Office of the State Coroner for Western Australia

Annual Report 2024/25

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Our ref: Annual Report

Hon Dr Tony Butti BPE DipEd MIR LLB DPhil MLA
Attorney General
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WEST PERTH WA 6005

Dear Attorney General

ANNUAL REPORT 2024-2025

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 2025.

Yours sincerely

SH Linton
Acting State Coroner

30 September 2025

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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.

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 **3,360** cases finalised by Coroners this reporting year, with **98%** of them being finalised by way of administrative finding, and the balance of **2%** being finalised by inquest
- clearance rate, being the number of incoming reportable deaths compared to the number of finalisations of coronial investigations, sits at **98.7%**
- backlog has increased by **30%** to **1,049** cases in 2024/2025, when compared to 2023/2024

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, considers if the matter is a reportable death, 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, where possible.

The Coronial Counselling and Information Service is available 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.

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 findings.

The overall backlog has increased from 804 cases (2023/2024) to 1,049 cases (2024/2025). This has predominantly occurred through delays to the provision of toxicology reports and post-mortem examination reports, by the responsible agencies.

The backlog of cases pending analysis at the Coroner's Court has increased slightly from 255 as at the end of the last reporting year (2023/2024) to 310 as at the end of this reporting year (2024/2025)

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 diligently 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 98.7%. This means that the court is finalising marginally less cases than have been reported to the Coroner.

Overall, there were 3,360 cases finalised by Coroners this reporting year, with 98% 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 2%, 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 56 recommendations this reporting year. Responses to coronial recommendations are published on the website of the Coroner's Court of Western Australia.

Throughout this reporting year, in addition to their work on the coronial investigations, staff members of the Coroner's Court have worked on a number of projects that support the Coroner's death prevention role. These are outlined in my Report.

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 2025.

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.

For certain periods of this reporting year, I have been acting in the role of the State Coroner while the State Coroner is on leave. It is in that capacity that I have overseen the preparation of this report.

I would like to acknowledge the hard work of 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.

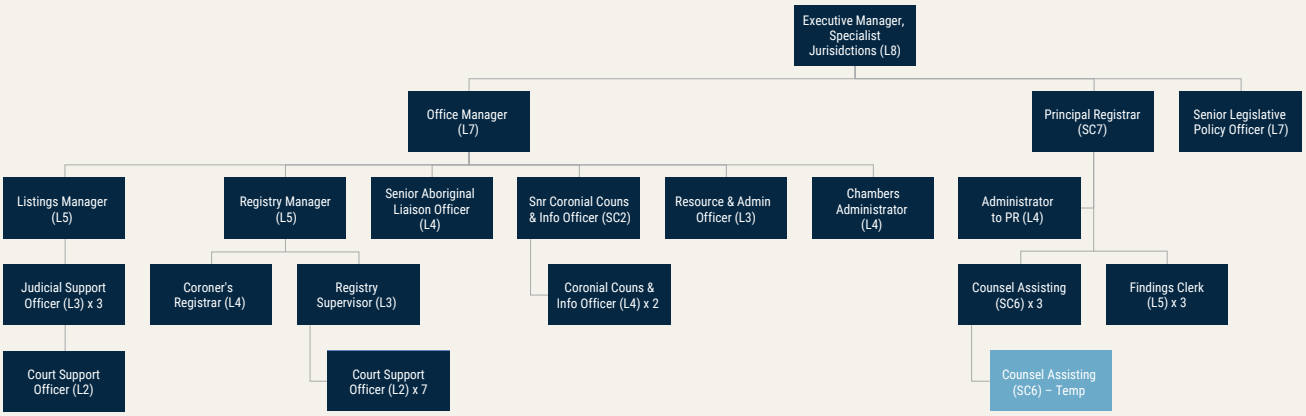
I am pleased to present the 2024/25 Annual Report of the Office of the State Coroner.

SH LINTON
ACTING STATE CORONER

OFFICE STRUCTURE

The Coroner's Court of WA comprises the State Coroner, Deputy State Coroner, two Coroners and funding for 32 non-judicial full-time employees. In addition, in order to backfill Coroners' leave, there has been an additional Coroner appointed for parts of this financial year.

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 provided funding for six additional fixed term positions to the Court. This includes an additional Counsel Assisting position, two additional Findings Clerks, two additional Court Support Officer positions, and an Administrator to the Principal Registrar.



Level	Permanent	Temporary	Total FTE
SC7	1		1
SC6	3	1	4
SC2	1		1
L7	2		2
L5	5		6
L4	6		6
L3	5		2
L2	8		11
Total FTE	**31**	**1**	**32**

OUTCOMES

Under section 8 of the *Coroners Act 1996* (WA) (Coroners Act) one of the functions of the State Coroner 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 2024/25 appear below.

CASES RECEIVED AND CASES COMPLETED

The following Table provides an overview of the work of the Coroner's Court in the 2024/25 year, by reference to incoming reports of death, those for which a death certificate was ultimately accepted, cases completed by the coroner, overall backlog and overall number of cases on hand:

Cases received	Perth	Country	Total
Full Investigation	2469	849	3318
Death Certificates	1547	287	1834

Cases completed	Perth	Country	Total
Finalised by Inquiry	2586	718	3304
Finalised by Inquest	49	7	56
TOTALS	**2635**	**725**	**3360**

Backlog	Perth	Country	Total
	847	**202**	**1049**

Cases on hand	Perth	Country	Total
	2489	**831**	**3320**

INQUIRY/INQUEST FINALISATION RATIO

The following Table shows the breakdown between cases finalised by administrative finding (Inquiry) and the cases finalised by Inquest for the 2024/25 year.

Finalised By Inquiry	**3304**	**98%**
Finalised By Inquest	**56**	**2%**

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 2024/2025 year.

It will be seen that 57.3% (1926) of files were closed in under 12 months and 42.7% (1434) of files were over 12 months old at closure (i.e. backlog files). The backlog is impacted by the timing of information provided by external agencies. Inquest matters will often fall into backlog due to the extra investigation required and the need to hold a hearing and the Coroner to then complete their written findings.

	INQUIRY		INQUEST	
Timelines	**Perth**	**Country**	**Perth**	**Country**
< 3 mths	795	175	2	0
3-6 mths	190	26	0	0
6-12 mths	554	176	8	0
12-18 mths	755	195	6	1
18-24 mths	203	96	7	0
>24 mths	89	50	26	6
TOTALS	**2586**	**718**	**49**	**7**

CASES REPORTED AND COMPLETED BY REFERENCE TO PERTH AND REGIONAL WA

The following table shows cases reported to the Coroner and cases completed by the Coroner as between Perth and Regional WA, including whether they were finalised by administrative finding (Inquiry) or by Inquest, for the 2024/2025 year.

CASES REPORTED

Metropolitan deaths	2469
Regional deaths	849
TOTAL NUMBER OF REPORTABLE DEATHS	**3318**

Cases completed	**Perth**	**Country**	**Total**
Finalised by Inquiry	2586	718*	3304
Finalised by Inquest	49	7*	56
TOTALS	**2635**	**725**	**3360**

*Some of the regional matters were completed by the Perth Coroners Court, including all inquest matters. All cases originating from South Hedland are administered centrally at the Perth Coroner's Court.

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.

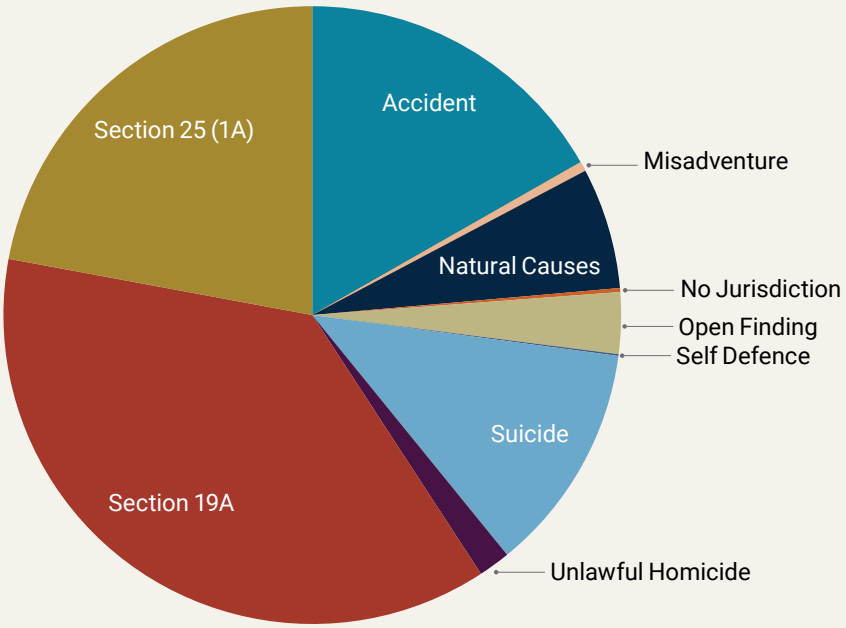
The following Table and Chart show the data relating to the coroner's findings on manner of death for the 2024/2025 year.

Manner of death	2024-25
Accident	563
Misadventure	17
Natural Causes	213
No Jurisdiction	7^
Open Finding	108
Self Defence	3
Suicide	404
Unlawful Homicide	56
Section 19A (Natural Causes)	1247
Section 25 (1A)	742*
TOTALS	**3360**

^No jurisdiction can include matters such as stillbirths, which may require a certain amount of initial investigation, including post mortem examination, to determine if they fall within the coroner's jurisdiction.

*To include elderly falls, cases relating to elderly persons where it is the forensic pathologist's opinion death was due or consistent with natural causes but cannot provide a definitive cause and where a single vehicle collision has occurred.

MANNER OF DEATH



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 2024/2025 year.

Immediate post mortem	55
No objection to post mortem	2374
*Objection to post mortem	837
No post mortem conducted (missing person, death certificate originally issued or by order of coroner etc)	52
NUMBER OF REPORTED DEATHS	**3318**

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 approved by Coroner	991
PRE not approved by Coroner – Full PM	16
TOTAL PATHOLOGIST RECOMMENDED EXTERNAL	**1007**

*Where objection to post mortem is lodge, an external examination will take place and the coroner will determine if a full internal post mortem is required. In 2024-2025 all objections were upheld following an external investigation.

BACKLOG

As noted earlier, 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 2023/2024 and 2024/2025 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.

	2023/24	2024/25	% Change Last 12 Months
Inquest Cases	47	56	17%
Pending Reports (External Entities)	502	664	32.3%
Pending Analysis Prior to Finalisation (Coroner's Court)	255	330	29.4%
TOTAL BACKLOG	**804**	**1049**	**-30.5%**

SUMMARY OF FINALISATIONS

The following Table shows the summary figures for the finalisations of cases for the 2023/2024 and 2024/2025 years, divided as between inquest cases and non-inquest cases, and also divided as between backlog cases and non-backlog cases.

		2023/24	2024/25	% Change Last 12 Months
By Administrative Finding	Non-Backlog	1,579	1,916	21.3%
	Backlog (12+Months)	1,698	1,388	-18.2%
By Inquest	Non-Backlog	2	10*	400.0%
	Backlog (12+Months)	50	46	-8%
TOTAL FINALISATIONS		**3,329**	**3,360**	**0.9%**

*This increase is attributable to long Term Missing Persons (90 days) cases in which the Acting State Coroner has been working closely with the Western Australian Police Homicide Squad Missing Person Team to identify suitable cases that may require an inquest and family are supportive of an early inquest.

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

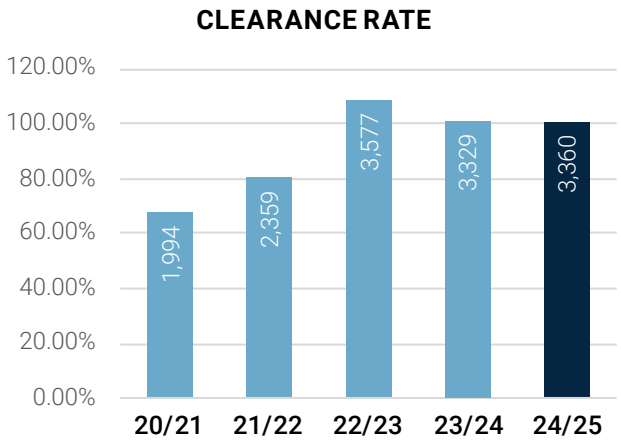
The following tables show the number of deaths reported to the Coroner and the number of death certificates accepted by the Coroner over the last five years, with the percentage change from the previous year.

	Reportable Deaths	% Change from previous year	Death Certificate Accepted	% Change from previous year
2020/21	2,942	14.3%	1,425	26.2%
2021/22	2,944	0.1%	1,614	13.3%
2022/23	3,294	11.9%	1,634	1.2%
2023/24	3,317	0.7%	1,783	9.1%
2024/25	3,318	0%	1,834	2.8%

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.

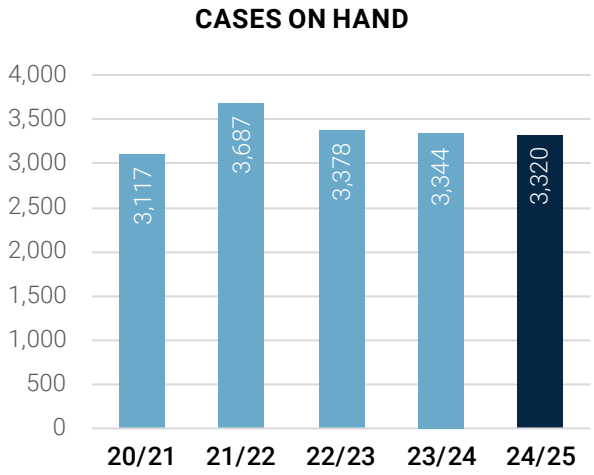
	Reportable Deaths	Finalisations	Clearance Rate
2020/21	2,942	1,994	67.8%
2021/22	2,944	2,359	80.1%
2022/23	3,294	3,577	108.6%
2023/24	3,317	3,329	100.4%
2024/25	3,318	3,360	100.3%



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
2020/21	3,117	50.8%
2021/22	3,687	18.3%
2022/23	3,378	-8.4%
2023/24	3,344	-1.0%
2024/25	3,320	-0.7%



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 normal 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.

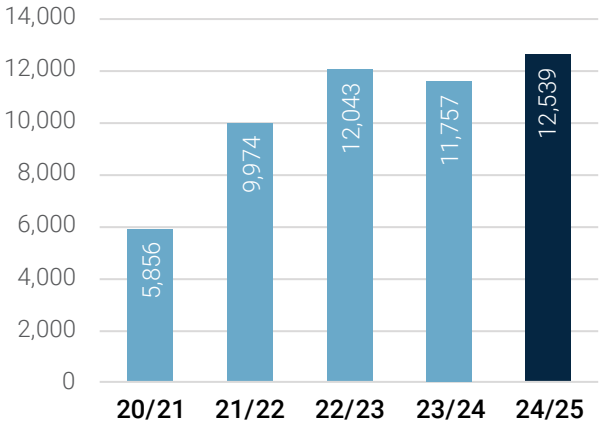
During this reporting year, the Department of Justice, in consultation with the State Coroner, strengthened the court's focus on providing culturally appropriate services to Aboriginal and Torres Strait Islander clients by providing funding and creating a new position for a Senior Aboriginal Liaison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

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.

2020/21	5,856
2021/22	9,974
2022/23	12,043
2023/24	11,757
2024/25	12,539

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 COMMENTS AND 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 124 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. This includes where the case has been finalised by the Coroner (referred to as a closed suicide case), and since January 2025 suspected suicide cases (referred to as open cases). 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. The MHC is now receiving, from the Coroner's Court, weekly data files of information contained within the Coroner's Court Integrated Computer Management System (ICMS) in relation to de-identified closed and suspected (open) suicide cases. This initiative is providing the MHC with recent data (1 week delay) which assists the MHC to develop important strategies and apply resources where necessary that work towards suicide prevention in Western Australia, almost immediately after a suspected suicide. The open cases allows the MHC to identify any trends and patterns at the earliest possible opportunity.

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, and Surf Life Saving WA, 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.

OFFICE OF THE INSPECTOR OF CUSTODIAL SERVICES AND WA OMBUDSMAN

The Office of the State Coroner works cooperatively with other relevant bodies with similarly designed death prevention interests, such as the Office of the Inspector of Custodial Services and the WA Ombudsman.

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 56 investigations finalised by inquest in the past financial year and of those, a total of 49, being 87%, comprised investigations where an inquest was mandated by law.

The 49 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;
- 16 mandated inquests in relation to the suspected deaths of missing persons;
- 7 mandated inquests where it appeared that the death may have been caused, or contributed to, by an action of the police force.

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

A deceased will have been a "person held in care" if they come 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:

- 17 investigations were finalised by inquest in respect of deaths of persons held in custody under the *Prisons Act 1981*;
- 2 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*;
- 7 investigations were finalised by inquest in respect of the death of an involuntary patient within the meaning of the *Mental Health Act 2014*;

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 4 such cases, the Coroner expressed concern about aspects of supervision, treatment and/or care, as follows:

Veltman, P B
Cound, R
Lowe, D S
Lynch, S P C

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 23 to 24 of this report. Following that Table, at pages 25 to 42 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 7 inquests in this category. In each of the 7 instances the Coroner found that the police did not cause or contribute to the death.

The Table of the 7 investigations appears at page 21 of this Report.

(c) Mandated inquests – suspected deaths

There were 16 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 16 investigations appears at page 22 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 56 investigations finalised by inquest in the past financial year, a total of 7, being approximately 12%, comprised investigations where the inquest was discretionary.

TOTAL NUMBER OF INQUESTS

The Table of all of the investigations that were finalised in the 2024/2025 year by inquest (56) appears below as Table A. The seven discretionary inquests are marked as such (*) leaving the remainder on the Table (49) as the mandated inquest.

TABLE A

Name of Deceased	Date of Death	Inquest Date(s)	Finding	Date of Finding
THOMPSON Jason Anthony	5/5/2023	2/7/2024	Natural Causes	10/7/2024
KEATH Kevin John	20/8/2023	5/7/2024	Natural Causes	10/7/2024
VELTMAN Phillip Benjamin	16/7/2020	14-17/11/2023	Natural Causes	19/7/2024
McDONALD, Trevor Henry Albert	On or about 7/8/2021	16/7/2024	Open Finding	19/7/2024
ABELA Joseph Charles	25/10/2021	5-7/7/2024	Homicide by way of self-defence	31/7/2024
*WOODS Lindsay	19/2/2022	11/6/2024	Natural Causes	9/8/2024
DEANE-JOHNS Amy Rebecca	On or about 29/3/2022	27/6/2024	Accident	13/8/2024
RODIER Frank Edward	25/5/1975	14/8/2024	Accident	14/8/2024
BOLTON Peter Johnathon Rex	20/11/2022	23/4/2024	Suicide	28/8/2024
PICKIN Matthew John	7/4/2022	3/10/2023	Natural Causes	28/8/2024
EXELL Robert Allan	30/7/2022	21/8/2024	Natural Causes	3/9/2024
SCHOENHOFER Werner	On or about 20/1/1997	27/8/2024	Open Finding	3/9/2024
PETERA Marek	On or about 27/6/1999	4/9/2024	Suicide	4/9/2024
PARNELL Robert Freddrick	16/5/2022	28/8/2024	Accident	5/9/2024
LEACH Matthew Francis	20/12/2021	16-17/4/2024	Suicide	6/9/2024
*SHERWOOD Stephen Kenneth	On or about 13/4/2022	14/5/2024	Suicide	11/9/2024
CHEEK Raymond Sydney	19/9/2021	22/8/2024	Natural Causes	24/9/2024
TURNER David Arthur	6/12/2022	17/9/2024	Accident	22/10/2024
SQUIRES Dane Lindon	11/9/2022	25/9/2024	Homicide by way of self-defence	22/10/2024
GUEST Sydney Ronald	Unknown	15/10/2024	Open Finding	22/10/2024
TUPPER Chloe Grace	9/6/2020	1/2/2024 & 28/3/2024	Natural Causes	13/11/2024
GARLETT Kingsley Dean	31/7/2022	8-9/10/2024	Suicide	15/11/2024
NW (Name subject to suppression order)	On or about 9/10/2021	29-30/10/2024	Unlawful Homicide	2/12/2024

INQUESTS
(continued)

Name of Deceased	Date of Death	Inquest Date(s)	Finding	Date of Finding
*KINNANE Jaxon Charles	On or about 12/10/2020	16-19/1/2024	Open Finding	6/12/2024
MIKHAIL Frank	23/2/2023	6/12/2024	Natural Causes	23/12/2024
HILLSTEAD Christopher John	18/1/2021	11-13/3/2024	Suicide	3/1/2025
HUANG Tanghui	On or about 21/4/2012	8/1/2025	Open Finding	10/1/2025
JENG Muh Tuu	On or about 7/9/1988	8/1/2025	Accident	10/1/2025
BEVERIDGE Aaron James	7/6/2024	9/1/2025	Accident	23/1/2025
VAN TRIGT Benjamin Jacob	17/11/2022	4/12/2024	Suicide	23/1/2025
DIXON Jesse Kyel and RANDALL Nathan Alan	18/8/2022	29/1/2025	Accident	3/2/2025
*VULICH Kimberley Michael	30/11/2020	5-6/8/2024	Accident	12/2/2025
BUBBA E (Name subject to suppression order)	3/9/2023	11/2/2025	Accident	17/2/2025
COFFIN Fabian Alec	5/2/2024	18/2/2025	Natural Causes	21/2/2025
NORRIS Jalen Hunter	9/4/2021	19-20/11/2024 & 16/12/2024	Suicide	6/3/2025
COUND Ricky-Lee	25/3/2022	6-9/5/2024	Suicide	10/3/2025
MAHER Lex Gregory	27/12/2022	10/12/2024	Natural Causes	18/3/2025
BAUMGARTEN Travis Dion	5/12/2022	14/1/2025	Natural Causes	27/3/2025
LOWE Dannielle Stacey	24/12/2022	5-6/3/2025	Natural Causes	10/4/2025
GREENWOOD David	On or about 14/10/1984	10/4/2025	Open Finding	17/4/2025
GUIDERA Peter James	On or about 8/5/1998	10/4/2025	Open Finding	24/4/2025
*HC And Child HR (Names subject to suppression order)	On or about 23/4/2022 & 12/8/2022	22-24/10/2024	Suicide & Natural Causes	5/5/2025
*NICHOLSON Colin Stanley Francis	18/11/2021	30/9/2024 to 3/10/2024	Natural Causes	9/5/2025
YUNGE Hans Jurgen	31/12/1969	23/4/2025	Open Finding	9/5/2025
GOVAN Lisa Joanne	On or about 8/10/1999	4-8/11/2024, 9/12/2024 & 24/4/2025	Open Finding	13/5/2025
LE VAUX George William	27/03/2022	06/06/2025	Open Finding	27/05/2025
TOLLI Ian Steven	15/12/2020	8/5/2025	Accident	28/5/2025
INGRAM David Benjamin	On or about 24/9/2021	17/2/2025	Open Finding	6/6/2025

Name of Deceased	Date of Death	Inquest Date(s)	Finding	Date of Finding
CLARKE Joyce Gladis (JC)	17/9/2019	8-11/7/2024 & 23/10/2024	Lawful Homicide	9/6/2025
LYNCH Sam Phillip Chisholm	5/3/2024	24-28/3/2025	Accident	12/6/2025
BUTLER Graham John	22/10/2023	28/5/2025	Natural Causes	12/6/2025
D'ARCY Jeanne Christine	On or about 13/4/2022	10/6/2025	Open Finding	20/6/2025
WOOD Leighton Michael	On or about 18/11/2023	11/6/2025	Accident	24/6/2025
*PEEL Houston	On or about 30/3/2023	15-16/3/2025	Suicide	30/6/2025

The Coroners' findings appear on the website of the Coroner's Court of Western Australia **www.coronerscourt.wa.gov.au**.

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 2024/25 year into deaths that appeared to have possibly been 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
ABELA Joseph Charles	25/1/2021	5-7/7/2024	Homicide by way of self-defence [Police Shooting]	31/7/2024
SQUIRES Dane Lindon	11/9/2022	25/9/2024	Homicide by way of self-defence [Police Shooting]	22/10/2024
NW (Name subject to suppression order)	On or about 9/10/2021	29-30/10/2024	Unlawful Homicide [Police Response]	2/12/2024
DIXON Jesse Kyel and RANDALL Nathan Alan	18/8/2022	29/1/2025	Accident [Police Pursuit]	3/2/2025
NORRIS Jalen Hunter	9/4/2021	19-20/11/2024 and 16/12/2024	Suicide [Police Presence]	6/3/2025

In each of the 6 instances, the Coroner found that the police did not cause or contribute to the death.

The Coroners' findings appear on the website of the Coroner's Court of Western Australia **www.coronerscourt.wa.gov.au**.

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 (16) finalised in 2024/25 year into suspected deaths.

TABLE C

Name of Deceased	Date of Death	Inquest Date	Finding	Date of Finding
McDONALD Trevor Henry Albert	On or about 7/8/2021	16/7/2024	Open Finding	19/7/2024
RODIER Frank Edward	25/5/1975	14/8/2024	Accident	14/8/2024
SCHOENHOFER Werner	On or about 20/1/1997	27/8/2024	Open Finding	3/9/2024
PETERA Marek	On or about 27/6/1999	4/9/2024	Suicide	4/9/2024
GUEST Sydney Ronald	Unknown	15/10/2024	Open Finding	22/10/2024
HUANG Tanghui	On or about 21/4/2021	8/1/2025	Open Finding	10/1/2025
JENG Muh Tuu	On or about 7/9/1988	8/1/2025	Accident	10/1/2025
BEVERIDGE Aaron James	7/6/2024	9/1/2025	Accident	23/1/2025
GREENWOOD David	On or about 14/10/1984	10/4/2025	Open Finding	17/4/2025
GUIDERA Peter James	On or about 8/5/1998	10/4/2025	Open Finding	24/4/2025
YUNGE Hans Jurgen	31/12/1969	23/4/2025	Open Finding	9/5/2025
GOVAN Lisa Joanne	On or about 8/10/1999	4-8/11/2024, 9/12/2024 and 24/4/2025	Open Finding	13/5/2025
LE VAUX George William	27/3/2022	6/6/2025	Open Finding	27/5/2025
TOLLI Ian Steven	15/12/2020	8/5/2025	Accident	28/5/2025
INGRAM David Benjamin	On or about 24/9/2021	17/2/2025	Open Finding	6/6/2025
D'ARCY Jeanne Christine	On or about 13/4/2022	10/6/2025	Open Finding	20/6/2025

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 **www.coronerscourt.wa.gov.au**.

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 2024/25 year into deaths of persons held in care.

TABLE D

Name of Deceased	Date of Death	Inquest Date	Finding	Date of Finding
THOMPSON Jason Anthony	5/5/2023	2/7/2024	Natural Causes	10/7/2024
KEATH Kevin John	20/8/2023	5/7/2024	Natural Causes	10/7/2024
VELTMAN Phillip Benjamin	16/7/2020	14-17/11/2023	Natural Causes	19/7/2024
DEANE-JOHNS Amy Rebecca	On or about 29/3/2022	27/6/2024	Accident	13/8/2024
BOLTON Peter Johnathon Rex	20/11/2022	23/4/2024	Suicide	28/8/2024
PICKIN Matthew John	7/4/2022	3/10/2023	Natural Causes	28/8/2024
EXELL Robert Allan	30/7/2022	21/8/2024	Natural Causes	3/9/2024
PARNELL Robert Freddrick	16/5/2022	28/8/2024	Accident	5/9/2024
LEACH Matthew Francis	20/12/2021	16-17/4/2024	Suicide	6/9/2024
CHEEK Raymond Sydney	19/9/2021	22/8/2024	Natural Causes	24/9/2024
TURNER David Arthur	6/12/2022	17/9/2024	Accident	22/10/2024

INQUESTS
(continued)

Name of Deceased	Date of Death	Inquest Date	Finding	Date of Finding
TUPPER Chloe Grace	9/6/2020	1/2/2024 & 28/3/2024	Natural Causes	13/11/2024
GARLETT Kingsley Dean	31/7/2022	8-9/10/2024	Suicide	15/11/2024
MIKHAIL Frank	23/2/2023	6/12/2024	Natural Causes	23/12/2024
HILLSTEAD Christopher John	18/1/2021	11-13/3/2024	Suicide	3/1/2025
VAN TRIGT Benjamin Jacob	17/11/2022	4/12/2024	Suicide	23/1/2025
BUBBA E (Name subject to suppression order)	3/9/2023	11/2/2025	Accident	17/2/2025
COFFIN Fabian Alec	5/2/2024	18/2/2025	Natural Causes	21/2/2025
COUND Ricky-Lee	25/3/2022	6-9/5/2024	Suicide	10/3/2025
MAHER Lex Gregory	27/12/2022	10/12/2024	Natural Causes	18/3/2025
BAUMGARTEN Travis Dion	5/12/2022	14/1/2025	Natural Causes	27/3/2025
LOWE Dannielle Stacey	24/12/2022	5-6/3/2025	Natural Causes	10/4/2025
Child HR (Names subject to suppression order)	On or about 23/4/2022 & 12/8/2022	22-24/10/2024	Suicide & Natural Causes	5/5/2025
LYNCH Sam Phillip Chisholm	5/3/2024	24-28/3/2025	Accident	12/6/2025
BUTLER Graham John	22/10/2023	28/5/2025	Natural Causes	12/6/2025
WOOD Leighton Michael	On or about 18/11/2023	11/6/2025	Accident	24/6/2025

The Coroners' findings appear on the website of the Coroner's Court of Western Australia **www.coronerscourt.wa.gov.au**.

The individual cases summaries follow.

PERSONS HELD IN CARE – SPECIFIC REPORTS

Jason Anthony THOMPSON
Inquest held in Perth 2 July 2024, before Coroner Jenkin, investigation finalised 10 July 2024

Mr Jason Anthony Thompson died on 5 May 2023 at Casuarina Prison, Casuarina. The cause of death was metastatic lung cancer with terminal palliative care. The Coroner found the manner of death was natural causes. He was 54 years old.

Immediately before death, Mr Thompson 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.

The Coroner was satisfied that the supervision, treatment and care that Mr Thompson received whilst he was incarcerated was of an acceptable standard.

The Coroner did not make any recommendations.

The Finding is on the website of the Coroner's Court of Western Australia **www.coronerscourt.wa.gov.au**.

Kevin John KEATH
Inquest held in Perth 5 July 2024, before Coroner Jenkin, investigation finalised 10 July 2024

Mr Kevin John Keath died on 20 August 2023 at Bethesda Health Care, Claremont. The cause of death was Metastatic prostate cancer with terminal palliative care. The Coroner found the manner of death was natural causes. He was 76 years old.

Immediately before death, Mr Keath 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.

The Coroner was satisfied that the supervision, treatment and care that Mr Keath received whilst he was incarcerated was of an acceptable standard.

The Coroner did not make any recommendations.

The Finding is on the website of the Coroner's Court of Western Australia **www.coronerscourt.wa.gov.au**.

Phillip Benjamin VELTMAN

Inquest held in Perth 14-17 November 2023, before Coroner Urquhart, investigation finalised 19 July 2024

Mr Phillip Benjamin Veltman died on 16 July 2020 at Bentley Health Services, Mills Street, Bentley. The cause of death was unascertained. The Coroner found the manner of death was natural causes. He was 49 years old.

Immediately before death, Mr Veltman was a "person held in care" under section 3 of the *Coroners Act 1996* as he was subject to a Form 1A – Referral for Examination by Psychiatrist pursuant to the *Mental Health Act 2014*. He was being detained at the Bentley Health Services.

The Coroner was not satisfied that the supervision, treatment and care that Mr Veltman received whilst he was an involuntary patient at Bentley Health Services was of an acceptable standard.

The Coroner did make one recommendation.

In order to provide an improved standard of physical care for mental health patients, that funding sought for the Community and Virtual Care's "Sensibles" project be provided by the Future Health Research and Innovation Fund with the Department of Health, so that technology that enables patient observations to be taken remotely can be developed and made available through a secure and confidential system.

The Finding is on the website of the Coroner's Court of Western Australia **www.coronerscourt.wa.gov.au**.

Amy Rebecca DEANE-JOHNS

Inquest held in Perth 27 June 2024, Coroner Jenkin, investigation finalised 13 August 2024

Ms Amy Rebecca Deane-Johns died on or about 29 March 2022 at Scarborough. The cause of death was combined drug toxicity (predominantly methadone). The Coroner found the manner of death was accident. She was 48 years old.

Immediately before death, Ms Deane-Johns was a "person held in care" under section 3 of the *Coroners Act 1996* because she was subject to a community treatment order (CTO) pursuant to the *Mental Health Act 2014*.

The Coroner was satisfied that the supervision, treatment and care that Ms Deane-Johns the subject of a CTO was of an acceptable standard.

The Coroner did not make any recommendations.

The Finding is on the website of the Coroner's Court of Western Australia **www.coronerscourt.wa.gov.au**.

Peter Johnathon Rex BOLTON
Inquest held in Perth 23 April 2024, before Coroner Urquhart, investigation finalised 28 August 2024

Mr Peter Johnathon Rex Bolton died on 20 November 2022, St John of God Midland Hospital. The cause of death was ligature compression of the neck. The Coroner found the manner of death was suicide. He was 36 years old.

Immediately before death, Mr Bolton was a "person held in care" under section 3 of the *Coroners Act 1996* as he was subject to a Form 6A – Inpatient Treatment Order in Authorised Hospital, pursuant to the *Mental Health Act 2014*. He was being detained at the St John of God Midland Hospital.

The Coroner was satisfied that the supervision, treatment and care that Mr Bolton received whilst he was incarcerated was of an acceptable standard.

The Coroner did not make any recommendations, however did make some comments.

The Finding is on the website of the Coroner's Court of Western Australia **www.coronerscourt.wa.gov.au**.

Matthew John PICKIN
Inquest held in Perth 3 October 2023, before State Coroner Fogliani, investigation finalised 28 August 2024

Mr Matthew John Pickin died on 7 April 2022 at Fiona Stanley Hospital, Murdoch. The cause of death was complications, including sepsis, of a left leg infection in association with metastatic lung cancer. The Coroner found the manner of death was natural causes. He was 56 years old.

Immediately before death, Mr Pickin 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 the Bunbury Regional Prison.

The Coroner was satisfied that the supervision, treatment and care that Mr Pickin received whilst he was incarcerated was of an acceptable standard.

The Coroner did not make any recommendations, however did make some comments.

The Finding is on the website of the Coroner's Court of Western Australia **www.coronerscourt.wa.gov.au**.

Robert Allan EXELL

Inquest held in Perth 21 August 2024, before Deputy State Coroner Linton, investigation finalised 3 September 2024

Mr Robert Allan Exell died on 30 June 2022 at Bethesda Hospital. The cause of death was complications of liver cirrhosis and helpatocellular carcinoma in a man with multiple comorbidities with terminal palliative care. The Coroner found the manner of death was natural causes. He was 55 years old.

Immediately before death, Mr Exell 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.

The Coroner was satisfied that the supervision, treatment and care that Mr Exell received whilst he was incarcerated was of an acceptable standard.

The Coroner did not make any recommendations.

The Finding is on the website of the Coroner's Court of Western Australia **www.coronerscourt.wa.gov.au**.

Robert Fredrick PARNELL

Inquest held in Perth 28 August 2024, before Coroner Jenkin, investigation finalised 5 September 2024

Mr Robert Fredrick Parnell died on 16 May 2022 at Albany Health Campus. The cause of death was butane and propane toxicity. The Coroner found the manner of death was accident. He was 29 years old.

Immediately before death, Mr Parnell 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 Albany Regional Prison.

The Coroner was satisfied that the supervision, treatment and care that Mr Parnell received whilst he was incarcerated was of an acceptable standard.

The Coroner did not make any recommendations.

The Finding is on the website of the Coroner's Court of Western Australia **www.coronerscourt.wa.gov.au**.

Matthew Francis LEACH

Inquest held in Perth 16-17 April 2024, before Deputy State Coroner Linton, investigation finalised 6 September 2024

Mr Matthew Francis Leach died on 20 December 2021 at Hakea Prison, Nicholson Road, Canning Vale. The cause of death was ligature compression of the neck. The Coroner found the manner of death was suicide. He was 50 years old.

Immediately before death, Mr Leach 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 on remand at Hakea Prison.

The Coroner was satisfied that the supervision, treatment and care that Mr Leach received whilst he was incarcerated was of an acceptable standard.

The Coroner made two recommendations.

Recommendation No. 1

I recommend that, as a matter of urgency, the State Government give strong consideration to approving funding requests by the Honourable Minister for Corrective Services to recruit suitably qualified staff and extend existing facilities to provide appropriate mental health care (including counselling) to prisoners at Hakea Prison, starting with funding to enable the Department to develop a project definition plan.

Recommendation No. 2

I recommend that, looking towards future planning, the Department of Health and the Department of Justice consult to consider whether an alternative model of mental health care for prisoners, such as the Queensland Model, should be implemented in Western Australia, in order to put into action some of the principles of the National Statement and reduce the pressure on the limited mental health resources of Hakea Prison.

The Finding is on the website of the Coroner's Court of Western Australia **www.coronerscourt.wa.gov.au**.

Raymond Sydney CHEEK

Inquest held in Perth 22 August 2024, before Coroner Urquhart, investigation finalised 24 September 2024

Mr Raymond Sydney Cheek died on 19 September 2021 at Fiona Stanley Hospital, Murdoch. The cause of death was complications in association with a gastrointestinal illness. The Coroner found the manner of death was natural causes. He was 89 years old.

Immediately before death, Mr Cheek 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.

The Coroner was satisfied that the supervision, treatment and care that Mr Cheek received whilst he was incarcerated was of an acceptable standard.

The Coroner did not make any recommendations, however made some comments.

The Finding is on the website of the Coroner's Court of Western Australia **www.coronerscourt.wa.gov.au**.

David Arthur TURNER

Inquest held in Perth 17 September 2024, before Coroner Jenkin, investigation finalised 22 October 2024

Mr David Arthur Turner died on 6 December 2022 at Tuart Hill. The cause of death was combined drug toxicity. The Coroner found the manner of death was accident. He was 49 years old.

Immediately before death, Mr Turner was a "person held in care" under section 3 of the *Coroners Act 1996* because he was subject to a community treatment order (CTO) pursuant to the *Mental Health Act 2014*.

The Coroner was satisfied that the supervision, treatment and care that Mr Turner received whilst he was in care of an acceptable standard.

The Coroner did not make any recommendations.

The Finding is on the website of the Coroner's Court of Western Australia **www.coronerscourt.wa.gov.au**.

Chloe Grace TUPPER

Inquest held in Perth 1 February 2024 and 28 March2024,before Deputy State Coroner Linton, investigation finalised 13 November 2024

Ms Chloe Grace Tupper died on 9 June 2024 at Joondalup Health Campus. The cause of death was organ failure due to anorexia nervosa. The Coroner found the manner of death was natural causes. She was 31 years old.

Immediately before death, Ms Tupper was a "person held in care" under section 3 of the *Coroners Act 1996* because she was an involuntary patient pursuant to the *Mental Health Act 2014*.

The Coroner was satisfied that the supervision, treatment and care that Ms Tupper received whilst she was in care was of an acceptable standard.

The Coroner made two recommendations.

Recommendation No. 1

I recommend that the Department of Health continue to collect hospital-based eating disorders data and the Mental Health Commission undertake demand modelling to support future state-wide investment. Further to this, I recommend the Mental Health Commission undertake regular benchmarking of WA youth and adults with eating disorders against National trends and data.

Recommendation No. 2

I recommend that the Mental Health Commission consider developing a working group to explore unmet needs for people with chronic and complex or severe and enduring eating disorders to ensure that evidence-based programs are offered and primary care providers are supported in managing the high level of risk associated with this cohort. The working group should give specific consideration to how best to transition care from child specialist services to adult services (recognising crossover of care is likely for patients with severe and enduring eating disorders), in order to ensure good continuity of care.

The Finding is on the website of the Coroner's Court of Western Australia **www.coronerscourt.wa.gov.au**.

Kingsley Dean GARLETT

Inquest held in Perth 8-9 October 2024, before Coroner Jenkin, investigation finalised 15 November 2024

Mr Kingsley Dean Garlett died on 31 July 2022 at Casuarina Prison, Casuarina. The cause of death was ligature compression of the neck. The Coroner found the manner of death was suicide. He was 32 years old.

Immediately before death, Mr Garlett 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.

The Coroner was satisfied that the supervision, treatment and care that Mr Garlett received whilst he was incarcerated was of an acceptable standard.

The Coroner made four recommendations.

Recommendation No. 1

In order to better manage prisoners and thereby enhance security at Casuarina Prison (Casuarina), the Department should, as a matter of the utmost urgency, take immediate steps to ensure all cells at Casuarina are three-point ligature minimised as quickly as possible, with a view to ensuring all cells at Casuarina are fully ligature minimised over time. Further, the Department of Justice should finalise its review of all bunk beds in cells at Casuarina, and as soon as practicable should ensure that all bunk beds at Casuarina are fit for purpose and in particular, can properly be described as "ligature approved".

Recommendation No. 2

In order to provide strategic guidance to its efforts to reduce the flow of illicit substances into prisons, the Department of Justice should implement a replacement strategy for the now expired Western Australian Prisons Drug Strategy 2018 - 2021.

Recommendation No. 3

In order to improve the support provided to prisoners, the Department of Justice should take urgent steps to recruit additional prison counsellors and Aboriginal Support Workers for Casuarina Prison. More broadly, the Department of Justice should review staffing levels of prison counselling staff and mental health staff at prisons across the State to determine if these levels are appropriate.

Recommendation No. 4

In order to better manage prisoners at Casuarina Prison who have polysubstance use issues, the Department of Justice should consider expanding its methadone and buprenorphine programs so that the wait time for prisoners to enter these programs is reduced.

The Finding is on the website of the Coroner's Court of Western Australia **www.coronerscourt.wa.gov.au**.

Frank MIKHAIL

Inquest held in Perth 6 December 2024, before Coroner Jenkin, investigation finalised 23 December 2024

Mr Frank Mikhail died on 23 February 2023 at Acacia Prison. The cause of death was bronchopneumonia in a man with carcinoma in the lung and chronic obstructive pulmonary disease. The Coroner found the manner of death was natural causes. He was 68 years old.

Immediately before death, Mr Mikhail 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.

The Coroner was satisfied that the supervision, treatment and care that Mr Mikhail received whilst he was incarcerated was of an acceptable standard.

The Coroner did not make any recommendations.

The Finding is on the website of the Coroner's Court of Western Australia **www.coronerscourt.wa.gov.au**.

Christopher John HILLSTEAD

Inquest held in Perth 11-13 March 2024, before Coroner Urquhart, investigation finalised 3 January 2025

Mr Christopher John Hillstead died on 18 January 2021 at Acacia Prison, Wooroloo. The cause of death was ligature compression of the neck. The Coroner found the manner of death was suicide. He was 59 years old.

Immediately before death, Mr Hillstead 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.

The Coroner was satisfied that the supervision, treatment and care that Mr Hillstead received whilst he was incarcerated was of an acceptable standard.

The Coroner did not make any recommendations.

The Finding is on the website of the Coroner's Court of Western Australia **www.coronerscourt.wa.gov.au**.

Benjamin Jacob VAN TRIGT

Inquest held in Perth 4 December 2024, before Deputy State Coroner Linton, investigation finalised 23 January 2025

Mr Benjamin Jacob Van Trigt died on 17 November 2022 at Maddington. The cause of death was from electrical injury. The Coroner found the manner of death was suicide. He was 38 years old.

Immediately before death, Mr Van Trigt was a "person held in care" under section 3 of the *Coroners Act 1996* because she was subject to a community treatment order (CTO) pursuant to the *Mental Health Act 2014*.

The Coroner was satisfied that the supervision, treatment and care that Mr Van Trigt received whilst he was incarcerated was of an acceptable standard.

The Coroner did not make any recommendations.

The Finding is on the website of the Coroner's Court of Western Australia **www.coronerscourt.wa.gov.au**.

BUBBA E (Name subject to suppression order)

Inquest held in Perth 11 February 2025, before Coroner Jenkin, investigation finalised 17 February 2025

Bubba E died on 3 September 2023 at Fortescue. The cause of death was Multiple injuries. The Coroner found the manner of death was accident. Bubba E was 8 years old.

Immediately before death, Bubba E was a "person held in care" under section 3 of the *Coroners Act 1996* because Bubba E had been taken into care by the Director General of the Department of Communities, pursuant to the *Children and Community Services Act 2004*.

The Coroner was satisfied that the supervision, treatment and care that Bubba E received whilst incarcerated was of an acceptable standard.

The Coroner did not make any recommendations, however did make a comment.

The Finding is on the website of the Coroner's Court of Western Australia **www.coronerscourt.wa.gov.au**.

Fabian Alec COFFIN

Inquest held in Perth 18 February 2025, before Coroner Jenkin, investigation finalised 21 February 2025

Mr Fabian Alec Coffin died on 5 February 2024 at Fiona Stanley Hospital, Murdoch. The cause of death was myocardial infarction and ischaemic heart disease. The Coroner found the manner of death was natural causes. He was 51 years old.

Immediately before death, Mr Coffin was a "person held in care" under section 3 of the Coroners Act 1996 because he was subject of an order under the *Dangerous Sexual Offenders Act 2006*, and later the High Risk Serious Offenders Act 2020 and a sentenced prisoner 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.

The Coroner was satisfied that the supervision, treatment and care that Mr Coffin received whilst he was incarcerated was of an acceptable standard.

The Coroner did not make any recommendations.

The Finding is on the website of the Coroner's Court of Western Australia **www.coronerscourt.wa.gov.au**.

Ricky-Lee COUND

Inquest held in Perth 6-9 May 2024, before Coroner Urquhart, investigation finalised 10 March 2025

Mr Ricky-Lee Cound died on 25 March 2022 at Fiona Stanley Hospital, Murdoch. The cause of death was ligature compression of the neck. The Coroner found the manner of death was suicide. He was 22 years old.

Immediately before death, Mr Cound 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.

The Coroner was not satisfied that the supervision, treatment and care that Mr Cound received whilst he was incarcerated was of an acceptable standard.

The Coroner made eight recommendations.

Recommendation No. 1

In order to enhance the care of prisoners with FASD, the Department introduces mandatory training regarding the management and care of prisoners with FASD to new prison officers undertaking training at the Corrective Services Training Academy and to current prison officers.

Recommendation No. 2

In order to enhance the care of prisoners with FASD and other intellectual disabilities, the Department reviews its operating policies and procedures in order to provide specific guidance to Health Services and custodial staff as to the management and care of these prisoners. Further, this review should address how these prisoners can be supported to manage their intellectual disabilities.

Recommendation No. 3

In order to enhance the care of prisoners, the Department is to ensure it applies the relevant provisions of the *Sentencing Act 1996* (WA) in order to use court-ordered psychiatric or psychological reports prepared for the sentencing process of a prisoner who is subsequently sentenced to an immediate term of imprisonment. The Department should continue its efforts to formalise its internal information sharing practices to ensure its Health Services staff are aware of the existence of such reports and can readily access them.

Recommendation No. 4

In order to enhance the care of prisoners and thereby the security of the prison, custodial staff directly responsible for the care of prisoners with diagnosed mental health conditions or intellectual disabilities that may affect their behaviour and/or how they are managed, are informed of these disorders without requiring them to access TOMS in order to obtain that information.

Recommendation No. 5

The Department continues to take necessary and practical steps directed towards investment in body-worn cameras for prison officers at Hakea.

Recommendation No. 6

In order to better manage vulnerable prisoners and thereby enhance security, the Department should take immediate steps to ensure all cells at Hakea are three-point ligature minimised as quickly as possible, with a view to ensuring all cells at Hakea are fully ligature minimised over time. Further, the Department should conduct an urgent review of all three-point and fully ligature minimised cells at Hakea to ensure those cells are fit for purpose and in particular, that the light fittings in those cells can properly be described as "ligature approved".

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Ricky-Lee COUND (continued)
Inquest held in Perth 6-9 May 2024, before Coroner Urquhart, investigation finalised 10 March 2025

Recommendation No. 7
In order to improve the provision of health care (including mental health care) to prisoners, the Department should, as a matter of utmost urgency, prioritise the funding for works to improve the infrastructure used to provide health care at Hakea.

Recommendation No. 8
In order to better manage vulnerable prisoners, the Department introduces an operational policy that requires the placement in a safe cell of a prisoner who has made that request due to the prisoner's concerns they may self-harm. If the placement does not occur, there must be a sound basis for doing so and only after consultation with the prison's MHAOD services. The reason(s) for not complying with the prisoner's request must be recorded.

The Finding is on the website of the Coroner's Court of Western Australia **www.coronerscourt.wa.gov.au**.

Lex Gregory MAHER

Inquest held in Perth 10 December 2024, before Coroner Hartley, investigation finalised 8 March 2025

Mr Lex Gregory Maher died on 27 December 2022 at Greenough Regional Prison, Greenough. The cause of death was atherosclerotic heart disease. The Coroner found the manner of death was natural causes. He was 45 years old.

Immediately before death, Mr Maher 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 a remand prisoner at Greenough Regional Prison.

The Coroner was satisfied that the supervision, treatment and care that Mr Maher received whilst he was incarcerated was of an acceptable standard.

The Coroner did not make any recommendations.

The Finding is on the website of the Coroner's Court of Western Australia **www.coronerscourt.wa.gov.au**.

Travis Dion BAUMGARTEN

Inquest held in Perth 14 January 2025, before Coroner Hartley, investigation finalised 10 April 2025

Mr Travis Dion Baumgarten died on 5 December 2022 at Royal Perth Hospital. The cause of death was complications of human immunodeficiency virus infection with terminal palliative care. The Coroner found the manner of death was natural causes. He was 48 years old.

Immediately before death, Mr Baumgarten 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.

The Coroner was satisfied that the supervision, treatment and care that Mr Baumgarten received whilst he was incarcerated was of an acceptable standard.

The Coroner did not make any recommendations.

The Finding is on the website of the Coroner's Court of Western Australia **www.coronerscourt.wa.gov.au**.

Dannielle Stacey LOWE
Inquest held in Perth 5-6 March 2025, before Coroner Jenkin, investigation finalised 10 April 2025

Ms Dannielle Stacey Lowe died on 24 December 2022 at Fiona Stanley Hospital, Murdoch. The cause of death was complication of intracerebral haemorrhage due to ruptured aneurysm. The Coroner found the manner of death was natural causes. She was 41 years old.

Immediately before death, Ms Lowe was a "person held in care" under section 3 of the *Coroners Act 1996* because she was a sentenced prisoner, and pursuant to the *Prisons Act 1981* she was in the custody of the Chief Executive Officer of the Department of Justice. She was serving her sentence at Wandoo Rehabilitation Prison, Murdoch.

The Coroner was not satisfied that the supervision, treatment and care that Ms Lowe received whilst she was incarcerated was of an acceptable standard.

The Coroner made four recommendations.

Recommendation No. 1
The Department of Justice should make it mandatory for all prison nurses and doctors to successfully complete Advance Life Support Course Level 2 (ALS2) or an appropriate alternative course, within six months after their initial employment, and every three years thereafter.

Recommendation No. 2
Given the critical importance of ensuring that all medication issued to prisoners by custodial staff is recorded and can be reviewed daily by nursing staff, the Department of Justice should issue a Commissioner's Bulletin (or similar) reminding all custodial staff of the importance of strict and ongoing compliance with "COPP 6.4 - Officers issuing medication".

Recommendation No. 3
For the avoidance of doubt, the Department of Justice should issue an instruction to all nursing and medical staff providing health services at Wandoo Rehabilitation Prison, that where a prisoner makes a written request to be reviewed by a nurse or doctor, the health professional conducting that review ensures that all of the issues referred to by the prisoner in their written request form are addressed, whether raised by the prisoner at the review or not.

Recommendation No. 4
In order to provide culturally safe care to Aboriginal prisoners in Western Australia, the Department of Justice should redouble its efforts to recruit Aboriginal staff at its prisons, including medical officers, nurses, psychologists, social workers, and prisoner support officers. Culturally safe care for Aboriginal prisoners in Western Australia may also be achieved by establishing partnerships with Aboriginal community controlled health organisations and medical services, to provide access to visits from Aboriginal health practitioners, and by developing an Aboriginal Elders visiting program.

The Finding is on the website of the Coroner's Court of Western Australia **www.coronerscourt.wa.gov.au**.

Child HR (Name subject to suppression order)

Inquest held in Perth 22-23 October 2024, before Deputy State Coroner Linton, investigation finalised 17 April 2025

Child HR died on 12 August 2022 at Perth Children's Hospital, Nedlands. The cause of death was terminal palliative care in a girl with a clinical diagnosis of aspiration pneumonia and cerebral palsy. The Coroner found the manner of death was natural causes. Child HR was 12 years old.

Immediately before death, Child HR was a "person held in care" under section 3 of the *Coroners Act 1996* because Child HR had been taken into care by the Director General of the Department of Communities, pursuant to the *Children and Community Services Act 2004*.

The Coroner was satisfied that the supervision, treatment and care that Child HR received whilst incarcerated was of an acceptable standard.

The Coroner did not make any recommendations, however made comments.

The Finding is on the website of the Coroner's Court of Western Australia **www.coronerscourt.wa.gov.au**.

Sam Phillip Chisholm LYNCH

Inquest held in Perth 24-28 March 2025, before Coroner Jenkin, investigation finalised 12 June 2025

Mr Sam Phillip Chisholm Lynch died on 5 March 2024 at Fiona Stanley Hospital, Murdoch. The cause of death was from effects of fire. The Coroner found the manner of death was accident. He was 27 years old.

Immediately before death, Mr Lynch 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.

The Coroner was not satisfied that the supervision, treatment and care that Mr Lynch received whilst he was incarcerated was of an acceptable standard.

The Coroner made twelve recommendations.

Recommendation No. 1
To enhance the safety of prisoners and staff at Hakea Prison (Hakea), and to prevent any future loss of life, the Department of Justice (the Department) should install a fire suppression system at Hakea so that all cells and common areas are protected in the event of fire. The Department should consider whether this initiative can be funded by way of an internal funding allocation, or whether it is necessary to seek additional funding from the Treasury.

Recommendation No. 2
To ensure the safety of prisoners and staff at Hakea Prison (Hakea) the Department of Justice (the Department) should expedite a ban on smoking at Hakea, and take all reasonable steps to ensure that prisoners do not have access to tobacco products (including cigarettes), matches and/or lighters. To ensure the good order and safety of prisoners at Hakea whilst the smoking ban is being implemented, the Department should ensure that all prisoners who were smokers are given access to nicotine substitutes (e.g.: patches, lozenges), and support services including counselling, and diversionary activities.

Recommendation No. 3
To ensure the safety of prisoners and staff at Hakea Prison, whilst the initiatives referred to in Recommendations 1 and 2 are being implemented, the Department of Justice should develop and institute an interim management policy to restrict access to lighters and matches by prisoners with a heightened risk profile, including but not limited to prisoners convicted of arson and/or prisoners who have lit fires in prison.

Recommendation No. 4
To ensure the safety of prisoners and staff at Hakea Prison (Hakea), the Department of Justice should enhance the preparedness of staff at Hakea to respond to fires by all possible means, including by:

a. Reviewing Hakea's Emergency Management Plan and Fire Safety Plan to ensure they are fit for purpose and effectively implemented;

b. Conducting refresher training for custodial staff on first response to fire including safe work procedures the use of R kits; fire extinguishers; fire blankets; and fire hoses, using realistic scenarios and environments;

c. Enhancing the skills of officers qualified to use Breathing Apparatus (BA) by:

a. Conducting quarterly BA training exercises using realistic scenarios;

b. Requiring all BA qualified officers to conduct monthly don and doff practices (under air) with BA equipment and PPE;

c. Providing additional training for officers willing to assume the position of Entry Control Officer;

d. Enhancing incentives (whether financial or otherwise) to encourage custodial officers to maintain the currency of their BA qualification; and

continued over

Sam Phillip Chisholm LYNCH (continued))
Inquest held in Perth 24-28 March 2025, before Coroner Jenkin, investigation finalised 12 June 2025

e. Developing a system to ensure that staff in the Master Control Room at Hakea are aware of all BA qualified officers on shift and their respective locations.

Recommendation No. 5
To ensure the safety of prisoners and staff at Hakea Prison (Hakea), the Department of Justice should expedite the installation of Closed-Circuit TV cameras in all accommodation units and common areas at Hakea.

Recommendation No. 6
To ensure the safety of prisoners and staff at Hakea Prison (Hakea), the Department of Justice should expedite the rollout of Body Worn Cameras for all custodial staff at Hakea.

Recommendation No. 7
The Department of Justice should introduce training packages aimed at officers preparing to undertake the positions of Senior Officer (i.e. Unit Manager), and Principal Officer, respectively. The training packages for these positions should include advanced training in de-escalation techniques for managing disruptive and aggressive prisoners, as well as leadership, tactical commander, and other key skills deemed necessary for officers undertaking in these positions.

Recommendation No. 8
The Department of Justice should redouble its efforts in recruiting and importantly, retaining, suitably skilled custodial officers.

Recommendation No. 9
The Department of Justice (the Department) should take all reasonable steps to ensure that the provisions of "EMF-DIR-022 Operational debriefing" are complied with. In particular, in relation to critical incidents involving deaths in custody, the Department should ensure that wherever possible, personnel involved in the critical incident participate in immediate and formal debriefs, so that valuable insights from those officers can be captured and incorporated into any "lessons learned" process. The Department should also ensure that lessons learned reports are disseminated to relevant staff, including those involved in the management and conduct of emergency response skills.

Recommendation No. 10
The Department of Justice (the Department) should consider providing automatic standdown leave for all staff directly involved in a critical incident, including, but not limited to, incidents involving a death in custody. The Department should also take all reasonable steps to ensure that all relevant staff are provided with the "stress checks and support mechanisms" referred to in "EMF-DIR-022 Operational debriefing".

Recommendation No. 11
The Department of Justice should continue the current regime of quarterly checks by external contractors of fire extinguishers and fire hose reels at Hakea Prison (Hakea), and the ventilation ducts at Hakea should be regularly cleaned to remove dust and/or other materials which may represent a fire hazard.

Recommendation No. 12
The Department of Justice should consider amending relevant policies to make it clear that after a prisoner has been declared life extinct by an authorised person, any restraints on the prisoner at that time, should be removed as soon as reasonably practicable.

The Finding is on the website of the Coroner's Court of Western Australia **www.coronerscourt.wa.gov.au**.

Graham John BUTLER
Inquest held in Perth 28 May 2025, before Coroner Jenkin, investigation finalised 12 June 2025

Mr Graham John Butler died on 22 October 2023 at St John of God Midland Public Hospital. The cause of death was an out of hospital cardiac arrest. The Coroner found the manner of death was natural causes. He was 76 years old.

Immediately before death, Mr Butler 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.

The Coroner was satisfied that the supervision, treatment and care that Mr Butler received whilst he was incarcerated was of an acceptable standard.

The Coroner did not make any recommendations.

The Finding is on the website of the Coroner's Court of Western Australia **www.coronerscourt.wa.gov.au**.

Leighton Michael WOOD
Inquest held in Perth 28 May 2025, before Coroner Jenkin, investigation finalised 12 June 2025

Mr Leighton Michael Wood died on or about 18 November 2023 at Wembley. The cause of death was bronchopneumonia in the setting of combined drug effect. The Coroner found the manner of death was accident. He was 44 years old.

Immediately before death, Mr Wood was a "person held in care" under section 3 of the *Coroners Act 1996* because he was subject to a community treatment order (CTO) pursuant to the *Mental Health Act 2014*.

The Coroner was satisfied that the supervision, treatment and care that Mr Wood received whilst he was incarcerated was of an acceptable standard.

The Coroner did not make any recommendations.

The Finding is on the website of the Coroner's Court of Western Australia **www.coronerscourt.wa.gov.au**.

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