OFFICE OF THE STATE CORONER
FOR WESTERN AUSTRALIA

2023-24 Annual Report

STATE CORONER'S CHAMBERS
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Our ref: Annual Report

Hon John R Quigley LLB JP MLA
Attorney General
11th floor, Dumas House
2 Havelock Street
WEST PERTH WA 6005

Dear Attorney

ANNUAL REPORT 2023-2024

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 2024.

Yours sincerely

R V C FOGLIANI
STATE CORONER

30 September 2024

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ACKNOWLEDGEMENT OF COUNTRY

The Coroner's Court of Western Australia acknowledges the Traditional Owners and Custodians of the lands and waterways across the State of Western Australia. The Court pays its respects to Elders past, present, and emerging. We value the culture and traditions of Aboriginal and Torres Strait Islander people, and their contributions to our communities.

The Court commits itself to working with Aboriginal and Torres Strait Islander people in Western Australia to improve access to the Court's services and to ensure that those services are culturally sensitive and culturally safe.

2022 Aboriginal Artwork Design Story
Artist: Acacia Collard, *Balladong Noongar, Badimia Yamatji*

This design represents the journey of the deceased person – like a river sitting below the surface, the water travels towards its destination. Depicted in the design is the Coroner and the important role they play for the deceased person and their family. Each circular shape represents the delicate pieces that need to be put together in order to reach the Court's outcomes.

Along the riverbank – like a drop of water, the ripples flow outwards and touch the others. This symbolises the effects the person has had on others throughout their lives – being comforted by the many people in their life.

WARNING: Please be advised some content in this report may be distressing to readers. Aboriginal and Torres Strait Islander people are advised that this report contains the names of people who have passed away.

NOTE: The data in this Annual Report is drawn from the ICMS case management system.

STATE CORONER'S OVERVIEW

- **there were 3,329 cases finalised by Coroners this reporting year, with 98.5% of them being finalised by way of administrative finding, and the balance of 1.5% being finalised by inquest**
- **clearance rate, being the number of incoming reportable deaths compared to the number of finalisations of coronial investigations, sits at 100.4%**
- **backlog has reduced by 28% to 804 cases in 2023/2024, when compared to 2022/2023**

The State coronial system is a multidisciplinary system, operating with the support of external agencies, primarily the Western Australia Police Force (with every member of the Police Force being a coroner's investigator), PathWest Laboratory Medicine WA (through the services of the forensic pathologists, neuropathologists and forensic biologists who prepare reports for the Coroner) and ChemCentre (through the services of the toxicologists who prepare reports for the Coroner).

As an independent judicial officer, the Coroner reviews the reports and evidentiary material, in respect of reportable deaths (such as sudden or unexpected deaths). The Coroner considers whether further evidence should be gathered, and makes findings, if possible, on how death occurred, and the cause of the death.

A coronial investigation is a fact-finding exercise, aimed not at apportioning blame, but at establishing the circumstances surrounding the death. It is in the public interest for there to be a careful and thorough review of the information so that reportable deaths are properly investigated, and the cause and manner of each death is properly found and recorded.

The Coronial Counselling and Information Service is able to provide initial support and counselling to persons coming into contact with the coronial system and provides information to families about the progress of their loved one's case through the coronial system. The involvement of the Coroner often comes at a time when family members are experiencing feelings of intense grief and loss. The officers of the Coronial Counselling and Information Service aim to impart clear and accurate information, with compassion. During this reporting year, funding has been made available for the creation of a new position for a Senior Aboriginal Liaison Officer, to provide support, guidance and information to Aboriginal families.

As with previous years, the focus of the work of the Coroner's Court has been on the backlog 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 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.

The Coroner is reliant upon the conduct of investigations by external agencies such as the police (who attend at the scene of death and obtain information for the Coroner) and the forensic pathologists (who perform the post mortem examinations and provide an opinion on the cause of death for the Coroner). The provision of this information assists the Coroner in making the findings.

The overall backlog has decreased from 1120 cases (2022/2023) to 804 cases (2023/2024). This has been achieved through increased resourcing for the Coroner's Court and some external agencies, and a proactive approach taken by Coroner's Court staff to contact external agencies with a view to expediting the preparation of reports for the Coroner, matched by concerted efforts on the part of those external agencies.

The backlog of cases pending analysis at the Coroner's Court has decreased from 503 as at the end of the last reporting year (2022/2023) to 255 as at the end of this reporting year (2023/24).

Whilst it would be desirable for the backlog pending analysis at the Coroner's Court to decrease even further, I bear in mind that the Coroner's Court has also experienced a particularly high workload in connection with a number of complex inquest cases of significant public interest, requiring preparation and/or hearing during a relatively concentrated period of time during this reporting year.

As with previous years, the Coroners and staff members at the Coroner's Court, and the regional Magistrates (who are contemporaneously Coroners) and their registrars have worked carefully and assiduously to review and finalise coronial investigations in as timely a manner as is possible.

I am able to report that the clearance rate, that compares the number of incoming reportable deaths to the number of finalisations of coronial investigations, sits at 100.4%. This means that the court is finalising marginally more cases, than have been reported to the Coroner.

Overall, there were 3,329 cases finalised by Coroners this reporting year, with 98.5% of them being finalised by way of administrative finding. These are findings made by Coroners in chambers, they are provided to the next of kin, but are otherwise confidential. The balance of the total cases finalised, being 1.5% were finalised by inquest. An inquest is a court hearing, presided over by a Coroner, that examines the circumstances surrounding the death. Inquests are conducted in accordance with the principles of open justice and procedural fairness and are generally open to the public. Inquest findings are published on the website of the Coroner's Court.

It is said that the role of the Coroner is to speak for the dead and to protect the living. Within the context of an inquest, Coroners may make recommendations directed towards avoiding deaths in similar circumstances. Coroners made a total of 52 recommendations this reporting year. Ministerial responses to coronial recommendations are published on the website of the Coroner's Court of Western Australia.

The first part of my Report provides statistical and other information on the operations of the Office of the State Coroner in the reporting year ended 30 June 2024.

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 s 27(1) of the *Coroners Act 1996*. 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 prisoners, persons under the custody of police, children the subject of protection orders and involuntary mental health patients.

I acknowledge the dedication and the efforts of the Deputy State Coroner Sarah Linton, Coroner Michael Jenkin and Coroner Philip Urquhart.

The reduction of the backlog, and the solid clearance rate, is a credit to the Coroners and staff of the Coroner's Court, the regional Magistrates and their registrars, all of the coroner's investigators, including the police at the Coronial Investigation Squad, the forensic pathologists, neuropathologists, forensic biologists and other PathWest staff, and the toxicologists and other ChemCentre staff. I take 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 pleased to present the 2023/2024 Annual Report of the Office of the State Coroner.

R V C FOGLIANI
STATE CORONER

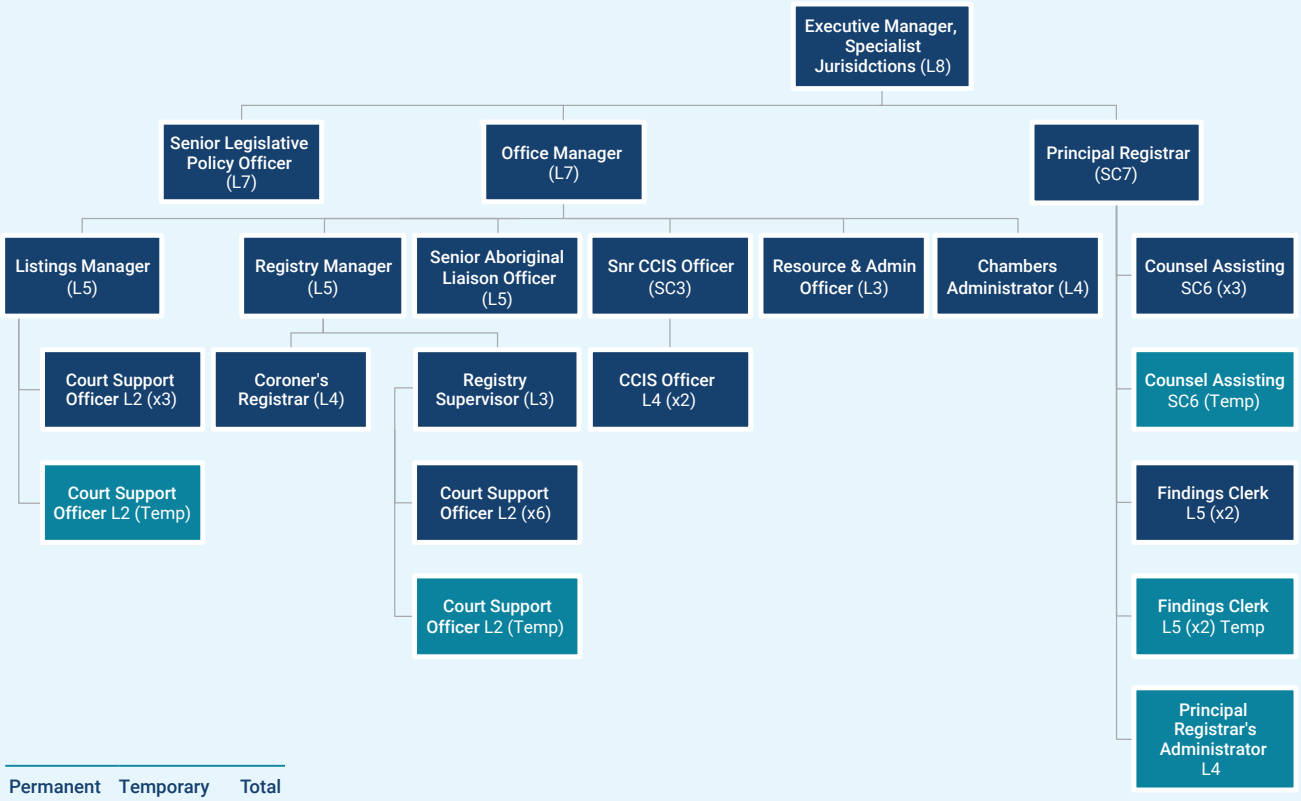
OFFICE STRUCTURE

The Coroner's Court of WA comprises the State Coroner, Deputy State Coroner, two Coroners and funding for 28 permanent non-judicial full-time employees.

In order to address the backlog within the control of the Court and provide a more efficient service to the community, the Department of Justice has renewed the funding for five fixed term positions, that was provided to the Court last financial year. This includes a Counsel Assisting position, two Findings Clerks, and two Court Support Officer positions.

The Department also provided funding for a temporary Administrator the Principal Registrar that has subsequently been made permanent during the course of the 2023/24 year, and has also provided permanent funding for a Senior Aboriginal Liaison Officer (which is in the process of being filled) and a Senior Legislative Policy Officer that was filled in 2023/24.

The fixed term positions that have been gradually filled are differentiated on the Table below. It is expected that, with the continued funding of these fixed term positions, the backlog of cases will be more efficiently addressed.



Permanent	Temporary	Total
SC7 x 1		1
SC6 x 3	SC6 x 1	4
SC2 x 1		1
L7 x 2		2
L5 x 4	L5 x 2	6
L4 x 6		6
L3 x 2		2
L2 x 9	L2 x 2	11
28	**5**	**33**

OUTCOMES

Under section 8 of the *Coroners Act 1996* (WA) (Coroners Act) one of my functions is to ensure that the State Coronial system is administered and operates efficiently. The Tables showing outcomes for the Office of the State Coroner for 2023/24 appear below.

CASES RECEIVED AND CASES COMPLETED

The following Table provides an overview of the work of the Coroner's Court in the 2023/24 year, by reference to incoming reports of death, cases completed by the coroner, overall backlog and overall number of cases on hand:

Cases received	Perth	Country	Total
Full Investigation	**2472**	**845**	**3317**
Death Certificates	**1537**	**246**	**1783**

Cases completed	Perth	Country	Total
Finalised by Inquiry	2509	768	3277
Finalised by Inquest	48	4	52
TOTALS	**2557**	**772**	**3329**

Backlog	Perth	Country	Total
	669	**135**	**804**

Cases on hand	Perth	Country	Total
	2619	**725**	**3344**

INQUIRY/INQUEST FINALISATION RATIO

The following Table shows the breakdown as between cases finalised by administrative finding (Inquiry) and the cases finalised by Inquest for the 2023/24 year.

Finalised By Inquiry	**3277**	**98.5%**
Finalised By Inquest	**52**	**1.5%**

CASES CLOSED BY REFERENCE TO AGE OF CASE

The following Table shows the age of a coronial file when closed calculated from the date of death, for the 2023/24 year.

It will be seen that 47.5% (1581) of files were closed in under 12 months and 52.5% (1747) of files were over 12 months old at closure (i.e. backlog files).

	INQUIRY		INQUEST	
Timelines	**Perth**	**Country**	**Perth**	**Country**
< 3 mths	339	145	0	0
3-6 mths	285	76	1	0
6-12 mths	509	225	1	0
12-18 mths	876	175	3	0
18-24 mths	273	84	10	0
>24 mths	227	63	33	4
TOTALS	**2509**	**768**	**48**	**4**

CASES REPORTED AND COMPLETED BY REFERENCE TO PERTH AND REGIONAL WA

The following table shows cases reported to the Coroner and cases and completed by the Coroner as between Perth and Regional WA, including whether they were finalised by administrative finding (Inquiry) or by Inquest, for the 2023/24 year.

Metropolitan deaths	2472
Regional deaths	845
TOTAL NUMBER OF REPORTABLE DEATHS	**3317**

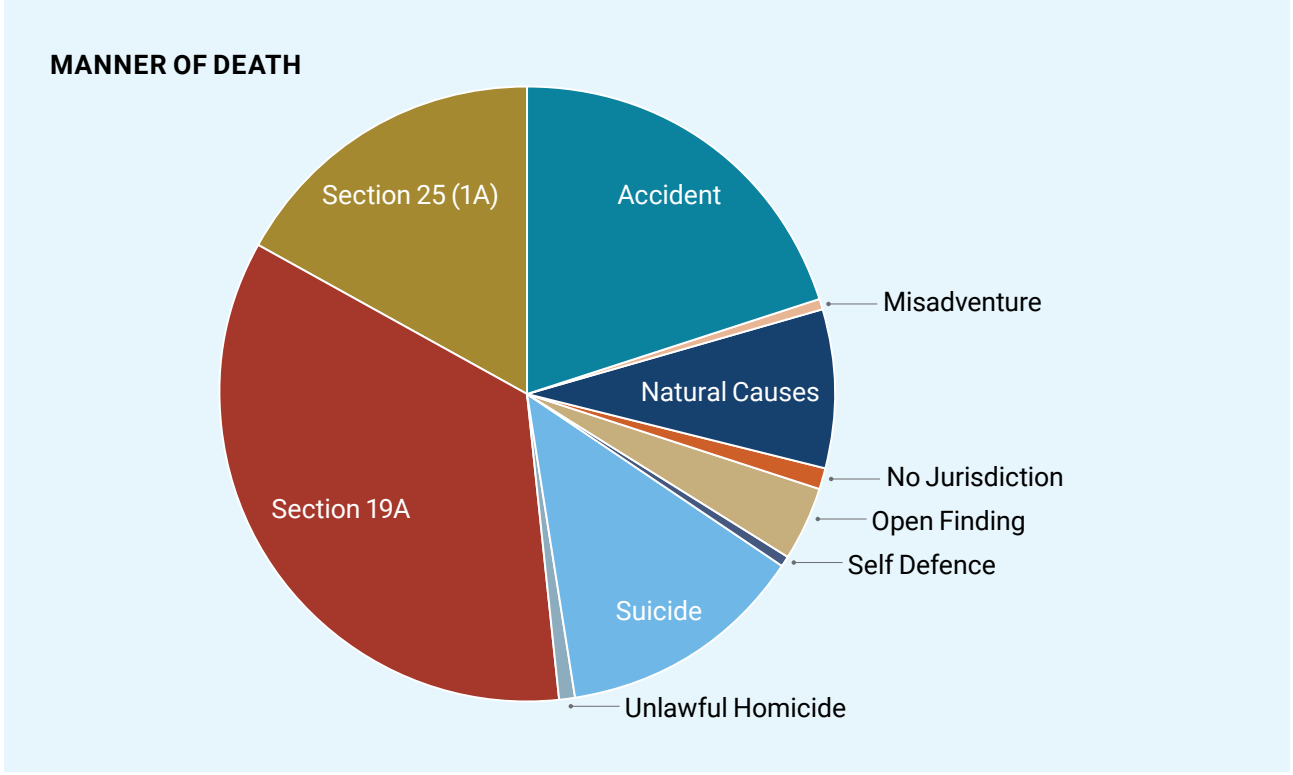
Cases completed	**Perth**	**Country**	**Total**
Finalised by Inquiry	2509	768	3277
Finalised by Inquest	48	4	52
TOTALS	**2557**	**772**	**3329**

CASES CLOSED BY MANNER OF DEATH

Under s 25(1)(b) of the Coroners Act, a Coroner investigating a death must find if possible, how death occurred. This is the Coroner's finding on manner of death.

The following Table and Chart show the data relating to the coroner's findings on manner of death for the 2023/2024 year.

Manner of death	2023-24
Accident	671
Misadventure	16
Natural Causes	282
No Jurisdiction	36
Open Finding	130
Self Defence	14
Suicide	436
Unlawful Homicide	33
Section 19A (Natural Causes)	1154
Section 25 (1A)	557
TOTALS	**3329**



POST MORTEM EXAMINATIONS

Under s 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.

Under s 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.

NUMBER OF POST MORTEM EXAMINATIONS

The following Table shows the number of post mortem examinations performed for the 2023/24 year.

Immediate post mortem	57
No objection to post mortem	2493
Objection to post mortem	725
No post mortem conducted (missing person, death certificate originally issued or by order of coroner etc)	42
NUMBER OF REPORTED DEATHS	**3317**

OBJECTIONS TO POST MORTEM EXAMINATIONS

The following Table shows the number of objections to post mortem examinations and their outcomes, for the 2023/24 year:

Objection accepted	697
Objection withdrawn	28
Objection overruled	0
TOTAL OBJECTIONS TO POST MORTEMS	**725**

PATHOLOGISTS RECOMMENDED EXTERNAL POST MORTEM EXAMINATIONS (PRE'S)

Consistent with s 34(1) of the Coroners Act, and the adoption of the least invasive post mortem procedure that is available and appropriate in the circumstances, the forensic pathologist may recommend to the Coroner 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 is consulted, and the Coroner makes a decision as to whether to approve the forensic pathologist's recommendation for an external examination.

The following Table 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.

PRE recommended by Pathologist	1010
PRE approved by Coroner	993
PRE not approved by Coroner – Full PM	12
PRE rejected by next of kin – Full PM	0
PRE approved – Partial PM	5
TOTAL PATHOLOGIST RECOMMENDED EXTERNAL	**1010**

BACKLOG

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.

The following Table shows the total backlog of cases for the 2022/2023 and 2023/2024 years, divided as between inquest cases, and non-inquest cases, and also divided as between cases as follows:

- Cases where no further finalisations were possible at the Coroner's Court as at the end of the relevant reporting year, because the Coroner was awaiting reports from external entities; and
- Cases that were pending analysis at the Coroner's Court prior to finalisation, as at the end of the relevant reporting year.

	2022/23	2023/24	% Change Last 12 Months
Inquest Cases	65	47	-27.7%%
Pending Reports (External Entities)	552	502	-9%
Pending Analysis Prior to Finalisation (Coroner's Court)	503	255	-49.3%
TOTAL BACKLOG	**1,120**	**804**	**-28.2%**

SUMMARY OF FINALISATIONS

The following Table shows the summary figures for the finalisations of cases for the 2022/2023 and 2023/2024 years, divided as between inquest cases and non-inquest cases, and also divided as between backlog cases and non-backlog cases.

		2022/23	2023/24	% Change Last 12 Months
By Administrative Finding	Non-Backlog	1,936	1579	-18.3%
	Backlog (12+Months)	1,599	1,698	6.2%
By Inquest	Non-Backlog	2	2	-50.0%
	Backlog (12+Months)	40	50	-22.5%
TOTAL FINALISATIONS		**3,577**	**3329**	**-6.9%**

KEY DATA OVER THE LAST FIVE YEARS

The following tables show key data over the last five years, for comparison purposes.

CORONER'S COURT REPORTABLE DEATHS & DEATH CERTIFICATES ACCEPTED

The following tables show the number of deaths reported to the coroner and the number of death certificates accepted by the coroner over the last five years, with the percentage change from the previous year.

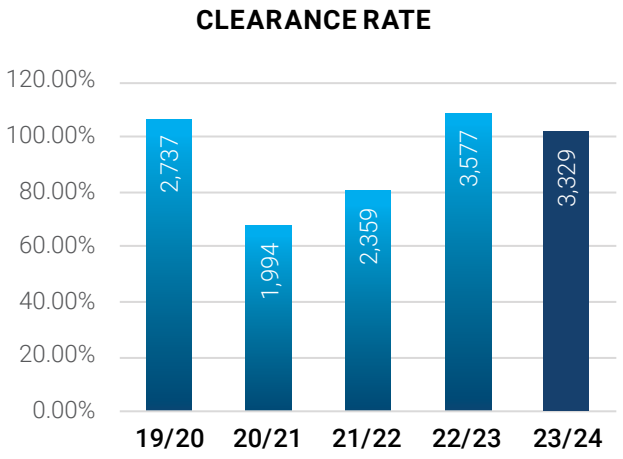
	Reportable Deaths	% Change from previous year
2019/20	2,573	4.9%
2020/21	2,942	14.3%
2021/22	2,944	0.1%
2022/23	3,294	11.9%
2023/24	3,317	0.7%

	Death Certificate Accepted	% Change from previous year
2019/20	1,129	-22.6%
2020/21	1,425	26.2%
2021/22	1,614	13.3%
2022/23	1,634	1.2%
2023/24	1,783	9.1%

CLEARANCE RATE

The clearance rate represents the number of deaths reported to the coroner for the relevant financial year, as compared to the number of finalisations for the same year, expressed as a percentage. The following table shows the clearance rates over the last five years.

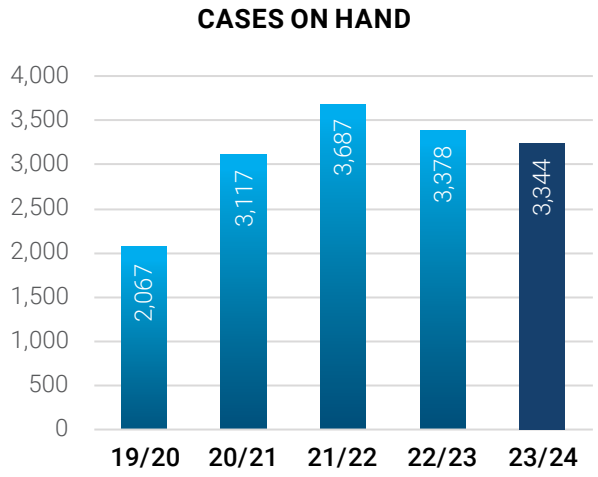
	Reportable Deaths	Finalisations	Clearance Rate
2019/20	2,573	2,737	106.4%
2020/21	2,942	1,994	67.8%
2021/22	2,944	2,359	80.1%
2022/23	3,294	3,577	108.6%
2023/24	3,317	3,329	100.4%



CASES ON HAND

The cases on hand are the number of active coronial cases within the coronial system that are under investigation as at the end of the relevant financial year.

		% Change from previous year
2019/20	2,067	-9.3%
2020/21	3,117	50.8%
2021/22	3,687	18.3%
2022/23	3,378	-8.4%
2023/24	3,344	-1.0%



CORONIAL COUNSELLING AND INFORMATION SERVICE

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

The CCIS provides initial support and counselling to those affected by sudden death. The CCIS explains the coronial process, including the process of objecting to a post mortem examination, provides associated information to the next of kin concerning the progression of the case through the coronial system, and also facilitates connections to agencies that may assist with other aspects of the bereavement process. The CCIS is available Monday to Friday during Court business hours.

The discussions with the CCIS are targeted to and supportive of the client's immediate needs. Referrals for longer term counselling options may be explored with clients as required.

Support options for the next of kin are available from the CCIS in relation to inquest matters. The CCIS acknowledges that each family has different needs which may vary. This process involves supporting the next of kin during an inquest as appropriate and being there as a calming presence for them.

The CCIS also facilitates a culturally relevant counselling and information service for Aboriginal and Torres Strait Islander clients and for culturally and linguistically diverse (CALD) clients.

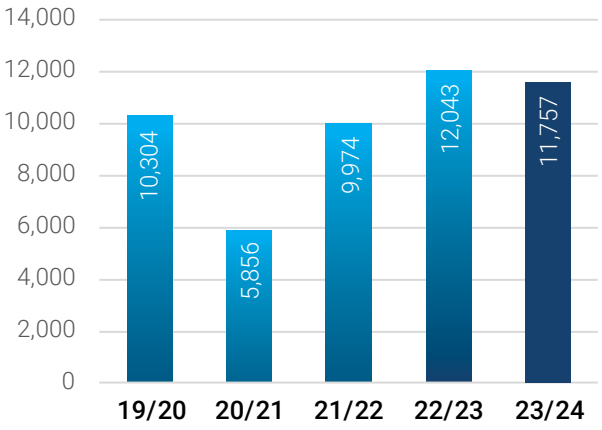
During this reporting year, the Department of Justice, in consultation with the State Coroner, strengthened the court's focus on providing culturally appropriate services to Aboriginal and Torres Strait Islander clients by providing funding and creating a new position for a Senior Aboriginal Liaison Officer (SALO).

Whilst the SALO reports to the Office Manager, the SALO works closely with the CCIS to provide support, guidance, and information to Aboriginal families that come into contact with the Coroner's Court, through the provision of services and accurate information that contributes to an efficient, effective and more culturally responsive service. The position is currently in the process of being filled.

The following Tables show the total number of contacts that the CCIS have had each year for the past five reporting years. Where there have been multiple contacts per case per day, they have been separately counted.

2019/20	10,304
2020/21	5,856
2021/22	9,974
2022/23	12,043
2023/24	11,757

CORONIAL COUNSELLING AND INFORMATION SERVICE CONTACTS



CORONER'S DEATH PREVENTION ROLE

The coroner's death prevention role is an important aspect of a coronial system. This role is carried out in various ways in WA:

INQUEST RECOMMENDATIONS

Under s 25(2) of the Coroners Act, the coroner holding an inquest may comment on any matter connected with the death, including public health, safety or the administration of justice. These comments are often made in the form of recommendations, directed towards avoiding deaths in similar circumstances. The inquest finding and any responses to the recommendations are published on the website of the Coroner's Court of WA.

THERAPEUTIC GOODS ADMINISTRATION

The Office of the State Coroner has 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 212 such notifications to the TGA this reporting year.

SUICIDE PREVENTION

The Office of the State Coroner has a working relationship with the Mental Health Commission (MHC) in relation to the sharing of data about deaths by suicide, where the case has been finalised by the coroner (referred to as a closed suicide case). The MHC has managed and maintained the Western Australian Coronial Suicide Information System (WACSIS) that stores de-identified information specific to a death by suicide in Western Australia. As foreshadowed in the 2022/2023 annual report the MHC is now receiving, from the Coroner's Court, monthly data files of information contained within the Coroner's Court Integrated Computer Management System (ICMS) in relation to de-identified closed suicide cases. This initiative will assist the MHC in continuing to develop its important strategies that work towards suicide prevention in Western Australia, within a significantly improved time frame.

RAISING AWARENESS OF DEATH PREVENTION MATTERS

During a coronial investigation, the Coroner's Court may identify matters relating to death prevention such as outstanding training needs within an organisation or public safety matters. Where those matters are identified by the Coroner's Court, the Principal Registrar will write to the organisation involved, or to an organisation such as the WA Consumer Product Advocacy Network, to raise the matter, for their consideration. The Coroner's Court is also greatly assisted by organisations such as KidSafeWA, through the provision of reports and statistics, where death prevention matters relating to safety arise in a particular case. This provides assistance to the Coroner in considering public health and safety matters, and whether an inquest might be desirable.

WA CORONIAL ETHICS COMMITTEE

The WA Coronial Ethics Committee was established pursuant to s 58 of the Coroners Act and has operated in compliance with the National Health and Medical Research Council's National Statement on Ethical Conduct in Human Research and its associated guidelines. A function of the WA Coronial Ethics Committee has included the review of requests for statistical information from entities conducting research in the areas of health promotion and/or safety in furtherance of the death prevention role, and to ensure that confidentiality and privacy issues are addressed.

Following a review by the State Coroner the functions of the WA Coronial Ethics Committee ceased in October 2023. Third party research projects are now for submission to the National Coronial Information System (NCIS) Research Committee and the Victorian Justice Human Research Ethics Committee. The State of Victoria hosts the NCIS on behalf of participating jurisdictions (which includes Western Australia).

The State Coroner was satisfied that NCIS access rules and controls currently in place are robust and effective. Therefore, the requirement for a separate WA Coronial Ethics Committee was no longer necessary.

The State Coroner acknowledges the substantial and valuable contributions made by members of the WA Coronial Ethics Committee, on a voluntary basis, over many years.

The operations of the WA Coronial Ethics Committee have now been wound up with a handover to NCIS having been completed.

Tables showing the membership of the WA Coronial Ethics Committee and the projects and requests approved for this reporting year up until October 2023 appear below:

Committee Member	Membership Category
Dr Jodi White	Chairperson, Forensic Pathologist, PathWest
Mr Philip Urquhart	Coroner until 24 July 2023
Ms Sarah Linton	Deputy State Coroner from 8 August 2023
Ms Caroline Pittman	Until January 2023
Ms Alice Barter	Legal Member
Dr Natalie Gately	Member with relevant research experience
Dr Thomas Hitchcock	Member with relevant research experience
Ms Antoinette Fedele	Until November 2022
Dr Astra Lees	Member with relevant professional experience

Number of projects considered	Number of projects approved	Number of projects not approved	Deferred
3	3	0	0
Number of requests for renewal considered	**Number of requests for renewal approved**	**Number of requests for renewal not approved**	**Deferred**
2	2	0	0
Number of amendments	**Number of amendments approved**	**Number of amendments not approved**	
6	6	0	0

INQUESTS

REPORT ON INQUESTS THAT ARE REQUIRED BY LAW TO BE HELD (MANDATED INQUESTS)

Under s 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 52 investigations finalised by inquest in the past financial year and of those, a total of 42, being 80%, comprised investigations where an inquest was mandated by law.

The 42 mandated inquests were finalised by Coroners in the following categories and these are described below:

- 26 mandated inquests in relation to persons held in care immediately before death;
- 6 mandated inquests where it appeared that the death was caused, or contributed to, by an action of the police force;
- 10 mandated inquests in relation to the suspected deaths of missing persons.

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

In the past financial year there were 26 investigations of deaths of persons held in care finalised by mandated inquest. Of those:

- 18 investigations were finalised by inquest in respect of deaths of persons held in custody under the *Prisons Act 1981*;
- 3 investigations were finalised by inquest in respect of a child who was the subject of a protection order under the *Children and Community Services Act 2004*;
- 5 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 26 investigations of deaths of persons held in care finalised by mandated inquest this past reporting year, the coroner was required under s 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 19 such cases, the Coroner expressed concern about aspects of supervision, treatment and/or care. The case summaries appear at pages 27 to 62 of this report.

Under s 27(1) of the Coroners Act, the annual report is required to include a specific report on the death of each person held in care. The Table of the 26 investigations into deaths of persons held in care that were finalised by inquest in the past financial year appears at pages 25 to 26 of this report. Following that Table, at pages 27 to 62 are the specific reports on the deaths of each person held in care.

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

There were a total of 6 inquests in this category. In each of the 6 instances the Coroner found that the police did not cause or contribute to the death.

The Table of the 4 investigations appears at page 21 of this Report.

(c) Mandated inquests – suspected deaths

There were 10 investigations into the suspected deaths of missing persons 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 s 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.

The Table of the 10 investigations appears at page 21 of this Report.

REPORT ON INQUESTS THAT ARE HELD PURSUANT TO AN EXERCISE OF DISCRETION BY THE CORONER (DISCRETIONARY INQUESTS)

Under s 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 generate further evidence to assist the Coroner in reaching the findings required to be made, if possible, under s 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 s 24(1) of the Coroners Act. Of the 52 investigations finalised by inquest in the past financial year, a total of 10, being approximately 19% comprised investigations where the inquest was discretionary.

TOTAL NUMBER OF INQUESTS

The Table of all of the investigations that were finalised in the 2023/2024 year by inquest (52) appears below as Table A. The ten discretionary inquests are marked as such (*) leaving the remainder on the Table (42) as the mandated inquests.

TABLE A

Name of Deceased	Date of Death	Inquest Date(s)	Finding	Date of Finding
*REINDL Ashlee Jade	27/10/2019	7-9/2/2023	Misadventure	7/7/2023
WORTHINGTON Matthew James	24/11/2020	18-19/7/2023	Suicide	14/7/2023
INMAN Stanley John	13/7/2020	9-10/5/2023	Suicide	19/7/2023
MAJOR Frank Kenneth	10/10/2021	20/6/2023	Natural Causes	25/7/2023
JENNINGS Terry Frank	On or about 31/3/2022	25/7/2023	Open Finding	28/7/2023
MILGIN Richard	On a date unknown in early 1994	6/12/2022 and 1-3/8/2023	Open Finding	18/8/2023
BLANKET Jomen	12/6/2019	26-27/7/2022 and 14-16/12/2022	Suicide	21/8/2023
LOCKYER Veronica Philomena PARTRIDGE Adell Sherylee	Unknown	28/6/2023	Open Finding	23/8/2023
CAMPBELL Lincoln Arthur	On or about 24/12/2005	5/9/2023	Natural Causes	6/9/2023
*DOBSON Justin	19/7/2019	15-17/3/2023	Natural Causes	31/8/2023
HOWLETT Kevin George	24/2/2022	24/8/2023	Natural Causes	30/8/2023
*TWINE Darren Ross	8/7/2020	8-9/3/2023	Accident	31/8/2023
NARRIER Shane Reynold	5/6/2020	21-22/3/2023	Natural Causes	14/9/2023
WATERFALL John Henry	16/12/2021	19/9/2023	Natural Causes	21/9/2023
*PAPANASTASIOU Kathryn	15/3/2020	2/10/2023	Natural Causes	11/10/2023
*KEELEY Corazon Contreras	27/7/2020	22-24/2/2023	Natural Causes	18/10/2023
WEBER Peta Simon	On or about 22/6/1997	15/8/2023	Open Finding	27/10/2023
FILDES Ashley	1/5/2020	29/5/2023	Lawful Homicide	20/10/2023
STINSON Bradley James Raymond	2/2/2022	23/5/2023	Natural Causes	2/11/2023
CHILD ML	24/2/2019	26-28/9/2023	Open Finding	10/11/2023
CHILD MD	12/5/2021	27/6/2023	Natural Causes	17/11/2023
ASHBY Samuel Edward	9/2/2021	10/10/2023	Open Finding	29/11/2023
*HUNTER Ashleigh Rebecca	27/12/2019	28/11/2022-2/12/2022	Natural Causes	13/12/2023

INQUESTS
(continued)

Name of Deceased	Date of Death	Inquest Date(s)	Finding	Date of Finding
ROBERTS Shane Nathan	24/6/2019	13-14/6/2023	Suicide	21/12/2023
BRENNAN James John	Unknown date after 8/5/1967	9/1/2024	Open Finding	19/1/2024
MACKAY Herbert William	3/4/2021	10/1/2023	Natural Causes	12/1/2024
FRANK Tristan	On or about 3/12/2020	12/1/2024	Open Finding	22/1/2024
ALLEN Phillip John	29/7/2020	11-12/7/2023	Suicide	6/2/2024
BUCHANAN Iain Campbell	1/5/2019	14-16/2/2023	Unlawful Homicide	21/2/2024
HEAD Ian	25/8/2022	8/1/2024	Natural Causes	23/2/2024
KENNEDY Tony Wayne	8/3/2022	4/7/2023	Suicide	6/3/2024
PETROVA-CIZEK Petya Evgenieva	16/12/2020	6-7/2/2024	Suicide	7/3/2024
WOODS Damien Lyndon	27/2/2021	21/3/2024	Accident	26/3/2024
EATTS Alexander Robert	5/7/2022	20/3/2024	Natural Causes	28/3/2024
REILLY Laureen Kaye	3/5/2022	19/3/2024	Accident	28/3/2024
DAVIS Suzzanne Denise	13/8/2020	27-28/2/2024	Suicide	28/3/2024
*CHILD LT	18/8/2021	17-18/10/2023	Open Finding	4/4/2024
HOLMES Karl Frederick	14/1/2023	27/3/2024	Natural Causes	4/4/2024
KOBELT Neil Lindsay	8/2/1982	19/3/2024	Open Finding	5/4/2024
*CHILD SK	23/7/2020	1/5/2024 and 3-12/4/2023	Suicide	8/4/2024
McLOUGHLIN Paul	21/1/2022	26/3/2024	Suicide	8/4/2024
RATCLIFF Alan David	20/6/2022	4/4/2024	Natural Causes	10/4/2024
BULLOCK Warren John	1/7/2022	19/4/2024	Natural Causes	26/4/2024
*GINBEY Devan Beau	17/1/2022	2/11/2023	Suicide	6/5/2024
*FYFE Cameron Anthony	20/6/2021	12-13/9/2023	Suicide	28/5/2024
BABY BE	26/5/2019	4-13/12/2023	Homicide	23/5/2024
BOROS Richard Anthony	14/1/2021	8-9/8/2023	Suicide	17/5/2024
BIRD Michael	17/3/2022	9/4/2024	Suicide	8/5/2024
MARQUIS Petra Michelle	9/6/2022	12/2/2024	Suicide	12/6/2024
EADES Alf Deon	11/3/2019	1-2/5/2024	Unlawful Homicide	12/6/2024
WILSON Peter James	1/11/2021	21-22/5/2024	Natural Causes	26/6/2024

The Coroners' findings appear on the website of the Coroner's Court of Western Australia.

The Tables appearing after Table A (Tables B, C, and D) are subsets of the information contained in Table A, 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 s 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 B below shows the number of inquests (6) finalised in 2023/24 year into deaths that appeared to be caused, or contributed to, by any action of a member of the Police Force.

TABLE B

Name of Deceased	Date of Death	Inquest Date	Finding	Date of Finding
WORTHINGTON Matthew James	24/11/2020	18-19/7/2023	Suicide	14/7/2023
FILDES Ashley	1/5/2020	29/5/2023	Lawful Homicide	20/10/2023
KENNEDY Tony Wayne	8/3/2022	4/7/2023	Suicide	6/3/2024
BULLOCK Warren John	1/7/2022	19/4/2024	Natural Causes	26/4/2024
BIRD Michael	17/3/2022	9/4/2024	Suicide	8/5/2024
MARQUIS Petra Michelle	9/6/2022	12/2/2024	Suicide	12/6/2024

In 5 instances, the Coroner found that the police did not cause or contribute to the death. In 1 case (Ashley Dean FILDES) the Deputy State Coroner found the police officer, in shooting the deceased, caused the death but had acted within the bounds of his training and in self-defence of others.

The Coroners' findings appear on the website of the Coroner's Court of Western Australia.

SUSPECTED DEATHS – MISSING PERSONS

Under s 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 C below shows the number of inquests (10) finalised in 2023/24 year into suspected deaths.

TABLE C

Name of Deceased	Date of Death	Inquest Date	Finding	Date of Finding
JENNINGS Terry Frank	On or about 31/3/2022	25/7/2023	Open Finding	28/7/2023
MILGIN Richard	On a date unknown in early 1994	6/12/2022 and 1-3/8/2023	Open Finding	18/8/2022
LOCKYER Veronica Philomena PARTRIDGE Adell Sherylee	Unknown	28/6/2023	Open Finding	23/8/2023
CAMPBELL Lincoln Arthur	On or about 24/12/2005	5/9/2023	Natural Causes	6/9/2023
WEBER Peta Simon	On or about 22/6/1997	15/8/2023	Open Finding	10/1/2023
BRENNAN James John	On an unknown date after 8/5/1967	9/1/2024	Open Find-ing	19/1/2024
FRANK Tristan	On or about 3/12/2020	12/1/2024	Open Find-ing	22/1/2024
WOODS Damien Lyndon	27/2/2021	21/3/2024	Accident	26/3/2024
KOBELT Neil Lindsay	8/2/1982	19/3/2024	Open Finding	5/4/2024

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

The Coroners' findings appear on the website of the Coroner's Court of Western Australia.

PERSONS HELD IN CARE

Under s 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 s 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 ss 10, 13, 15 or 16 of that Act, whether that person is at a custodial place as defined in that Act, is being moved between custodial places or escapes, or becomes absent, from a custodial place or during movement between custodial places; 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* s 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 D below shows the number of inquests (26) finalised in 2023/24 year into deaths of persons held in care.

TABLE D

Name of Deceased	Date of Death	Inquest Date	Finding	Date of Finding
INMAN Stanley John	13/7/2020	9-10/5/2023	Suicide	19/7/2023
MAJOR Frank Kenneth	10/10/2021	20/6/2023	Natural Causes	25/7/2023
BLANKET Jomen	12/6/2019	26-27/7/2022 and 14-16/12/2022	Suicide	21/8/2023
HOWLETT Kevin George	24/2/2022	24/8/2023	Natural Causes	30/8/2023
NARRIER Shane Reynold	5/6/2020	21-22/3/2023	Natural Causes	14/9/2023
WATERFALL John Henry	16/12/2021	19/9/2023	Natural Causes	21/9/2023
CHILD ML	24/2/2019	26-28/9/2023	Open Finding	10/11/2023
CHILD MD	12/5/2021	27/6/2023	Natural Causes	17/11/2023
STINSON Bradley James Raymond	2/2/2022	23/5/2023	Natural Causes	23/11/2023
ASHBY Samuel Edward	9/2/2021	10/10/2023	Open Finding	29/11/2023
ROBERTS Shane Nathan	24/6/2019	13-14/6/2023	Suicide	21/12/2023

INQUESTS
(continued)

Name of Deceased	Date of Death	Inquest Date	Finding	Date of Finding
MACKAY Herbert William	3/4/2021	10/1/2023	Natural Causes	12/1/2024
ALLEN Phillip John	29/7/2020	11-12/7/2023	Suicide	6/2/2024
BUCHANAN Iain Campbell	1/5/2019	14-16/2/2023	Unlawful Homicide	21/2/2024
HEAD Ian	25/8/2022	8/1/2024	Natural Causes	23/2/2024
PETROVA-CIZEK Petya Evgenieva	16/12/2020	6-7/2/2024	Suicide	7/3/2024
EATTS Alexander Robert	5/7/2022	20/3/2024	Natural Causes	28/3/2024
REILLY Laureen Kaye	3/5/2022	19/3/2024	Accident	28/3/2024
DAVIS Suzzanne Denise	13/8/2020	27-28/2/2024	Suicide	28/3/2024
HOLMES Karl Frederick	14/1/2023	27/3/2024	Natural Causes	4/4/2024
McLOUGHLIN Paul	21/1/2022	26/3/2024	Suicide	8/4/2024
RATCLIFF Alan David	20/6/2022	4/4/2024	Natural Causes	10/4/2024
BABY BE	26/5/2019	4-13/12/2023	Homicide	23/5/2024
BOROS Richard Anthony	14/1/2021	8-9/8/2023	Suicide	17/5/2024
EADES Alf Deon	11/3/2019	1-2/5/2024	Unlawful Homicide	12/6/2024
WILSON Peter James	1/11/2021	21-22/5/2024	Natural Causes	26/6/2024

The Coroners' findings appear on the website of the Coroner's Court of Western Australia.

The individual cases summaries follow.

Stanley John INMAN

Inquest held in Perth 9 to 10 May 2023, investigation finalised 19 July 2023

Mr Stanley John Inman (Mr Inman) died on 13 July 2020 at St John of God Midland Hospital. The cause of death was complications of ligature compression of the neck. The Coroner found the manner of death was suicide. He was 19 years old.

Immediately before death, Mr Inman 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 Justice.

He was serving his sentence at Acacia Prison.

From 4 to 8 July 2020, Mr Inman made numerous phone calls to his mother, and his partner and in a number of these calls he expressed suicidal ideation. On 8 July 2020, Mr Inman told staff he had been self-harming by cutting himself. He was placed on the At Risk Management System (ARMS) on hourly observations, and moved to an observation cell.

On 9 July 2020 Mr Inman was seen by a psychologist. He denied suicidal or self-harm ideation and expressed an interest in further counselling. Prison authorities were unaware of the content of the phone calls Mr Inman had been making, and he said he wanted to be returned to his prison unit, where he had strong *"family support"*, and that he regretted his self-harming behaviour.

On 10 July 2020, Mr Inman was reviewed by another psychologist, and although he had a "flat affect", he again denied suicidal or self-harm ideation, and expressed regret about his recent self-harm. The psychologist recommended Mr Inman's ARMS observations be reduced from "medium" to "low and that he be returned to his unit.

After being returned to his unit, Mr Inman called his partner numerous times, but his calls were not answered. He also called his mother and told her not to come in the following day for a scheduled visit. On 11 July 2020, Mr Inman seemed to be fine, and he was seen interacting with other prisoners and playing a computer game.

During the lunch-time muster on 11 July 2020 at about 11.20 am, Mr Inman was not standing outside his cell as he was required to do. A search was instituted, and Mr Inman was found hanging in a storeroom in his unit, with a rope around his neck that was tied to a fixture that was used as a ligature point.

The ligature was removed and prison officers started CPR, before ambulance officers arrived and took Mr Inman to hospital. Over the next two days, Mr Inman's condition deteriorated and he was declared deceased at 10.54 am on 13 July 2023.

The Coroner concluded that although that the management of Mr Inman's general health was appropriate, the overall quality of Mr Inman's supervision, treatment and care was of a lower standard than it should have been because his level of risk was not properly understood. This occurred because Mr Inman's background risk level was not properly appreciated when he was first admitted to prison, and because the content of the calls he had been making in the days before his death was not assessed when his level of risk was assessed.

The Coroner noted that since Mr Inman's death the phone calls and mail of prisoners who are on ARMS are now the subject of some level of scrutiny. In addition, the previously unfettered access by prisoners to storerooms in their units has been removed.

The Coroner did not make any recommendations.

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

Frank Kenneth MAJOR
Inquest held in Perth 20 June 2023, investigation finalised 25 July 2023

Mr Frank Kenneth Major (Mr Major) died on 10 October 2021 at Bethesda Hospital. The cause of death was complications of metastatic prostate cancer and end-stage chronic obstructive pulmonary disease, with terminal palliative care. The Coroner found the manner of death was natural causes. He was 75 years old.

Immediately before death Mr Major 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 Justice.

He was serving his sentence at Casuarina Prison.

In November 2018, a routine blood test found Mr Major's prostate-specific antigen (PSA) level was raised, and following an MRI in February 2019, he was diagnosed with metastatic prostate cancer, meaning the cancer had spread. He was treated with radiotherapy and chemotherapy and managed in the infirmary at Casuarina Prison, where he was regularly reviewed by prison nurses and medical officers.

On 25 April 2021, Mr Major was identified as a Stage 1 terminally ill prisoner, due to the progression of his prostate cancer, and he was escalated to Stage 4 on 30 September 2021, when his medical condition deteriorated. On 1 October 2021, Mr Major was transferred to Fiona Stanley Hospital with laboured breathing. Later the same day, he was admitted to Bethesda for end-of-life care. At about 3.10 pm on 10 October 2021, security officers supervising Mr Major at Bethesda noticed he appeared to have stopped breathing. The officers alerted nursing staff, who conducted end-of-life checks, and confirmed that Mr Major had died.

The Coroner concluded that the management of Mr Major's prostate cancer was of a very good standard. Further, with the exception of the inappropriate application of restraints during hospital transfers on three occasions, the Coroner concluded that Mr Major's supervision, treatment and care was of an acceptable standard.

The Coroner made one recommendation directed towards improving the assessment of the need for restraints during the external movement of terminally ill prisoners.

The Finding and response to the recommendation is on the website of the Coroner's Court of Western Australia.

Jomen BLANKET

Inquest held in Perth 26 to 27 July 2022 and 14 to 16 December 2022, investigation finalised 21 August 2023

Mr Jomen Blanket (Mr Blanket) died on 12 June 2019 at Acacia Prison. The cause of death was ligature compression of the neck (hanging). The Coroner found the manner of death was suicide. He was 30 years old.

Immediately before death Mr Blanket 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 Justice.

Mr Blanket commenced a 12-month term of imprisonment on 23 October 2018. This was the first time Mr Blanket had been imprisoned. On 6 November 2018, he was transferred to Acacia Prison.

Throughout his imprisonment, Mr Blanket struggled with the burden on his mental health and cultural beliefs. He self-harmed and expressed suicidal ideation on a number of occasions which resulted in regular placements on the Department of Justice's primary suicide prevention strategy (ARMS) and under the management of Acacia Prison's PRAG (the Prisoner Risk Assessment Group). He was often placed in a ligature-free safe cell so he could be closely monitored when he was considered to be at high risk.

On 22 April 2019, Mr Blanket was advised that he had been denied eligibility for parole. That had a significant impact on his mental wellbeing. On that same day, he assaulted two other prisoners and attempted to hang himself using a torn bedsheet which he had knotted at one end to provide an anchor point with a structure in his cell. He showed prison officers the torn bedsheet and explained how he had tried to hang himself.

On 10 May 2019, Mr Blanket met briefly with the prison psychiatrist who formed a view that he had an evident psychotic illness in its early stages that had been preceded by affective depressive symptoms. At a second appointment with the psychiatrist on 30 May 2029, Mr Blanket declined to take any antipsychotic medications. He had also stopped taking the antidepressant medication that had previously been prescribed by the prison doctor.

On the morning of 12 June 2019, a prison officer noticed Mr Blanket appearing distressed. As this was a component of Mr Blanket's risk management plan, the prison officer raised her concerns with the PRAG chairperson. A decision was made by the PRAG chairperson that Mr Blanket should be relocated to a ligature-free safe cell due to the heightened risk of self-harm. Although such a relocation ordinarily took 10 to 15 minutes, on this occasion there was a delay. During that delay, Mr Blanket moved from the common area of the unit he was housed in, to his one-person cell. After entering his cell, he closed the door and locked it from the inside.

At about 10.10 am, the prison officer who had earlier noticed Mr Blanket's distressed state decided to check on him in his cell. When she found the door to be prisoner-locked from the inside, she unlocked it. As she opened the door, she observed Mr Blanket unresponsive against the inside of the door with a torn bedsheet around his neck. Despite repeated attempts to resuscitate him, Mr Blanket could not be revived.

The Coroner formed the view that, in taking his life, Mr Blanket had used the same method he had described to prison officers in April 2029 and to a prison social worker on 14 May 2029.

The Coroner was generally satisfied with the treatment and care provided to Mr Blanket by the mental health service providers at Acacia Prison.

continued over

Jomen BLANKET (continued)

Inquest held in Perth 26 to 27 July 2022 and 14 to 16 December 2022, investigation finalised 21 August 2023

However, although it was appropriate to allow Mr Blanket to enter his cell on the morning of 12 June 2029, the Coroner found that Acacia Prison staff should not have permitted him to close his cell door. It meant Mr Blanket was not adequately supervised, and he had the opportunity and the means to implement his known suicide plan at a time when he was at an elevated risk of self-harm. The Coroner was also critical of the inadequate number of safe cells at Acacia Prison which meant there was a delay in relocating Mr Blanket to such a cell on the morning he died.

The Coroner found that both these issues were contributory factors in Mr Blanket's death.

The Coroner made seven recommendations directed towards the delivery of better mental health care and support to prisoners (including when they are informed of decisions regarding parole eligibility) and to give short-term prisoners greater opportunities to complete treatment programs that will enhance their prospects for parole.

The Finding and response to the recommendations is on the website of the Coroner's Court of Western Australia.

Kevin George HOWLETT
Inquest held in Perth 24 August 2023, investigation finalised 30 August 2023

Mr Kevin George Howlett (Mr Howlett) died on 24 February 2022 at Fiona Stanley Hospital, Murdoch. The cause of death was complications of ruptured abdominal aortic aneurysm (AAA). The Coroner found the manner of death was natural causes. He was 83 years old.

Immediately before death, Mr Howlett 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 Justice.

He was serving his sentence at Casuarina Prison.

Mr Howlett had an extensive medical history and during his incarceration, his medical condition slowly deteriorated. As a result he was transferred to the infirmary at Casuarina Prison on 12 July 2021, where he was regularly reviewed by nursing and medical staff. He was given a walking frame due to his history of falls. After another fall, due to his back pain on 26 August 2021 he had an x-ray at Fiona Stanley Hospital, which incidentally disclosed a large abdominal aortic aneurysm (AAA) that had been asymptomatic. The Prison Doctor made a timely request for an ultrasound to confirm the presence at size of the AAA, but did not indicate any degree of urgency. The ultrasound and CT scan were performed on 2 February 2022 (some five months later).

At about 7.10 am on 23 February 2022, Mr Howlett collapsed in his cell and he complained of spinal and generalised body pain. He was taken to Fiona Stanley Hospital were he was diagnosed with a ruptured AAA. This is a medical catastrophe and about 50% of patients do not make it to hospital alive. Of those that do, a further 50% die after surgery, making the mortality rate for a ruptured AAA about 75%.

Although Mr Howlett underwent emergency surgery and his ruptured aorta was successfully repaired, following the procedure he developed multi-organ failure, abdominal compartment syndrome and low blood pressure. His condition continued to deteriorate, and he was declared deceased at 4.49 am on 24 February 2022.

The Coroner concluded that although the management of Mr Howlett's general health was of a good standard, the management of his AAA was sub-optimal. The Coroner concluded that Mr Howlett should have undergone confirmatory tests within a few weeks of the x-ray he had on 26 August 2021 which first identified he had a large AAA, and that the AAA should have been repaired (most likely by stenting) within a few months thereafter. In view of various changes implemented by the Department of Justice since Mr Howlett's death, the Coroner determined that it was not necessary to make any recommendations in this case.

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

Shane Reynold NARRIER
Inquest held in Perth 21 to 22 March 2023, investigation finalised 14 September 2023

Mr Shane Reynold Narrier (Mr Narrier) died on 5 June 2020 at St John of God Midland Hospital. The cause of death was coronary artery atherosclerosis. The Coroner found the manner of death was natural causes. He was 40 years old.

Immediately before death Mr Narrier 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 Justice.

Mr Narrier commenced his term of imprisonment on 6 December 2019, and his earliest eligible date for parole was 30 August 2020. From 7 January 2020 he was serving his sentence at Acacia Prison.

On 27 May 2020, Mr Narrier sent an electronic message using Acacia Prison's Custody Messaging System requesting an appointment with a prison doctor as he had been getting "chest pains". A Prison Nurse read Mr Narrier's message later that day and an appointment was administratively made for Mr Narrier to see a prison nurse on 31 May 2020. Mr Narrier did not attend that appointment and it was later rescheduled for 11 June 2020.

On the morning of 5 June 2020, Mr Narrier was sitting on a small wall in an outside area of the prison block where his cell was situated. He suddenly collapsed and fellow prisoners who went to assist him noticed he was struggling to breathe. Prison officers and medical staff responded quickly, and first aid was provided before Mr Narrier was taken to the medical centre at Acacia Prison.

As he was being treated at the medical centre, Mr Narrier became unresponsive. CPR was commenced and a call was made for an ambulance to attend. Despite intensive medical treatment from Acacia Prison medical staff and ambulance officers, Mr Narrier's heart stopped beating as he was being taken by ambulance to St John of God Midland Hospital. Despite ongoing resuscitation by hospital staff, Mr Narrier died shortly after midday on 5 June 2020.

The cause of Mr Narrier's death was coronary artery atherosclerosis, and his death occurred by way of natural causes.

The Coroner found that Mr Narrier's complaint of chest pains on 27 May 2020 clearly identified a potentially serious medical issue that should have warranted an immediate medical response. That response, in accordance with Acacia Prison's policy, required an immediate medical examination. As that did not occur, the Coroner found a serious error had been committed by the Prison Nurse in not making urgent arrangements for Mr Narrier's chest pains to be promptly examined.

The Coroner also found that when Mr Narrier did not attend his scheduled appointment with a Prison Nurse on 31 May 2020, there should have been an immediate follow-up with every effort made to have him medically examined. That did not occur, which the Coroner described as a missed opportunity.

Having regard to Mr Narrier's cardiac risk factors, the Coroner was also satisfied that Mr Narrier's treatment and care with respect to his undiagnosed heart disease which caused his death was sub-optimal even before he complained of chest pains for the first time on 27 May 2020.

The Coroner found that had Mr Narrier's complaint of chest pains been correctly actioned on 27 May 2020, the outcome was very likely to have been different.

The Coroner did not make any recommendations.

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

John Henry WATERFALL

Inquest held in Perth 19 September 2023, investigation finalised 21 September 2023

Mr John Henry Waterfall (Mr Waterfall) died on 16 December 2021 at St John of God Midland Hospital. The cause of death was bronchopneumonia with multiple organ failure in the setting of advanced metastatic prostatic adenosquamous carcinoma (medically palliated). The Coroner found the manner of death was natural causes. He was 76 years old.

Immediately before death, Mr Waterfall 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 Justice.

He was serving his sentence at Acacia Prison.

During his incarceration Mr Waterfall frequently declined recommended medical investigations, treatments and appointments (internal and external). On 10 December 2021, Mr Waterfall was reviewed by a prison medical officer. His medical condition had deteriorated, and he appeared frail and had lost weight. Mr Waterfall was transferred to St John of God Midland Hospital, where he underwent x-rays, CT scans and blood tests which confirmed he had metastatic disease. Although the primary cancer was unclear, it was thought that his primary tumour was in his prostate. After discussions with his treating team, Mr Waterfall declined any further investigations or management, and instead he expressed a strong preference for palliative care.

At 12.10 pm on 16 December 2021, officers from Ventia, the company the Department of Justice uses to supervise prisoners admitted to hospital, noted that Mr Waterfall appeared to have stopped breathing. Clinical staff were alerted, and Mr Waterfall was declared deceased at 12.19 pm.

During his transfer to hospital and whilst he was an inpatient, Mr Waterfall was improperly restrained, contrary to the Department of Justice's policy. The Coroner noted that the Department of Justice is planning amendments to its policies and procedures relating to the restraint of terminally prisoners. On that basis the Coroner determined that it was not necessary for any recommendations to be made in this case, but the Coroner strongly urged the Department of Justice to complete the consultation and approval process in relation to the proposed changes to prisoner restraint procedures, so that the changes could be implemented as quickly and efficiently as possible.

With the exception of the restraint issue, the Coroner concluded that the standard of supervision, treatment and care that Mr Waterfall received whilst he was incarcerated was of an acceptable standard.

The Coroner made no recommendations.

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

Child ML (Name Subject to Suppression Order)
Inquest held in Bunbury 26 to 28 September 2023, investigation finalised 10 November 2023

Child ML died on 24 February 2019 at a home in Australind. The cause of death was a pneumonia complicating a viral respiratory illness with acute combined drug effect in a young girl with cerebral palsy, recurrent aspiration, and chronic seizure disorder. The Coroner found the manner of death was natural causes. Child ML was 7 years old.

Immediately before her death, Child ML was a "person held in care" under the Coroners Act 1996 because she had been taken into care by the Director General of the Department of Communities, pursuant to the *Children and Community Services Act 2004*.

Child ML had been diagnosed with spastic quadriplegia, a severe form of cerebral palsy that causes jerking movements and stiffness in the limbs. She was unable to control her head, trunk and limbs and was confined to a wheelchair. She was also diagnosed with a seizure disorder, which was relatively well controlled, and she had chronic lung disease. Child ML did not have a *"safe swallow or gag reflex"* and was unable to protect her airways, or safely consume food or drink orally. As a result, Child ML was eventually fed by means of a percutaneous endoscopic jejunostomy tube, which passed through her abdominal wall into her jejunum.

Child ML was admitted to Bunbury Regional Hospital on 21 February 2017, and diagnosed with severe weight loss and dehydration. Although there were concerns she would die in the days after her admission, over the next six weeks, Child ML regained the weight she had lost and she was discharged into her mother's care on 5 April 2017. However, Child ML was readmitted to Bunbury Regional Hospital on 7 April 2017 with very high levels of sodium in her blood (hypernatremia), a serious and potentially fatal medical condition.

Following these two admissions, and after years of repeated welfare concerns, Child ML was finally taken into the care of the Department of Communities on 28 April 2017. Child ML was placed into foster care in August 2017, and the Coroner concluded that Child ML's foster carer had provided an excellent standard of care to Child ML, and had managed her complex care needs in a diligent, skilled, and caring manner.

After carefully considering all of the available evidence, the Coroner also concluded there were inadequacies in the standard of supervision and support provided to Child ML, and her carers whilst she was in the Department of Communities' care. At the time she died, Child ML was having a supervised access visit with her mother. Following her death, Child ML was found to have a number of medications in her system, including high levels of paracetamol and gabapentin, and an overdose of codeine.

Child ML was not prescribed codeine, and the feeding bags and tubes which were attached to her body at the time of her death were not seized by police and analysed at their behest. The people who had access to Child ML in the period leading up to her death, including Child ML's mother, all flatly denied having given Child ML any medication containing codeine (even inadvertently).

The Coroner noted that despite these denials, the evidence established that the levels of codeine and morphine detected in Child ML's system were "strongly implicated" as having contributed to her death, and had come from a large dose of codeine which was given to Child ML a few hours before her death. On the basis of the available evidence, the Coroner was unable to determine how and/or why Child ML came to have codeine in her system, a situation he described as *"clearly unsatisfactory and frustrating"*.

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Child ML (Name Subject to Suppression Order) (continued)
Inquest held in Bunbury 26 to 28 September 2023, investigation finalised 10 November 2023

The Coroner concluded that there were inadequacies in the standard of supervision and support provided to Child ML and her carers whilst she was in the Department of Communites' care.

The Coroner made three recommendations directed towards improving police investigations at the scene of a death of a vulnerable person (including a child) and directed towards improving the Department of Communities' management of children with complex care needs, through training of carers and oversight processes.

The Finding and responses to those recommendations are on the website of the Coroner's Court of Western Australia.

Child MD (Name Subject to Suppression Order)
Inquest held in Perth 27 June 2023, investigation finalised 17 November 2023

Child MD died on 12 May 2021 at Perth Children's Hospital, Nedlands. The cause of death was multiorgan failure in a boy with clinically suspected sepsis and Cockayne syndrome. The Coroner found the manner of death was natural causes. Child MD was 2 years old.

Immediately before his death, Child MD was a "person held in care" under the Coroners Act 1996 because he had been taken into care by the Director General of the Department of Communities, pursuant to the *Children and Community Services Act 2004*.

Child MD was born at King Edward Memorial Hospital, Subiaco, by emergency caesarean section on 1 July 2018. Shortly after he was born, he was admitted into the neonatal ICU at King Edward Memorial Hospital due to congenital abnormalities.

Child MD was subsequently diagnosed with Cockayne syndrome, an extremely rare and incurable genetic condition that has a limited life expectancy. It causes growth delay, progressive microcephaly and developmental delay. As there is no treatment to cure Cockayne syndrome, medical management is mainly supportive and aimed towards improving the person's quality of life. Throughout his short life, Child MD received multi-disciplinary treatment at King Edward Memorial Hospital, Perth Children's Hospital and Boddington Hospital.

Due to concerns involving his mother's mental health, drug use and exposure to family and domestic violence, the Department of Communities began an intake process for neglect and commenced pre-birth planning before Child MD was born. Two days after his birth, Child MD was placed into the provisional protection and care of the CEO of the Department of Communities. On 24 July 2018, Child MD was placed into the care of a foster carer from his family. He remained with that carer and under the protection and care of the Department of Communities' CEO for the remainder of his life.

On 25 April 2021, Child MD was taken to Boddington Hospital with increased lethargy, poor oral intake and vomiting. A decision was made to urgently transfer him to Perth Children's Hospital by Royal Flying Doctor Service where he was admitted to the paediatric ICU. On 29 April 2021, Child MD's condition deteriorated with severe cardiorespiratory collapse and multiorgan dysfunction. On 10 May 2021, a meeting involving Child MD's treating team, his foster carer, extended family and officers from the Department of Communities decided that Child MD would only be provided with medical treatment that would keep him comfortable.

On 12 May 2021, Child MD died in his foster carer's arms from multiorgan failure with clinically suspected sepsis and Cockayne syndrome.

The Coroner was satisfied that the care provided by the Department of Communities and from the many health service providers who looked after Child MD was of a very high standard. The Coroner also noted the very special bond that existed between Child MD and his foster carer who had provided him with her unconditional love and support.

The Coroner did not make any recommendations.

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

Bradley James Raymond STINSON
Inquest held in Perth 23 May 2023, investigation finalised 23 November 2023

Mr Bradley James Raymond Stinson (Mr Stinson) died on 2 February 2022 at St John of God Midland Hospital. The cause of death was cardiac arrhythmia in the presence of arteriosclerotic cardiovascular disease, pulmonary thromboembolism and metastatic cancer of the pancreas. The Coroner found the manner of death was natural causes. He was 66 years old.

Immediately before death, Mr Stinson 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 Justice.

He was serving his sentence at Acacia Prison.

After being held at Hakea Prison for just over a year, Mr Stinson spent his remaining eight years as a prisoner at Acacia Prison (Acacia). In that time, he underwent regular health assessments and was diagnosed with a number of additional health conditions. These included chronic obstructive pulmonary disease, hypertension and mild coronary artery disease.

On 6 December 2021, Mr Stinson was taken from Acacia to St John of God Midland Hospital after experiencing severe abdominal pain. A CT scan showed a primary pancreatic cancer that had spread to the liver and lungs. A subsequent liver biopsy confirmed adenocarcinoma of the pancreas. Mr Stinson was prescribed tapentadol and paracetamol to manage his pain and he was discharged from St John of God Midland Hospital on 9 December 2021.

On 12 January 2022, Mr Stinson had an outpatient appointment with a consultant at St John of God Midland Hospital . He was informed he had an aggressive pancreatic cancer that was unable to be surgically removed. Mr Stinson was given a prognosis of six to nine months, or possibly two to three years with chemotherapy. Mr Stinson elected not to have chemotherapy.

On 22 January 2022, Mr Stinson had severe nausea and vomiting with generalised abdominal pain, and he was taken by ambulance to St John of God Midland Hospital. A CT scan showed significant progression of the intra-abdominal cancer and ascites (fluid in the abdomen). Mr Stinson remained as an inpatient at St John of God Midland Hospital and by 28 January 2022, he was receiving palliative care medications. He died in the early hours of 2 February 2022.

The Coroner was satisfied that the medical supervision, care and treatment provided to Mr Stinson when he was in prison and in a hospital setting was appropriate. The Coroner, however, was not satisfied it was appropriate to restrain Mr Stinson during his transfer to, and subsequent admission at, St John of God Midland Hospital from 22 - 28 January 2022. The Coroner found that such restraints not only defied the Department's relevant policies and procedures, but they were entirely inappropriate given Mr Stinson's age, frailty, terminal illness and limited mobility.

The Coroner did not make any recommendations.

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

Samuel Edward ASHBY
Inquest held in Perth 10 October 2023, investigation finalised 29 November 2023

Mr Samuel Edward Ashby (Mr Ashby) died on 9 December 2021 at St John of God Midland Hospital. The cause of death was aspiration pneumonia in an obese man with a history of diabetes mellitis, obstructive sleep apnoea, recent right ankle fracture and clozapine effect. The Coroner made an open finding in respect of the manner of death. He was 46 years old.

Immediately before death, Mr Ashby 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 Justice.

He was serving his sentence at Acacia Prison.

Mr Ashby's medical history included high blood pressure, high cholesterol, type-1 diabetes, substance use disorder (including cannabis and alcohol), and intellectual impairment. Mr Ashby was also diagnosed with paranoid schizophrenia (which was regarded as treatment-resistant), and he had obstructive sleep apnoea, for which he used a continuous positive airway pressure machine (CPAP).

In June 2017, Mr Ashby was started on clozapine, regarded as the "first-line treatment" for treatment-resistant schizophrenia. Mr Ashby was also a very heavy smoker, and cigarettes have been found to lower clozapine levels in the blood by inducing the production of the primary liver enzyme which metabolises clozapine.

Mr Ashby's use of his CPAP machine was noted to be inconsistent. He often complained of oversedation, and at times, he was seen falling asleep during the day while sitting in a chair. Although a pharmacological cause for his sleepiness was considered, it was also noted that during periods when he used his CPAP machine regularly, Mr Ashby's daytime sleepiness reduced, and he also reported experiencing fewer auditory hallucinations.

At about 11.15 am on 7 February 2021, a "code blue" medical emergency was called when Mr Ashby collapsed in his block. Mr Ashby was taken to the medical centre, where he denied any loss of consciousness or head strike. However, he was unable to weight bear and was transferred to St John of God Midland Hospital for an x-ray, which confirmed he had fractured his ankle. He was admitted for surgical repair, but his condition deteriorated, and at 10.20 pm, he experienced acute respiratory distress. Although he was intubated, Mr Ashby continued to desaturate with what was suspected to be a massive aspiration. Mr Ashby subsequently went into cardiac arrest. Despite resuscitation efforts, he could not be revived, and he was declared deceased at 10.54 pm.

For several days prior to his admission to St John of God Midland Hospital, Mr Ashby had been accommodated in the health centre at Acacia Prison, where smoking is not permitted. It appears that during this time, Mr Ashby's clozapine levels rose, and the Coroner noted that it seemed likely that the aspiration event which led to Mr Ashby's death was related to sedation caused either by his elevated clozapine levels and/or his obstructive sleep apnoea. However, the Coroner was unable to establish the precise role clozapine played in Mr Ashby's death, the Coroner made an open finding as to the manner of Mr Ashby's death.

The Coroner was satisfied that, in general terms, the standard of supervision, treatment and care provided to Mr Ashby whilst he was incarcerated was reasonable. However, the coroner considered that Acacia Prison's failure to regularly monitor the cleanliness of Mr Ashby's CPAP machine (which was in a deplorable condition at the time of his death) and its failure to provide Mr Ashby with ongoing support to maintain the device in a clean and hygienic state, was poor.

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Samuel Edward ASHBY (continued)
Inquest held in Perth 10 October 2023, investigation finalised 29 November 2023

The Coroner did not make any recommendations.

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

Shane Nathan ROBERTS
Inquest held in Perth 13 to 15 June 2023, investigation finalised 21 December 2023

Mr Shane Nathan Roberts (Mr Roberts) died on 24 June 2019 at Hakea Prison, Canning Vale. The cause of death was ligature compression of the neck (hanging). The Coroner found the manner of death was suicide. He was 41 years old.

Immediately before death Mr Roberts 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 Justice.

Mr Roberts was remanded in custody at Hakea Prison on 27 February 2019.

At his initial assessment, it was considered Mr Roberts was at a high risk of self-harm and/or suicide. He was subsequently placed on the Department of Justice's primary suicide prevention strategy (ARMS) and under the management of the Prisoner Risk Assessment Group (PRAG). He remained on ARMS until 13 March 2019.

On 7 May 2019, Mr Roberts saw a Prison Doctor complaining of anxiety and depression. His anti-depressant medication was increased, and the prison doctor referred him to the Mental Health Team at Hakea. On 13 and 25 May 2019, Mr Roberts made written requests for a medical appointment, stating that his anxiety was getting worse and the increase in his medication had not helped. Although nurse appointments were made for Mr Roberts on 16 and 21 May 2019 in respect of his 13 May request, he did not attend either appointment. When he did not attend the second appointment, a nurse with the Mental Health Team listed Mr Roberts to be discussed at the Mental Health Team weekly meeting on 17 June 2019. At that meeting, a decision was made to refer Mr Roberts back to the Prison Doctor for further treatment. An appointment with the Prison Doctor had not been scheduled before Mr Roberts' death on 24 June 2019.

The Coroner was satisfied with the treatment and care provided to Mr Roberts with respect to his mental health concerns up to 7 May 2019. However, the treatment and care of Mr Roberts' mental health issues was not satisfactory from that date to when he took his life seven weeks later. The Coroner found that this sub-optimal care was due to the inadequate resources available to mental health service providers at Hakea Prison who had done their best with what they had to treat the large cohort of prisoners with significant mental health issues.

The Coroner made three recommendations (including in respect of funding and recruitment) directed towards delivering better health care, particularly mental health care, to prisoners in Hakea Prison.

The Finding and response to the recommendations are on the website of the Coroner's Court of Western Australia.

Herbert William MACKAY

Inquest held in Perth 10 January 2023, investigation finalised 12 January 2024

Mr Herbert William Mackay (Mr Mackay) died on 3 April 2021 at Fiona Stanley Hospital, Murdoch. The cause of death was complications associated with metastatic adenocarcinoma of the lung, treated palliatively. The State Coroner found the manner of death was natural causes. He was 45 years old.

Immediately before death, Mr Mackay was a "person held in care" under section 3 of the *Coroners Act 1996* because he was a prisoner, being held in custody at Casuarina Prison in accordance with an Indefinite Detention Order made under the *High Risk Serious Offenders Act 2020*, on 23 December 2020. Pursuant to the *Prisons Act 1981* he was in the custody of the Chief Executive Officer of the Department of Justice.

He was serving his sentence at Casuarina Prison.

Mr Mackay first displayed respiratory related symptoms in December 2020 when he was seen at the Casuarina Prison medical centre. Medical investigations were promptly commenced, with a referral to Fiona Stanley Hospital. Those investigations showed that Mr Mackay had lung cancer and that it was at an advanced stage. Curative treatment was not possible, and his symptoms were managed at the Casuarina Prison infirmary and Fiona Stanley Hospital.

In commenting on the quality of Mr Mackay's supervision treatment and care, the State Coroner took account of his multiple transfers to Fiona Stanley Hospital, outlining that he had five admissions to Fiona Stanley Hospital (his fifth being his final admission prior to his death), between December 2020 and April 2021. On four of those occasions, he was returned to the Casuarina Prison Infirmary. Questions were raised as to whether Mr Mackay should have remained at Fiona Stanley Hospital the whole time. The State Coroner accepted the evidence that Fiona Stanley Hospital is an acute care hospital and that patients are discharged when they no longer require acute care. If Mr Mackay had been living in the community, he would have been discharged to his home, with in-home nursing provided.

The State Coroner also considered the processes regarding the usage and removal of prisoner restraints and noted that Mr Mackay had not been transferred to Fiona Hospital on the fifth occasion for the purpose of end-of-life palliative care. In connection with his restraints, the Casuarina Prison staff and the Broadspectrum hospital sit staff acted in accordance with prevailing policies and procedures.

The State Coroner was satisfied that the treatment of Mr Mackay was fair, reasonable and appropriate, having regard to his supervision, the availability prisoner treatment programs, and the treatment and care that he received in connection with his medical condition. She accepted that this medical condition, and its seriousness, could not reasonably have been identified at an earlier stage during his incarceration.

The State Coroner noted, with approval, the proposed discussions between clinicians from Casuarina Prison infirmary, and clinicians from Fiona Stanley Hospital, aimed at reaching a greater understanding of the issues, when prisoners are discharged from hospital back to prison. The State Coroner also noted, with approval, the Department of Justice's plan to move towards smoke-free prisons in Western Australia.

The State Coroner did not make any recommendations.

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

Phillip John ALLEN
Inquest held in Perth 11 to 12 July 2023, investigation finalised 6 February 2024

Mr Phillip John Allen (Mr Allen) died on 29 July 2020 at Roebourne Regional Prison, Roebourne. The cause of death was ligature compression of the neck (hanging). The Coroner found the manner of death was suicide. He was 47 years old.

Immediately before death, Mr Allen 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 Justice.

After being charged with some serious offences, Mr Allen was remanded in custody at Roebourne Regional Prison on 27 February 2020 and remained there until his death.

Shortly after he had been placed in Roebourne Regional Prison, Mr Allen began complaining about "black magic". By 17 April 2020, Mr Allen's cell mates had advised custodial staff that he was behaving strangely and talking about spirits. On 6 May 2020, after receiving a report that he was contemplating self-harm, Mr Allen was placed on the Department of Justice's primary suicide prevention strategy (ARMS) under the management of PRAG (the Prisoner Risk Assessment Group). On 7 May 2020, following a risk assessment, Mr Allen was removed from ARMS and placed on SAMS (Support and Monitoring System), which is a step down from ARMS.

Mr Allen's behaviour continued to escalate and he complained he had been "sung". Although Mr Allen denied thoughts of self-harm or suicidal ideation during regular contact with prison mental health service providers and the Prison Support Officer, treatment of his mental health issues was complicated by his refusal to take medication for these issues. Following an appointment with Mr Allen on 15 July 2020, the prison psychiatrist noted he had an apparent delusional disorder and that cultural counselling may be beneficial to address apparent spiritual issues.

On the night of 28 and 29 July 2020, Mr Allen was housed in a six bed cell in Unit 2. Three nightly cell and body checks were required for each cell at Roebourne Regional Prison following the lock-up of cells and before the unlocking of cells the following morning. Although Mr Allen was sighted by a prison officer when she conducted the second cell and body check at about 11.10 pm, she failed to satisfy herself that all the prisoners were accounted for inside Mr Allen's cell when she conducted the final cell and body check at about 4.35 am.

In between the second and third cell and body checks, Mr Allen entered the cell's toilet cubicle, locked the toilet door and hanged himself from one of a number of ligature points that were in front of the cubicle's window. He was not discovered by prison officers until the cell was unlocked at about 6.35 am on 29 July 2020.

The Coroner was satisfied that the mental health care Mr Allen received in Roebourne Regional Prison was appropriate given the resources available to mental health service providers and the COVID-19 restrictions that were in place for much of Mr Allen's imprisonment. The Coroner was also satisfied that Mr Allen's suicide was unexpected and would have been difficult to predict.

However, the Coroner was not satisfied that the supervision of Mr Allen during the final cell and body check by a prison officer on 29 July 2020 was adequate. The Coroner was also satisfied that there was an inaccurate entry in the occurrence book by another prison officer who knew it misleadingly indicated that a body count had been done in all cells at Unit 2 during the final cell and body check.

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Phillip John ALLEN (continued)
Inquest held in Perth 11 to 12 July 2023, investigation finalised 6 February 2024

The Coroner noted that since Mr Allen's death, measures had been taken by the Department of Justice to cover the ligature points in front of toilet cubicle windows in cells. The Coroner also noted that similar points in front of windows in the common areas of cells are to be covered when air-conditioning is installed in these cells. This installation was scheduled to commence in mid-2024. In those circumstances, the Coroner did not consider it was necessary to make a recommendation that these obvious ligature points be rendered inaccessible to prisoners when they are in their cells.

The Coroner did not make any recommendations.

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

Iain Campbell BUCHANAN
Inquest held in Perth 14 to 16 February 2023, investigation finalised 21 February 2024

Mr Iain Campbell Buchanan (Mr Buchanan) died on 1 May 2019 at Royal Perth Hospital, Perth. The cause of death was complications, including pneumonia, of traumatic brain injury. The State Coroner found the manner of death was unlawful homicide. He was 65 years old.

Immediately before death, Mr Buchanan 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 Justice.

He was serving his sentence at Hakea Prison.

Beforehand, while Mr Buchanan was living in the community, he had an altercation with a male person (Prisoner AB) that resulted in criminal damage charges being laid against Prisoner AB. Mr Buchanan was recorded on the police computer system as a "witness" in respect of the charges against Prisoner AB (though there is no evidence that he gave police a witness statement in respect of the criminal damage charges).

Subsequently Mr Buchanan was imprisoned at Hakea Prison in respect of an unrelated matter, in the same unit as Prisoner AB. Prisoner AB spoke of his belief that Mr Buchanan had given police a statement implicating him in the criminal damage charges, including to his cellmate, Prisoner CD. On 15 April 2019, shortly after an initial heated interaction in the recreation compound where Prisoner AB pushed Mr Buchanan to the chest (with both walking away), Prisoner AB returned to where Mr Buchanan was, with Prisoner CD, and prisoner CD assaulted Mr Buchanan by punching him in the face. Mr Buchanan fell backwards and when his head hit the ground, he sustained the traumatic brain injury from when he subsequently died.

The State Coroner considered the quality of Mr Buchanan's supervision, treatment and care. The State Coroner made no criticism of the supervision performed by the individual prison officers on 15 April 2019, but was satisfied that there was room for improvement in the Department of Justice's training for prison officers and made a recommendation directed towards training in the management of aggressive behaviour.

The State Coroner was satisfied that there was room for improvement by the Department of Justice, in that the prison infrastructure was not conducive to appropriate supervision due to there being blind spots obscuring part of the prison officers' view of the prisoners in the recreation compound.

The State Coroner was satisfied that with the benefit of hindsight, there could have been better access for the Department of Justice, to information held by the Western Australia Police Force reflecting upon the potential for animosity as between Mr Buchanan and Prisoner AB (whilst acknowledging that at the material time this access was not possible).

Overall, the State Coroner was satisfied that the standard and quality of Mr Buchanan's medical treatment and care at Hakea Prison was appropriate and noted the improvements in the Department of Justice's procedures at Hakea Prison for calling an ambulance. She found that the prospect of survival for Mr Buchanan, given the severity of his traumatic brain injury, was very small.

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Iain Campbell BUCHANAN (continued)
Inquest held in Perth 14 to 16 February 2023, investigation finalised 21 February 2024

The State Coroner described Mr Buchanan's death by unlawful homicide, in a prison setting, as a catastrophe. She noted that while an absence of criticism may mean that minimum standards of acceptability have been met, if such deaths are to be avoided in future, there needs to be a commitment to continual improvement beyond a mere minimum standard of acceptability.

The State Coroner made three recommendations directed towards improvements for training for prison officers in the management of aggressive behaviour, the investment in body worn cameras and improved CCTV coverage for high-risk areas of Hakea Prison, including recreation areas, and the implementation of information sharing in respect of Offender and connected Victim and/or Witness information, so that a risk assessment can be undertaken as to appropriate placement of prisoners.

The Finding and response are on the website of the Coroner's Court of Western Australia.

Ian HEAD
Inquest held in Perth 8 January 2024, investigation finalised 23 February 2024

Mr Ian Head (Mr Head) died on or about 25 August 2022 at Acacia Prison, Wooroloo. The cause of death was cardiac arrhythmia in an elderly man with chronic obstructive pulmonary disease with COVID-19 infection, hypertension and kidney impairment. The Deputy State Coroner found the manner of death was natural causes. He was 74 years old.

Immediately before death Mr Head 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 Justice.

He was serving his sentence at Acacia Prison.

At the time of his death, Mr Head was housed in a four person cell in Acacia Prison. His cellmates recalled he had been unwell, with diarrhoea, for a couple of days prior. In hindsight, this was likely a symptom of COVID-19, but as Mr Head did not seek medical attention, it was undiagnosed.

On the evening of 24 February 2022, Mr Head seemed in reasonable spirits before going to sleep in his cell. Overnight, checks were made on the cell by prison officers but the checks were cursory. In the morning, the cell was unlocked and a head count was conducted but it was done quickly due to staff shortages and it seems Mr Head remained in bed and a prison officer did not personally check on him. Not long after, one of Mr Head's cellmates tried to wake him and found he was deceased. Resuscitation was attempted but it was ceased when ambulance officers arrived and identified that further resuscitation would be futile as he had died some time earlier.

A post mortem examination found Mr Head was positive for COVID-19 at the time of his death. There was evidence Mr Head had pre-existing airways disease and other co-morbidities. He was up to date with his COVID-19 vaccinations schedule, but had only recently recovered from a bout of the virus weeks before. This may have impacted on the severity of his illness the second time.

It was noted that Mr Head had initially received regular medical reviews at Hakea Prison, but he had not seen a doctor after his transfer to Acacia Prison in April 2022. He had missed an appointment on 3 August 2022 and was scheduled for follow-up, with no new appointment set. Mr Head had been given appropriate treatment when he had COVID-19 previously, and would likely have been given extra support by medical services to fight the disease if he had been diagnosed the second time, but it was not known that he was infected at that time. It was acknowledged there were pressures on all healthcare systems at the time due to the pandemic and, even if he had been diagnosed and given extra support, it cannot be said for certain that he would have survived.

The Deputy State Coroner concluded that the supervision, treatment and care provided to Mr Head during his incarceration was generally appropriate, although the lack of a medical review, or even a comprehensive nursing review, after he moved to Acacia Prison, was a missed opportunity to ensure Mr Head's various health conditions were managed effectively prior to his death. The Deputy State Coroner also noted the policy and procedures for formal head counts and the unlock process were not adhered to on the day of Mr Head's death, which was a missed opportunity to possibly identify that Mr Head was in extremis. In response, the Department of Justice/Corrective Services has recommended to Acacia Prison's management (noting the prison is managed by Serco for the Department) that they reinforce these policies and procedures to staff. Finally, in relation to the resuscitation attempts, it was noted there was

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Ian HEAD (continued)
Inquest held in Perth 8 January 2024, investigation finalised 23 February 2024

compelling evidence before the prison doctor that might have allowed the doctor to make a determination that Mr Head was deceased and resuscitation to cease, prior to the arrival of SJA officers. The Coroner was informed that the Department of Justice is currently reviewing the policies relevant to resuscitation of prisoners, to ensure that the policies and training are consistent with practices in the community, as much as practical.

Given the above issues had already been considered and addressed internally, the Deputy State Coroner did not make any recommendations.

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

Ms Petya Evgenieva PETROVA-CIZEK
Inquest held in Perth 6 to 7 February 2024, investigation finalised 7 March 2024

Ms Petya Evgenieva Petrova-Cizek (Ms Petrova-Cizek) died on 16 December 2020 at Bentley Health Service, Bentley. The cause of death was ligature compression of the neck (hanging). The Coroner found the manner of death was suicide. She was 41 years old.

Immediately before death, Ms Petrova-Cizek was a "person held in care" under the *Coroners Act 1996* as she was subject to an Inpatient Treatment Order made under the *Mental Health Act 2014*.

She was being detained at Bentley Health Service.

Following an assessment by a consultant psychiatrist on 10 December 2020, Ms Petrova-Cizek was admitted to Ward 6, a locked ward at Bentley Health Service. During her admission, Ms Petrova-Cizek's paranoia and suspiciousness persisted, and she spent most of her time in her room and generally declined to engage with clinical staff. Ms Petrova-Cizek's husband visited twice daily and brought in meals, and although some concerns had been raised about his interactions with his wife, these concerns were never substantiated before Ms Petrova-Cizek's death.

During lunch on 15 December 2020, Ms Petrova-Cizek was involved in a verbal and physical altercation with another patient, and she was reviewed by the psychiatric registrar. She was described as "more settled" after that review. However, later that day, she spoke with her mental health advocate, and said words to the effect that she *"would be better off dead"*. The advocate says Ms Petrova-Cizek also said she had a plan to take her life, and although the advocate recalled passing this information on to Ms Petrova-Cizek's nurse, the nurse was adamant she was not told this. In any case, the nurse went to speak with Ms Petrova-Cizek who said she was fine, and seemed dismissive of enquiries about her mental state.

On the morning of 16 December 2020, Ms Petrova-Cizek's husband brought in some breakfast and says he noticed a prominent mark on Ms Petrova-Cizek's neck which she claimed was *"from a strap"*. Although he raised this matter with nursing staff, there is no evidence of what (if anything) was done about these concerns at the time.

Shortly after 5.00 pm on 16 December 2020, a nurse conducted a routine observations of patients on the ward (known as rounding checks), and found Ms Petrova-Cizek hanging in her room. She was unresponsive, there was a ligature around her neck made of shoelaces (which had not been removed on her admission to Ward 6). Despite resuscitation efforts by clinical staff, Ms Petrova-Cizek could not be revived.

After carefully considering the evidence, the Coroner concluded that the supervision, treatment and care provided to Ms Petrova-Cizek whilst she was an involuntary patient at Bentley Health Service was inadequate. The Coroner also identified a number of missed opportunities where, with the benefit of hindsight, Ms Petrova-Cizek should have been provided with an enhanced level of care.

The Coroner made three recommendations directed towards enhancing the treatment provided to mental health consumers at Bentley Health Service.

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

Alexander Robert EATTS
Inquest held in Perth 20 March 2024, investigation finalised 28 March 2024

Mr Alexander Robert Eatts (Mr Eatts) died on 5 July 2022 at St John of God Midland Hospital. The cause of death was complications, including multiorgan failure and pneumonia, of chronic obstructive pulmonary disease, with terminal palliative care, in an elderly man with COVID-19 infection. The Deputy State Coroner found the manner of death was natural causes. He was 73 years old.

Immediately before death Mr Eatts 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 Justice.

He was serving his sentence at Acacia Prison.

Mr Eatts had been sentenced to a lengthy term of imprisonment on 19 October 2012. An appeal against his convictions and sentence was later dismissed and his earliest eligibility date for release on parole was 8 August 2026.

Mr Eatts had been a heavy smoker earlier in his life and he was diagnosed with severe chronic obstructive pulmonary disease (COPD). He was also diagnosed with congestive cardiac failure, hypertension and a number of other chronic health conditions. It appears his conditions were relatively stable for a number of years, but from July 2020, Mr Eatts' health began to decline. He was seen regularly by nursing and medical staff to monitor his cardiac and COPD issues, and he also saw a dentist to get new dentures fitted.

In May 2021, Mr Eatts was treated at St John of God Midland Hospital for pneumonia. He was discharged back to Acacia on 14 May 2021. By this time, he was generally using a wheelchair to mobilise and was on oxygen supplementation. His health continued to be regularly monitored over the next year and he received appropriate medical attention, as required.

On 7 June 2022, Mr Eatts was escalated to Stage 2 on the Terminally Ill register due to his reduced ability to mobilise and additional supplemental oxygen requirements.

On 26 June 2022, Mr Eatts was seen by a Prison Nurse and he reported he felt "shocking" and was unable to pass urine. Arrangements were made for Mr Eatts to be reviewed by a prison doctor and the next day he was transferred to St John of God Midland Hospital by ambulance. He was admitted to hospital that day and the next day he was escalated to Stage 4 on the Terminally Ill Register as his death was believed to be imminent. He was assessed as being in the end-stages of COPD and was exhibiting heart failure and multi-organ failure. Palliative care options were discussed, Mr Eatts' next of kin were notified and family visits were approved.

By 1 July 2022, Mr Eatts' condition had improved a little, but he indicated he did not want any further attempts to cure him. He told his daughter that he was ready to go and was at peace with himself. On 4 July 2022, it was recorded that Mr Eatts had declined any further active treatment. A request was made by a doctor for his restraints to be removed, which was completed soon after. The following day, security officers who were watching Mr Eatts noticed his breathing had stopped and they notified St John of God Midland Hospital staff, who confirmed his death at 4.57 am.

It was unclear from the evidence whether Mr Eatts contracted COVID-19 at Acacia Prison or while in hospital. He was fully vaccinated, but it does not prevent infection, only reduces its severity, and Mr Eatts was noted to be particularly vulnerable given his other health conditions.

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Alexander Robert EATTS (continued)
Inquest held in Perth 20 March 2024, investigation finalised 28 March 2024

The Deputy State Coroner was satisfied Mr Eatts received a high standard of treatment, supervision and care, commensurate with what he would have received in the community. He died as a result of the progression of his pre-existing illnesses and his death was due to natural causes.

The Deputy State Coroner did not make any recommendations.

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

Laureen Kaye REILLY
Inquest held in Perth 19 March 2024, investigation finalised 27 March 2024

Ms Laureen Kaye Reilly (Ms Reilly) died on or about 3 May 2022 at BP Luxury Care, Maddington. The cause of death was combined drug toxicity. The Deputy State Coroner found the manner of death was accident. She was 49 years old.

Immediately before his death, Ms Reilly was a "person held in care" under the *Coroners Act 1996* because he was the subject of a Community Treatment Order (CTO) made under the *Mental Health Act 2014*.

Ms Reilly had a long history of mental health concerns and illicit drug use. Her most recent psychiatric diagnosis was schizophrenia and she had also been diagnosed with an acquired brain injury with frontal lobe syndrome and cognitive impairment. She had been managed as an involuntary patient on CTO's in the past, but once she transitioned to voluntary patient status, she would generally be lost to follow up as there was no mandatory requirement to engage.

On 24 March 2021, police took Ms Reilly to hospital after she attempted to die by suicide by opening a gas tap in her caravan. She was brought before the Magistrates Court on some outstanding charges on 27 April 2021 but was unable to engage meaningfully with court staff and was placed on a hospital order. She was then transferred to the Frankland Centre for psychiatric treatment. She was recommenced on antipsychotic depot medication and eventually granted bail on 12 May 2021 with a condition that she comply with her psychiatric treatment. She was transferred to Armadale Hospital as an involuntary patient, where she remained until mid-June 2021. After receiving a course of ECT, she began to show signs of improvement.

Ms Reilly had an appointed guardian and her finances were managed by the Public Trustee. When she was well enough to be discharged on a CTO, her guardian arranged for Ms Reilly to be housed at a care facility, BP Luxury Mental Health Care Facility, in Maddington. She was assisted by staff at the facility to attend the Eudoria Street Clinic for regular appointment and depot injections. Ms Reilly showed little insight into her illness and was adamant she wanted to come off the CTO and move elsewhere. However, with encouragement, she remained compliant with her treatment and living arrangements. The continuation of her CTO was confirmed by the Mental Health Tribunal in December 2021.

Ms Reilly last received her depot medication on 20 April 2024 and last saw her care coordinator at the Eudoria Street Clinic on 29 April 2022. She exhibited no psychotic symptoms at that time. Ms Reilly was last seen at her residence on 1 May 2022 when she was given her morning medication. She often went out unaccompanied and it appears she went out and at some stage obtained some illicit drugs. She had not returned on 2 May 2022 when staff went to give her medication. On 3 May 2022, facility staff were informed Ms Reilly was due for her depot medication. A staff member went to collect her and identified her television was on, indicating she had returned home, but she did not answer the door. They obtained a key to her room and, upon entry, found her deceased on the floor with illicit drug paraphernalia nearby, suggesting she had injected heroin. A post mortem examination established Ms Reilly died as a result of combined drug toxicity.

The Deputy State Coroner was satisfied Ms Reilly received regular and consistent mental health treatment whilst on her CTO and that her overall supervision, treatment and care was of a high standard.

The Deputy State Coroner did not make any recommendations.

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

Suzzanne Denise DAVIS
Inquest held in Perth 27 to 28 February 2024, investigation finalised 28 March 2024

Ms Suzzanne Denise Davis (Ms Davis) died on 13 August 2020 at Melaleuca Women's Prison, Canning Vale. The cause of death was ligature compression of the neck (hanging). The Coroner found the manner of death was suicide. She was 47 years old.

Immediately before death, Ms Davis was a "person held in care" under section 3 of the *Coroners Act 1996* because she was a remand prisoner, and pursuant to the *Prisons Act 1981* she was in the custody of the Chief Executive Officer of the Department of Justice.

She was remanded at Melaleuca Prison.

In the days before her death, several members of staff, and a fellow inmate (Prisoner T) who was a life-long friend of Ms Davis noted that her mental state had changed. Although none of these people were of the view that Ms Davis was at any acute risk of self-harm, Ms Davis seemed confused and more withdrawn than usual. An appointment was made for Ms Davis to be reviewed by a psychiatrist on 13 August 2020, but she did not attend the appointment, and in a brief court appearance by video link that day, she was remanded in custody for a further period.

At about 1.50 pm on 13 August 2020, Prisoner T alerted prison officers to the fact that Ms Davis was in her cell and was not responding to knocks on her cell door or shouts. Three prison officers attended and when they unlocked the cell door, they found Ms Davis hanging with a bedsheet around her neck that was tied to a fitting within the cell.

Prisoner T helped a prison officer hold Ms Davis' body up as another prison officer cut Ms Davis down and started chest compressions. Prisoner T was then asked if she would like to assist by proving rescue breaths for Ms Davis, which she did. Ambulance officers arrived and took over resuscitation efforts, but Ms Davis could not be revived.

The Coroner was satisfied that in relation to her physical health, whilst incarcerated Ms Davis received a level of care that was commensurate with that available in the general community. The Coroner was also satisfied that with the exception of the fact that Ms Davis was placed in a cell that was not fully ligature-minimised, Ms Davis received an adequate level of care and supervision whilst in custody.

However, the Coroner found that there were a number of missed opportunities where the management of Ms Davis' mental health could have been improved, and the Coroner therefore concluded that the mental health care Ms Davis received whilst she was incarcerated was inadequate.

The Coroner made four recommendations directed towards improving and enhancing security at Melaleuca Women's Prison, including by ensuring that all cells are fully ligature minimised.

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

Karl Frederick HOLMES
Inquest held in Perth 27 March 2024, investigation finalised 4 April 2024

Mr Karl Frederick Holmes (Mr Holmes) died on 14 January 2023 at Fiona Stanley Hospital, Murdoch. The cause of death was complications of metastatic lung adenocarcinoma, with terminal palliative care, in a man with multiple comorbidities. The Deputy State Coroner found the manner of death was natural causes. He was 66 years old.

Immediately before death Mr Holmes was a "person held in care" under section 3 of the *Coroners Act 1996* because he was a sentenced prisoner. Pursuant to the *Prisons Act 1981* he was in the custody of the Chief Executive Officer of the Department of Justice.

Shortly before death he was serving his sentence at Casuarina Prison.

Mr Holmes was serving a lengthy term of imprisonment and was not eligible to be considered for release until February 2027. He had a significant number of health conditions at the time he was initially admitted to Bunbury Regional Prison in February 2022, so he was housed in a prison unit close to the medical centre and a health review was undertaken. He underwent some investigations that suggested he might have lung cancer, which was confirmed on 5 May 2022. This was in addition to previous diagnoses of liver cancer and chronic obstructive pulmonary disease (COPD). Mr Holmes received ongoing medical treatment for these various health conditions, both within the prison and with the support of public health specialist services.

In September 2022, Mr Holmes was told a new lesion in his lung had been identified on a scan. He indicated he did not want to make any decisions about ongoing treatment until he knew the outcome of his criminal appeal. He was counselled by doctors about his decision, but ultimately his choice to decline immediate treatment was respected.

In November 2022, Mr Holmes contracted COVID-19. He was given antiviral treatment and eventually recovered. On 5 January 2023, Mr Holmes had another medical review, including CT scans. He became unwell the following day and was transferred to Bunbury Hospital for treatment. A prison medical officer visited him at the hospital to discuss the results of his scans and advised him that the prognosis was not good and the time for treatment had passed. It was suggested he should now focus on palliative care with the goal to remain well and comfortable as long as possible. Mr Holmes indicated he wanted to talk to discuss his end of life care options with his daughters, which was facilitated.

Mr Holmes was discharged from Bunbury Hospital on 12 January 2023. He wanted to remain at Bunbury Prison, to be close to family, but due to his significant health needs, he was instead transferred to Casuarina Prison so he could be housed in the infirmary. His case was considered for recommendation for Release on the Royal Prerogative of Mercy, but release was not recommended.

On 13 January 2023, Mr Holmes was seen by a prison medical officer in the morning, and he seemed stable, but he rapidly deteriorated that afternoon and was transferred to Fiona Stanley Hospital. He was diagnosed with acute renal failure and infective exacerbation of his COPD. He was given palliative care until he died the following morning.

The Deputy State Coroner was satisfied that Mr Holmes' medical treatment was of an extremely high standard prior to his death. The Deputy State Coroner did raise some concern about the absence of prompt dental treatment for Mr Holmes while in custody and an issue in relation to his restraint on his transfer from Casuarina Prison to Fiona Stanley Hospital and for a brief period before his death, but the Deputy State Coroner made no recommendations.

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

Paul McLOUGHLIN
Inquest held in Perth 26 March 2024, investigation finalised 8 April 2024

Mr Paul McLoughlin (Mr McLoughlin) died on 21 January 2022 at 206 French Street, Tuart Hill. The cause of death was incised injuries to the neck. The Coroner found the manner of death was suicide. He was 59 years old.

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

He was being detained at Graylands Hospital, with permission for "day leave."

Mr McLoughlin had a long-standing history of mental illness and had been a patient of a community mental health service since 1998. He had a long-standing history of heavy, daily cannabis use and had been variously diagnosed with bipolar affective disorder, schizoaffective disorder, drug-induced psychosis, cannabis amotivational syndrome, generalised anxiety disorder with depressive features, dysthymia (milder, but long lasting form of depression), and dependent personality disorder.

Mr McLoughlin had been admitted to Sir Charles Gairdner Hospital a number of times, and had received electro-convulsive therapy on eight occasions. He had also been admitted to Graylands Hospital on five occasions since 2018, and he had attempted to take his life in 2003, 2008, 2018, and 2020 by medication overdoses of "high lethality".

On 4 January 2022, Mr McLoughlin presented to Sir Charles Gairdner Hospital in the company of his family. He had expressed suicidal ideation, and he was made an involuntary patient and transferred to Graylands Hospital for assessment. Mr McLoughlin was diagnosed with generalised anxiety disorder with depressive symptoms/dysthymia, and he was also considered to have cluster C personality disorder with dependent and anxious avoidant features.

He was placed on an inpatient treatment order made under the *Mental Health Act 2014* (WA), and a two to three week admission was planned to allow detoxification from cannabis, monitoring of Mr McLoughlin's mental state, and respite for his wife.

Mr McLoughlin's mental state improved during his admission and he was permitted to leave Graylands on *"day leave"* with his family. Mr McLoughlin successfully completed several periods of day leave without incident, and at about 3.00 pm on 21 January 2022, Mr McLoughlin's wife collected him from Graylands for a further period of leave.

Mr McLoughlin and his wife arrived at the family home at about 5.15 pm and sat in the backyard chatting until about 6.00 pm, when Mr McLoughlin's wife went inside to prepare dinner. At about 6.40 pm, Mr McLoughlin's wife went into the backyard to let Mr McLoughlin know dinner as ready, but he was nowhere to be seen. When she looked through the window of the back shed, she saw Mr McLoughlin lying face down next to a pool of blood. Mr McLoughlin had cut his throat and emergency services were called. Police and ambulance officers arrived a short time later and started CPR, but Mr McLoughlin could not be revived.

The Coroner was satisfied that it was appropriate for Mr McLoughlin to be placed on an inpatient treatment order and managed as an involuntary patient, given Mr McLoughlin's initial suicidal ideation, and his inability to guarantee his safety. The Coroner was also satisfied that Mr McLoughlin's actions in taking his life could not have been anticipated, and that it was appropriate for him to have been granted day leave with his family on 21 January 2022.

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Paul McLOUGHLIN (continued)
Inquest held in Perth 26 March 2024, investigation finalised 8 April 2024

After carefully considering the available evidence, the Coroner concluded that the supervision, treatment and care that Mr McLoughlin received while he was an inpatient at Graylands Hospital was of a good standard.

The Coroner made no recommendations.

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

Alan David RATCLIFF
Inquest held in Perth 4 April 2024, investigation finalised 10 April 2024

Mr Alan David Ratcliff (Mr Ratcliff) died on 20 January 2022 at Sir Charles Gairdner Hospital. The cause of death was intracranial haemorrhage, with terminal palliative care. The Coroner found the manner of death was natural causes. He was 65 years old.

Immediately before death Mr Ratcliff 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 Justice.

He was serving his sentence at Acacia Prison.

Mr Ratcliff's medical history included high blood pressure, high cholesterol, asthma, and migraines with sensory disturbances (aura). Mr Ratcliff had a CT scan at Fiona Stanley Hospital to investigate recurrent issues with migraine headaches and double vision. The CT scan indicated Mr Ratcliff may have posterior reversible encephalopathy syndrome, which is characterised by headaches and vision issues. Although a prison doctor referred him to a neurologist, prison records indicate that no neurology review appointment was made prior to Mr Ratcliff's death.

Shortly after 4.25 pm on 12 June 2022, prison officers responded to an emergency call from Mr Ratcliff's cellmate who said Mr Ratcliff was disorientated. Prison officers found Mr Ratcliff on the floor of his cell unable to answer basic questions and suspected he was having a stroke. He was taken the prison medical centre and found to have a left-sided facial droop and left sided weakness, and he also tested positive for COVID-19.

Mr Ratcliff was taken to Sir Charles Gairdner Hospital by ambulance, where tests confirmed he had experienced a haemorrhagic stroke. Mr Ratcliff was assessed as being an unsuitable candidate for surgery, and he was treated palliatively. At 6.25 am on 20 June 2022, the officers supervising Mr Ratcliff noticed that he appeared to have stopped breathing.

Following an assessment, clinical staff declared Mr Ratcliff deceased at 6.57 am.

After carefully considering the available evidence, the Coroner was satisfied that the supervision, treatment and care that Mr Ratcliff received whilst he was incarcerated was of an acceptable standard. The Coroner also noted that although it was clearly unfortunate Mr Ratcliff was not seen by a neurologist, on the basis of the available evidence, it was not possible to make any findings, to the relevant standard, about whether failure to have Mr Ratcliff reviewed by a neurologist had any impact on his death.

The Coroner made no recommendations.

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

Baby BE (Name Subject to Suppression Order)
Inquest held in Perth 4 to 8 December 2023, investigation finalised 24 May 2024

Baby BE died on 26 May 2019 at Perth Children's Hospital, Nedlands. The cause of death was brain death complicating head and neck injury. The Deputy State Coroner found the manner of death was homicide. Baby BE was 5 months old.

Immediately before her death, Baby BE was a "person held in care" under the *Coroners Act 1996* because she had been taken into care by the Director General of the Department of Communities, pursuant to the *Children and Community Services Act 2004*.

Baby BE was born extremely prematurely on 27 December 2018 following a failed abortion attempt. The Department of Communities had been involved with Baby BE's family as early as December 2016, due to concerns raised in relation to neglect of Baby BE's older siblings, as well as allegations of family violence. After her birth, Baby BE was cared for in the Paediatric Intensive Care Unit of King Edward Memorial Hospital. She was not visited regularly by her parents, despite encouragement, and on 6 February 2019 King Edward Memorial Hospital staff referred her case to the Department of Communities, due to fears she had been abandoned. A case was opened into possible child neglect and further concerns about family violence.

Department of Communities staff visited the family home on 21 February 2019 and noted the house appeared to be in a very poor state. Further visits were not reassuring. Two Signs of Safety meetings were held, during which the parents were encouraged to visit Baby BE more often in hospital so they could bond with her and learn how to care for her, given her extreme prematurity. The parents visited more regularly for a short time, before visits ceased again. The mother complained that the father was making it difficult for her to visit more often but she denied that she was subject to physical domestic violence.

On 2 April 2019, an MRI of Baby BE's brain was undertaken at King Edward Memorial Hospital , which was generally normal. The Department of Communities were informed that Baby BE was medically ready to be discharged home. She remained in hospital for a few more days while arrangements were made for the mother to stay in hospital overnight and demonstrate she could provide appropriate mothercrafting. She was noted to show appropriate attachment to her baby and on this basis, it was determined she could be sent home to her family. Baby BE was discharged home into the care of her parents on 9 April 2019, despite ongoing concerns about the family dynamic and the state of the family home.

Visits to the family home by Department of Communities' staff and child health nurses over the following weeks were not reassuring. Baby BE was not gaining appropriate weight and the home environment remained dirty and in need of repair. On 6 May 2019, a Department of Communities support worker and a child health nurse became concerned about a suspicious bruise on Baby BE's jawline, which was consistent with inflicted injury. The child health nurse suspected Baby BE may have been shaken. She told the mother to take the baby urgently to Joondalup Health Campus for medical assessment and advised the Department of Communities of her request. The mother did not take the baby to Joondalup Health Campus, but did attend a planned appointment with a King Edward Memorial Hospital paediatrician the next day. The paediatrician was not aware of the previous day's concerns and did a routine paediatric review. No concerns were identified during this routine review other than general weight concerns, but there was evidence the paediatrician would have done a different kind of examination if she had been aware of the abuse concerns. Later medical evidence established Baby BE had suffered

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Baby BE (Name Subject to Suppression Order) (continued)
Inquest held in Perth 4 to 8 December 2023, investigation finalised 24 May 2024

multiple skeletal injuries and a brain injury around this time, which might have been identified if there had been better communication with the paediatrician by Department of Communities staff.

Child health nurses continued to raise concerns and eventually, on 14 May 2019, the Department of Communities made a plan to open a full safety investigation, as well as requiring the family to move out of the family home for safety reasons. It had become apparent by that time that the family home did not have running water and there were major electrical issues that posed a serious risk to safety of the older children. A safe house was arranged and the family were encouraged to move there while repairs were undertaken, although the family continued to move between the two houses over the following days.

On 20 May 2019, Department of Communities workers visited the family at the family home at around 5.00 pm. Baby BE appeared well at the time, but the mother and older children were all unwell with a gastrointestinal illness. The mother returned to the safe house with all of the children after the visit. The father remained at the family home doing repairs. Later evidence revealed the mother left the safe house twice more during the afternoon/evening, before returning to the safe house for the last time around 9.30pm. The father returned to the safe house at 10.00 pm. All evidence suggests the older children were in bed by this time, so only the two parents and Baby BE were up and about.

At 1.00 am the next morning, the family arrived at Joondalup Health Campus and the mother brought Baby BE into the ED with a report that the baby was unwell. It was not initially apparent, but over the next hour it became clear that Baby BE was critically unwell, so steps were taken to transfer her to Perth Children's Hospital for specialist treatment. Scans taken at Perth Children's Hospital on 21 May 2019 showed Baby BE had suffered an acute severe brain injury in the hours before her presentation to hospital. Further testing also showed she had multiple healing skeletal fractures that had occurred at least 7 days prior to her presentation and also a brain injury that had occurred at least two weeks prior to her presentation.

The Deputy State Coroner found that the evidence established that Baby BE had been violently shaken by an adult at least twice (if not more), once before 6 May 2019 and once on 20 May 2019. The second incident caused her to suffer catastrophic brain and neck injuries that led to her death. The only people who could have caused those injuries were Baby BE's mother and father. Both parents denied harming Baby BE and denied any knowledge of the other parent shaking Baby BE.

A police investigation was unable to determine who inflicted the fatal injuries. Both parents gave evidence at the inquest. At the conclusion of the inquest, the Deputy State Coroner was unable to determine on the evidence before her to the requisite high standard, given the seriousness of the allegations, which parent caused the fatal injuries.

The Deputy State Coroner made comments that the Department of Communities missed a number of opportunities to intervene and protect Baby BE, prior to her suffering the injuries that led to her death.

The Deputy State Coroner made no recommendations.

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

Richard Anthony BOROS
Inquest held in Perth 8 to 9 August 2023, investigation finalised 17 May 2024

Mr Richard Anthony Boros (Mr Boros) died on 14 January 2021 at Fiona Stanley Hospital, Murdoch. The cause of death was upper airway obstruction (choking). The Coroner found the manner of death was suicide. He was 50 years old.

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

Mr Boros had a long-standing mental health condition which was diagnosed as paranoid schizophrenia. After an extended stay at Graylands Hospital, he was discharged to assisted living accommodation in May 2020. Despite initial good progress with the management of his schizophrenia, Mr Boros had an increase in his paranoia and agitation. By the end of 2020, he had become non-compliant with his medication.

At about 4.00 am on 14 January 2021, Mr Boros was located by police on the bridge at Canning Train Station. He was threatening to jump and was extremely paranoid, stating that people were out to get him. After an extended period of negotiations, police officers were able to grab Mr Boros and he was taken to Fiona Stanley Hospital.

At the ED of Fiona Stanley Hospital, Mr Boros was assessed as being at high risk to himself. He was admitted to the Mental Health Assessment Unit at about 1.10 pm where he was allocated a room with one bed and an ensuite bathroom. After an assessment by the Mental Health Assessment Unit consultant psychiatrist, Mr Boros was placed under an inpatient treatment order with visual observations by nursing staff to be completed every 15 minutes.

The Coroner was satisfied that nursing staff did not undertake the visual observations that had been specified. Although he was seen on several occasions by nursing staff between 4.00 pm and 6.53 pm, Mr Boros was not sighted by anyone when he was in his room with the door closed from 6.53 pm until 8.24 pm, when a nurse entered his room to perform a visual observation. The nurse found Mr Boros unresponsive in his bathroom with a wad of tissue paper blocking his airway. Despite extensive resuscitative efforts by Fiona Stanley Hospital staff, Mr Boros could not be revived.

The Coroner was satisfied that the visual observations of Mr Boros were inadequate for considerable periods of time. The Coroner found that the extended period of over 90 minutes when Mr Boros was not subject to any visual observations was a significant oversight.

The Coroner also found that the situation was made worse by misleading entries in Mr Boros' observation chart that had been completed by two nurses. These entries recorded he had been visually observed every half hour from 4.30 pm. CCTV footage clearly established that this was not the case.

The Coroner was satisfied of the changes that had been made at Fiona Stanley Hospital since Mr Boros' death. These changes have been designed to overcome the deficiencies in Mr Boros' case that existed for his visual observations and the entries in his observation chart.

The Coroner made no recommendations.

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

Alf Deon EADES
Inquest held in Perth 1 to 2 May 2024, investigation finalised 12 June 2024

Mr Alf Deon Eades (Mr Eades) died on 11 March 2019 at Royal Perth Hospital, Perth. The cause of death was head injury complicated by bronchopneumonia, with palliation. The Coroner found the manner of death was unlawful homicide. He was 46 years old.

Immediately before death Mr Eades 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 Justice.

He was on remand at Hakea Prison.

On 26 February 2019, at Hakea Prison, Mr Eades was brutally assaulted in his cell by a number of other prisoners, and was seriously injured. Several prisoners were subsequently convicted of Mr Eades murder.

Mr Eades was taken to Royal Perth Hospital, but his condition deteriorated. Following discussions between Mr Eades' family and his treating team, it was decided to withdraw active treatment, and he died shortly after he was extubated.

The Coroner examined the response of two prison officers to cell calls made from Mr Eades' cell on 26 February 2019, and concluded that many of those responses were highly inappropriate and unprofessional, and constituted a serious breach of the Department of Justice's Code of Conduct.

The Coroner also concluded that the supervision and care provided to Mr Eades during his last incarceration at Hakea was demonstrably unacceptable. The Coroner identified a number of missed opportunities where Mr Eades' safety and welfare could have been more comprehensively assessed. The Coroner also found that the lack of a response to Mr Eades' cell call at 3.45 pm on 26 February 2019 (in which he said other prisoners were alleging he was a child sex offender) was a major failure.

The Coroner made seven recommendations directed to improving responses to cell calls, and improved monitoring of prisoners.

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

Peter James WILSON
Inquest held in Perth 21 to 22 May 2024, investigation finalised 26 June 2024

Mr Peter James Wilson (Mr Wilson) died on 1 November 2021 at Fiona Stanley Hospital, Murdoch. The cause of death was complications in association with effects of fire, with terminal palliative care. The Coroner found the manner of death was suicide. He was 41 years old.

Immediately before death, Mr Wilson was a "person held in care" under the *Coroners Act 1996* because he was the subject of a Community Treatment Order (CTO) made under the *Mental Health Act 2014*.

Mr Wilson had a complex mental health history with an atypical presentation, and a history of polysubstance use including alcohol, cannabis and methylamphetamine. His first recorded interaction with mental health services occurred in 2000. During his mental health journey, Mr Wilson received various diagnoses, including bipolar affective disorder, psychosis, schizophrenia, schizoaffective disorder, personality disorder, and obsessive compulsive disorder. He had been trialled on various psychotropic medications, and he frequently complained of side effects relating to the medications he was prescribed.

Mr Wilson had a history of non-compliance with his medication regime, and he was known to unilaterally alter prescribed doses without seeking medical advice. Mr Wilson had various periods of engagement with his local community mental health service (the Service), and a number of inpatient admissions to hospital.

On 27 August 2021, Mr Wilson presented to hospital after ingesting drain cleaner. He gave conflicting accounts as to why he had done so, including that this was an attempt to take his life, and that he was trying to treat his constipation. After his condition stabilised, Mr Wilson was transferred to Graylands Hospital until his discharge home on 18 September 2021.

On 14 October 2021, Mr Wilson's mother contacted the Service and requested an urgent review as she and her former husband had become very concerned about Mr Wilson's welfare and were unable to manage his level of risk at home.

After assessment, Mr Wilson agreed to be admitted to the Mental Health Observation Area at Sir Charles Gairdner Hospital, where he remained until 15 October 2021, when he was transferred to Graylands Hospital. During his admission, Mr Wilson's treating psychiatrist formed the clinical opinion that Mr Wilson had a major mental health illness, which was either schizophrenia or schizoaffective disorder bipolar type.

Mr Wilson was commenced on a long-lasting depot injection of paliperidone, a medication he had been successfully treated with in the past, and he was discharged home under a community treatment order (CTO) on Friday, 29 October 2021.

Following his discharge, Mr Wilson reportedly experienced side effects relating to his medication, including a tremor and restlessness, although there is no evidence that Mr Wilson was experiencing any thoughts of suicide or self-harm, or that he was exhibiting any signs he was at acute risk of self-harm in the period between his discharge and his death.

The Coroner found that although Mr Wilson's discharge from Graylands Hospital on 29 October 2021 was justified, Mr Wilson's discharge plan was compromised. That was because prior to Mr Wilson's discharge, his consultant psychiatrist at Graylands Hospital did not speak directly with the consultant psychiatrist at the Service who would be assuming Mr Wilson's care in the community.

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Peter James WILSON (continued)
Inquest held in Perth 21 to 22 May 2024, investigation finalised 26 June 2024

The Coroner noted that since Mr Wilson's death, relevant clinical staff have been reminded of the policy requirement that all patient discharges involving a CTO require: *"verbal consultation between associated Consultant Psychiatrists"* before the patient is discharged.

The Coroner also noted that Mr Wilson's discharge summary from Graylands Hospital (which contained important information about the management of his mental health) was not sent to the Service on the day Mr Wilson was discharged. It was also regrettable that neither Mr Wilson nor his mother were provided with basic information about Mr Wilson's diagnosis of schizophrenia, or his medication regime, including the depot injections of paliperidone he had recently been started on.

The Coroner found that notwithstanding their familiarity with the mental health system, Mr Wilson and his mother should also have been given information about the likely, or potential side effects of Mr Wilson's medication, and concerning signs and symptoms to watch out for, as well as the pathway back to care should Mr Wilson's mental state deteriorate.

At about 10.30 am on 1 November 2021, Mr Wilson was dropped off at his father's home for a visit. After they went out and did some shopping, Mr Wilson's father made them some lunch, and they watched a movie on TV. At some point, Mr Wilson went outside for a cigarette, and whilst his father went inside to put some music on, Mr Wilson went into the garage and doused himself with fuel from a jerry can labelled *"boat fuel"*, before setting himself alight.

Mr Wilson was taken to hospital, but his condition deteriorated, and he was kept comfortable until he died at 6.58 pm on 1 November 2021.

After carefully considering the available evidence, and having regard to the relevant principles, the Coroner was unable to conclude (to the relevant standard) that any defect in Mr Wilson's discharge planning was causative of his death.

The Coroner made no recommendations.

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

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