under section 3 of the *Coroners Act 1996* because he was a sentenced prisoner, and pursuant to the *Prisons Act 1981* he was in the custody of the Chief Executive Officer of the Department of Corrective Services. Mr Hazelgrove was serving his sentence at Acacia Prison.

Mr Hazelgrove was described as being a well-mannered and courteous prisoner who abided by the rules and regulations of the prison and interacted well with his peers. When Mr Hazelgrove was first admitted to prison, he had no major health concerns and was not taking any medications. On 13 September 2013 reported to a doctor a smoker's cough and shortness of breath during a medical examination. A chest X-ray on 29 October 2013 showed signs consistent with COPD. On 17 December 2013 Mr Hazelgrove was reviewed again by a doctor in relation to his high blood pressure and was again encouraged to stop smoking but nothing was noted in relation to the COPD findings. Mr Hazelgrove continued to be monitored throughout 2014. From March 2015 Mr Hazelgrove's medical reviews reduced significantly and he did not have regular monitoring. It was noted that there was no follow-up of Mr Hazelgrove's COPD diagnosis until he experienced respiratory difficulties on 6 May 2017.

Mr Hazelgrove was taken to St John of God Hospital Midland on 6 May 2017 and a chest CT scan showed a large tumour in the right lung, with collapse of the middle and right lower lobes. After further investigations Mr Hazelgrove was diagnosed with lung cancer. Mr Hazelgrove remained at hospital, where treatment continued and Mr Hazelgrove's medical management was discussed with him. Mr Hazelgrove was eventually discharged back to Acacia Prison on 18 May 2017.

On 2 August 2017 Mr Hazelgrove was reviewed in the SJOG Midland Hospital Oncology Clinic and palliative chemotherapy was discussed. Mr Hazelgrove declined the treatment and no further follow up was arranged. Mr Hazelgrove's condition gradually deteriorated over the next few weeks. On 7 September 2017 Palliative Care Service assessed Mr Hazelgrove. A suggested medication regime to manage his pain was made. On 13 September 2017 Mr Hazelgrove was reviewed again by the Palliative Care Service and he was commenced on more regular morphine for pain relief. A plan was made to transfer him to Bethesda Hospital Palliative Care Unit once a bed became available.

Mr Hazelgrove was admitted to the Palliative Care Unit of Bethesda Hospital on the morning of 17 September 2017 and was kept comfortable until he passed away peacefully just after midnight on 18 September 2017.

Whilst the Coroner noted some missed opportunities for optimal care and potentially earlier diagnosis of lung cancer it was noted that closer monitoring may not necessarily have changed the outcome.

The Coroner was satisfied that Mr Hazelgrove's medical care after diagnosis was of a high standard.

The Coroner noted the Department of Justice had made some improvements to the prison health services to prompt more regular medical reviews with an emphasis on preventative health and identifying risk factors. Education had also been provided regarding appropriate response to abnormal observations through the Clinical Nurse.

The Coroner did not make any recommendation.

The Finding is on the website of the Coroner's Court of Western Australia.

Benedict Chifley David CANDY
Inquest held in Perth 19 March 2020, investigation finalised 2 April 2020

Mr Benedict Chifley David Candy (Mr Candy) died on 1 September 2017 at Bethesda Hospital. The cause of death was from bronchopneumonia in a man with invasive sarcoma-like tumour of the head, with terminal palliative medical care. The Coroner found the manner of death was by of natural causes. He was 66 years old.

Immediately before death Mr Candy was a "person held in care" under section 3 of the *Coroners Act 1996* because he was a sentenced prisoner, and pursuant to the *Prisons Act 1981* he was in the custody of the Chief Executive Officer of the Department of Corrective Services. Mr Candy was serving his sentence at various prisons including Albany Regional Prison, Casuarina Prison and Acacia Prison.

On 28 October 2003, Mr Candy was convicted of the murder of his wife and sentenced to life imprisonment. During his incarceration, Mr Candy was assessed as a quiet and courteous person who was well liked and who complied with prison rules. Mr Candy maintained positive relationships with other prisoners and displayed a high standard of personal hygiene. Mr Candy was consistently employed while in custody and performed all allocated duties to an excellent standard without supervision.

Mr Candy's medical history included bowel polyps, prostate cancer and numerous skin lesions, many of which were cancerous. In 1998, he had a Merkel cell carcinoma (a rare form of skin cancer associated with exposure to the sun) removed from the top of his head. The cancer recurred in 2014 and was removed, but Mr Candy declined chemotherapy and radiotherapy, despite being told that if he did not have these treatments, there was a significant risk that the cancer would recur.

On 5 May 2017, prison nurse noticed a lump on the top of Mr Candy's head. Mr Candy said the lump had been there for about a month and a prison doctor who subsequently reviewed Mr Candy felt the lump was a recurrence of the Merkel cell carcinoma that had been removed in 2014. Mr Candy declined to have the lump investigated and his condition slowly deteriorated.

On 1 June 2017, Mr Candy was registered as a Stage 2 terminally ill prisoner on the Department's prisoner database. Mr Candy was reviewed by a palliative care nurse from Bethesda Hospital on 2 August 2017, and declined any life prolonging measures and said he did not wish to be resuscitated. Mr Candy was transferred to Bethesda Hospital on 18 August 2017, and kept as comfortable with intravenous morphine and midazolam until his death on 1 September 2017.

After considering all of the available evidence, the Coroner was satisfied that the standard of supervision, treatment and care that Mr Candy received whilst he was in custody was reasonable.

The Coroner did not make any recommendations.

The Finding is on the website of the Coroner's Court of Western Australia.

Valerie KELLY
Inquest held in Perth 9 March 2020, investigation finalised 3 April 2020

Ms Valerie Kelly (Ms Kelly) died on 24 September 2016 at Royal Perth Hospital. The cause of death was from the combined effects of bronchopneumonia and acute liver failure on a background of liver cirrhosis and hepatocellular carcinoma in a woman with atherosclerotic cardiovascular disease and recent fractured neck of femur treated palliatively. The Coroner found the manner of death was by way of natural causes. She was 67 years old.

Immediately before death Ms Kelly was a "person held in care" under section 3 of the *Coroners Act 1996* because she was a sentenced prisoner, and pursuant to the *Prisons Act 1981* she was in the custody of the Chief Executive Officer of the Department of Corrective Services. Ms Kelly was serving her sentence at Bandyup Women's Prison.

Ms Kelly was arrested and charged with murder on 25 June 2015. When she was admitted to the Prison on 26 June 2015, her medical history was found to include: ischaemic heart disease, type-2 diabetes, alcohol related liver disease, chronic subdural haematomas, high cholesterol, osteoarthritis, osteoporosis, and low platelet levels. Ms Kelly disclosed a long standing issue with alcohol use and her surgical history included: the removal of her gallbladder, coronary artery bypass grafts and a total knee replacement.

On 23 December 2015 Ms Kelly was referred to the hepatology clinic at Fiona Stanley Hospital (FSH) after blood tests showed she had a low blood count that was possibly related to liver disease. Records show that an appointment was made for Ms Kelly to see a liver specialist at FSH on 10 February 2016, but there is no record that notification of that appointment was received by the Prison. Unfortunately prison medical staff at the Prison did not follow up on the referral. On 21 April 2016, Ms Kelly was referred to the gastroenterology clinic at FSH for a colonoscopy to investigate her reported rectal bleeding. Ms Kelly was placed on a waitlist and the procedure was scheduled for 14 June 2016.

At about 3.55 pm on 2 June 2016, Ms Kelly fell heavily in the doorway of her cell. Ms Kelly was taken to Royal Perth Hospital, where she was found to have fractured the neck of her left femur that was surgically repaired on 4 June 2016. During her admission, Ms Kelly was treated for a decline in her brain function caused by severe liver disease (hepatic encephalopathy), which caused her to become delirious and agitated and predisposed her to pneumonia.

On 16 June 2016, Ms Kelly was reviewed by the palliative care team at Royal Perth Hospital. Although her prognosis was uncertain, it was felt that her condition would deteriorate over the following few weeks. Ms Kelly was not a suitable candidate for hospice care because of her variable mental state, but she was regularly reviewed by the palliative care team. On 13 July 2016, all unnecessary medications were ceased. Ms Kelly received palliative care and remained largely unconscious over the next few weeks and her condition continued to deteriorate until her death on 24 September 2016.

The Coroner found that Ms Kelly's clinical care at Royal Perth Hospital was of a high standard and was satisfied that the supervision, treatment and care that she received while she was in custody was adequate.

The Coroner made one recommendation relating to the referral of prisoners to external specialist and agencies.

The Finding is on the website of the Coroner's Court of Western Australia.

Hassan BECHARA
Inquest held in Perth 7 April 2020, investigation finalised 24 April 2020

Mr Hassan Bechara (Mr Bechara) died on 6 July 2017 at Fiona Stanley Hospital. The cause of death was from ischaemic heart disease. The Coroner found the manner of death was by of natural causes. He was 52 years old.

Immediately before death Mr Bechara was a "person held in care" under section 3 of the *Coroners Act 1996* because he was a sentenced prisoner, and pursuant to the *Prisons Act 1981* he was in the custody of the Chief Executive Officer of the Department of Corrective Services. Mr Bechara was serving his sentence at various prisons including Hakea Prison, Casuarina Prison, Acacia Prison, Bunbury Regional Prison and Karnet Prison Farm.

On 19 March 2015 Mr Bechara was received at Hakea Prison. During his reception interview, he denied any self-harm or suicidal ideation but did say he felt at risk in the prison because of the nature of his offences. Mr Bechara was assessed by a nurse and then, on 20 March 2015 by a doctor. Mr Bechara self-reported medical history was noted, however, records from his doctors in New South Wales were not then available. Although Mr Bechara listed several of the medications he was currently taking, he did not tell the prison doctor that had been prescribed cholesterol lowering medication (atorvastatin). Mr Bechara was not always compliant with medication in the community and in the days after his admission, he declined his prescribed medications on the basis that they made him feel sick.

Mr Bechara's medical notes from New South Wales were subsequently received and although the notes contained a letter from Mr Bechara's cardiologist in New South Wales, his GP's progress notes were not comprehensive and did not refer to any cardiac concerns. The GP's notes did refer to the fact that Mr Bechara was taking atorvastatin, but due to an oversight, Mr Bechara was not immediately prescribed this medication on his admission to prison.

On 27 October 2016, Mr Bechara was reviewed by the Head of Cardiology at Fiona Stanley Hospital (FSH) who considered that Mr Bechara was clinically stable and had cardiomyopathy, which was probably ischaemic. The treatment plan was for Mr Bechara to be reviewed in six to eight weeks after he had undergone an echocardiogram and blood tests. Mr Bechara declined to have a coronary angiogram or to have an implantable cardioverter defibrillator fitted, both of which had been recommended. Mr Bechara also declined a suggested increase to his cholesterol lowering medication.

On 23 June 2017, Mr Bechara presented to the prison medical centre. Mr Bechara was grey, sweaty and looked unwell. He said he had vomited after lunch and felt dizzy. Mr Bechara's pulse rate was elevated and his blood sugar level was low and he was taken to Armadale Kelmscott Memorial Hospital by ambulance. On admission, Mr Bechara's pulse was very high and an ECG showed his heart was in an abnormal rhythm known as ventricular tachycardia. Mr Bechara was given some medication but he went into cardiac arrest. Mr Bechara was successfully defibrillated and his heart resumed a normal rhythm. An ECG showed signs of cardiac ischemia and following discussions with the cardiology

team at Royal Perth Hospital (RPH) Mr Bechara was transferred to RPH for urgent treatment.

Mr Bechara underwent tests and doctors at RPH recommended he undergo coronary bypass graft surgery. Although he was reluctant to do so, Mr Bechara agreed to be transferred to FSH on 2 July 2017 for consideration of coronary bypass grafting. On 6 July 2017 Mr Bechara suffered a cardiac arrest. Prolonged CPR resulted in a spontaneous return of circulation and he underwent an emergency angiogram. Cardiologists reviewed the angiogram and considered that coronary stenting would not improve his prognosis given the results of the previous myocardial viability study and Mr Bechara's long-standing cardiomyopathy. As Mr Bechara was being returned to the coronary care unit after the angiogram, he had a further cardiac arrest. Despite concerted resuscitation efforts Mr Bechara could not be revived.

After careful consideration of all the evidence the Coroner was satisfied that the standard of supervision, treatment and care that Mr Bechara received while Mr Bechara was in custody was adequate.

The Coroner did not make any recommendations.

The Finding is on the website of the Coroner's Court of Western Australia.

Nualla Christine REILLY
Inquest held in Perth 24-25 February 2020, investigation finalised 26 May 2020

Ms Nualla Christine Reilly (Ms Reilly) died on 9 June 2017 at Carlisle Train Station. The cause of death was multiple injuries. The Coroner found the manner of death was suicide. She was 74 years old.

Immediately before death Ms Reilly was a "person held in care" under the *Coroners Act 1996* because she was absent without leave from Fiona Stanley Hospital under s 97 of the *Mental Health Act 2014* (WA), after being 'detained' on a Form 1A and Form 4A as an involuntary patient.

Ms Reilly had a long history of mental health concerns.

In early 2017 Ms Reilly experienced a significant relapse of her mental health conditions that led to a prolonged stay at the Bentley Hospital. It was decided by medical staff and her family during that admission that she was no longer safe to live at home on her own. It was intended that she would move from hospital to a nursing home facility near her family. Ms Reilly was consulted and was willing to move to an aged care facility. Ms Reilly was transferred to a transitional care facility while a suitable placement was found at a nursing home. However, Ms Reilly was unhappy at the transitional care facility and on 9 June 2017 she attempted suicide. She was taken to Fiona Stanley Hospital for medical review and while there she indicated to hospital staff that she had attempted suicide as she felt it was the only way to resolve her current crisis. Ms Reilly was assessed as still being actively suicidal. She indicated she did not want to return to the transitional care facility nor Bentley Hospital.

Ms Reilly was reviewed by a psychiatrist and a decision was made that she would be referred to Bentley Hospital on forms for psychiatric review. Ms Reilly was informed of this decision. While psychiatric staff completed the relevant paperwork, there was some confusion amongst Emergency Department nursing staff as to what was happening with Ms Reilly. In the confusion, Ms Reilly was mistakenly permitted to leave the hospital unaccompanied. Ms Reilly travelled by taxi to Victoria Park Train Station, where she caught a train to Carlisle Train Station. After arriving at Carlisle Train Station, Ms Reilly left the platform and deliberately walked on to the train tracks, where she was hit by an oncoming train. Ms Reilly suffered fatal injuries and died at the scene.

The Coroner was satisfied Ms Reilly's death was an intentional act of suicide.

The Coroner was satisfied the medical care provided to Ms Reilly was appropriate.

The Coroner concluded there was a failure by hospital staff to supervise Ms Reilly for a very brief window of time, which unfortunately gave her an opportunity to leave the hospital and put her plan to suicide into effect. Once she had left the hospital, there was little that could be done to stop her.

The Coroner did not make any recommendations.

The Finding is on the website of the Coroner's Court of Western Australia.

Brian Vincent ATWELL
Inquest held in Perth 22 May 2020, investigation finalised 3 June 2020

Mr Brian Vincent Atwell (Mr Atwell) died on 13 July 2017 at Fiona Stanley Hospital. The cause of death was from cardiac failure in an elderly man with valvular heart disease and other co-morbidities. The Coroner found the manner of death was by way of natural causes. He was 74 years old.

Immediately before death Mr Atwell was a "person held in care" under section 3 of the *Coroners Act 1996* because he was a sentenced prisoner, and pursuant to the *Prisons Act 1981* he was in the custody of the Chief Executive Officer of the Department of Corrective Services. Mr Atwell was serving his sentence at Casuarina Prison immediately prior to his death. Mr Atwell served time custody on remand in 2012 and 2013 in Albany Regional Prison before being granted bail. After being sentenced in January 2014 he returned to Albany Prison.

On 25 February 2014 Mr Atwell was noted to have significantly deteriorated in his health and a physiotherapist reported he had poor dynamic balance and had developed a fear of falling. As his health needs could no longer be appropriately managed in the general unit at Albany Prison it was decided to transfer Mr Atwell to Casuarina Prison. On 18 March 2014 he was transferred Casuarina Prison where he could receive more supervised care in the infirmary.

Mr Atwell's health conditions were regularly monitored and he was provided with assistance with most of his activities of daily living. Over time his condition deteriorated, with worsening anaemia, renal failure and heart failure. Mr Atwell had a number of hospital admissions before his final admission to Fiona Stanley Hospital on 4 July 2017. On this admission it was apparent to the medical team that Mr Atwell had reached the end of his life and after discussions with his family, a decision was made to withdraw any life saving measures and to commence to treat him palliatively until his death on 13 July 2017.

The Coroner was satisfied Mr Atwell received a high standard of medical care while incarcerated.

The Coroner did not make any recommendation.

The Finding is on the website of the Coroner's Court of Western Australia.

Michael Warren DYBALL
Inquest held in Perth 22 May 2020, investigation finalised 9 June 2020

Mr Michael Warren Dyball (Mr Dyball) died on 1 May 2016 at Fiona Stanley Hospital. The cause of death was from bronchopneumonia complicated by multi-organ failure and hypoxic ischaemic encephalopathy in a man with treated squamous cell carcinoma of the tongue. The Coroner found the manner of death was by way of natural causes. He was 55 years old.

Immediately before death Mr Dyball was a "person held in care" under section 3 of the *Coroners Act 1996* because he was a sentenced prisoner, and pursuant to the *Prisons Act 1981* he was in the custody of the Chief Executive Officer of the Department of Corrective Services. Mr Dyball was serving his sentence at Casuarina Prison.

Prior to Mr Dyball's imprisonment he had been diagnosed with kidney disease and was seeing a kidney specialist. While serving his sentence he suffered chronic renal failure and was also diagnosed with an oropharyngeal tumour at the base of his tongue. Mr Dyball received medical treatment for both, but his health continued to deteriorate. The treatments for the tumour left Mr Dyball was unable to swallow or talk and he had to have a PEG tube inserted to be fed. Mr Dyball was cared for in the Casuarina Prison Infirmary with input from various specialist hospital teams.

On 28 April 2016 Mr Dyball was found unresponsive in his bed in the prison Infirmary. Cardiopulmonary resuscitation was commenced by health centre staff and an ambulance attended and took Mr Dyball to Fiona Stanley Hospital where he was admitted to the Intensive Care Unit. After consultation with his family, a decision was made to palliate him and he was kept comfortable until he died in hospital on 1 May 2016.

The Coroner considered all the evidence and concluded the care provided to Mr Dyball while he was a prisoner was of a high standard and equivalent to what he would have been able to receive if he was living in the community.

The Coroner did not make any recommendation.

The Finding is on the website of the Coroner's Court of Western Australia.