Office Of the State Coroner

Annual Report

2006 – 2007

State Coroner Western Australia

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The Honourable Jim McGinty
BA Bjuris(Hons) LLB JP MLA
Attorney General

Dear Minister

In accordance with Section 27 of the Coroners Act 1996 I hereby submit for your information and presentation to each House of Parliament the report of the Office of the State Coroner for the year ending 30 June, 2007.

The Coroners Act 1996 was proclaimed on 7 April, 1997 and this is the eleventh annual report of a State Coroner pursuant to that Act.

Yours sincerely

Alastair Hope
STATE CORONER

State Coroner's Overview

It is with regret that I must report that as the result of inadequate resources being provided to the Coroners Court by the Department of the Attorney General, it is possible that I will not be able to adequately perform the functions of the State Coroner set out in *section 8 of the Coroners Act 1996* and I may not be able to ensure that an adequate counselling service is available as required by *section 16* of that Act.

This Annual Report has been delayed in the hope that in the period from 1 July 2007 arrangements could be put in place to address the resourcing issues. While some action has been taken in that regard, it is insufficient to enable me to have confidence that my functions can be adequately performed and there is no further purpose in delaying provision of this report.

Section 8 of the Act details the functions of the State Coroner and provides in part as follows:

> **8. Functions of State Coroner**
>
> The functions of the State Coroner are –
>
> (a) to ensure that a State coronial system is administered and operates efficiently;
>
> (b) to oversee and coordinate coronial services;
>
> ...
>
> (d) to ensure that an inquest is held whenever there is a duty to do so under this Act or whenever it is desirable that an inquest be held;

During the year 2321 cases were referred to the Coroner's Court and 2,021 cases were finalised. The gap between the number of cases finalised and the cases received has increased as a direct result of inadequate resources being provided.

In respect of the counselling service the Coroner's Court only has two counsellors who provide a 365 day service for the entire State. That is an unsustainable situation, particularly as the counsellors have no administrative support.

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The Resources Allocated to the Coroner's Court

The Coroner's Court is staffed by 11.8 full-time equivalent (FTE) positions who provide support to two judicial officers (coroners). The Court deals with approximately 2,300 cases per year (in this year there were 2,341) in respect of which approximately 1800 are the subject of investigation (this year there were 1,782). About 3-4% of these matters are finalised by inquest, the remainder are finalised administratively.

The budget initiative paper prepared by the Office Manager which was submitted in its final form on 24 September 2007 referred to a backlog of 405 cases over 52 weeks old (this related to July-August 2007). Since that time the number of older cases has been reduced but the overall numbers continue to increase each month.

For the last ten years staffing levels at the Coroner's Court have remained static while the volume of work has increased in line with the increasing population and, more importantly, the increase in the public's expectation of the need or right to know.

The budget initiative paper provided advice that an extra two staff were required to finalise the outstanding cases and to reduce the number of backlog files.

On 2 October 2007 I wrote to the Director General, Department of the Attorney General, advising of this fact and pointing out that Coroner's Court staff deal with a range of issues relating to body movements, release of bodies and finalisation of investigations and provision of relevant information to the Registrar of Births, Deaths and Marriages. Inadequate provision of staff to deal with these matters would result in additional delays in families of deceased persons being able to obtain probate etc which would be unacceptable for many.

While some effort has been made to address this issue by provision of a trainee officer and temporary assistance provided by an officer seconded to the Court but working at another office, the issue has not been adequately addressed. In a letter to me dated 29 October 2007 the Director General stated:

> "The level of resources provided for Registry services is monitored against case load and whilst incremental adjustments can generally be funded from within existing resources, this must be done as a result of shifts in priority or improved efficiency. It is extremely rare that the government will provide additional resources without a detailed and compelling business case relating to the need. Increases in funding are more likely to be successful if they are linked to new initiatives and key performance indicators that greatly improve service and have a high priority across government".

Although a business case had been prepared which indicated that relevant staff members could only finalise approximately 256 cases per year each and that the number of staff available was not sufficient to address the backlog, it appears that this matter is not to be addressed in the near future by the Department. It should be emphasised in this context that not all of the 11.8 FTEs are directly involved in processing of files etc. Two of the FTEs are the coronial counsellors, .8 is Counsel Assisting and 1 person is required to work at the reception (although this person, who at present is a trainee officer, has additional responsibilities and is involved in preparing a number of the necessary documents)

All members of the staff are involved in multi-tasking. The Administrator of the Office of State Coroner, for example, performs the duties which would in any other court be those of Listings Clerk, Secretary, Associate and Usher as well as Administrator. In addition that person organises travel for the court and witnesses, liaises with the media in respect of inquest matters and deals with all enquiries relating to inquest hearings. There is no ability to adequately backfill and so if that person takes leave or is unwell, much of her work will have to be left until she returns.

With such a small staff it is almost impossible to allow for adequate leave which is particularly significant in a context where with an increasing backlog, staff are regularly subjected to abuse from members of the public in respect of the delays involved.

This also has the effect that while the backlog may be reduced from time to time by use of staff temporarily allocated to the Court by the Department or by special efforts of staff (working extended hours etc) in the long term the backlog must increase as some staff must eventually take holidays, be off work sick etc.

The Coronial Counselling Service

Section 16 of the *Coroner's Act 1996* refers to the Coronial Counselling Service and provides as follows:

> "(1) The State Coroner is to ensure that a counselling service is attached to the Court.
>
> (2) Any person coming into contact with the coronial system
> (3) may seek the assistance of the counselling service of the court and, as far as practicable, that service is to be made available to them."

Coronial Counsellors were operational prior to the proclamation of the *Coroner's Act* in 1997 and quickly proved their value and worth. Since the proclamation of the Act, however, their workload has increased considerably.

The Coroner's Court has only two counsellors who act as the interface between families of deceased persons and the coronial system. They assist families with a range of issues including mortuary viewings, objections to post mortems, organ retention issues and explaining causes of death. In the business case of 2007, it was noted that since July 2006 the counsellors have made over 1000 contacts in relation to the deaths of loved ones.

The counsellors provide cover for 77 hours each week (7am – 6pm) every day of the year, including weekends and public holidays. In reality, however, the counsellors provide a 24 hour service as deaths often occur at night and there are many cases when families require the urgent provision of counselling services.

The counsellors can be called out at very short notice and often work longer than normal on call hours. For out of hours callout the counsellors are paid $3.45 per hour.

The fact that the two coronial counsellors have been able to provide such a service for a number of years is testament to their dedication and commitment. Unfortunately, however, these attributes only stretch so far and the counsellors are becoming swamped by the sheer volume of work. In a letter to the Director General dated 2 October 2007 I advised in respect of this matter that:

> "If a reasonable counselling service is to be maintained, it is clear that an additional counsellor is required, and provision of a senior counsellor who could act as a co-ordinator, together with administrative support will enable the counselling service to be adequately organised and reasonably comprehensive.
>
> The present situation cannot continue."

In the response dated 29 October 2007 the Director General advised me that:

> "It is recognised that the present resource level of counselling services like other resources referred to in your letter is limited. This aspect needs to be addressed along with the other requirements by the same process referred to in the previous paragraph."

Unfortunately I have no confidence that the Department will take any action in respect to this matter. The issue of the adequacy of the coronial counselling service has been raised on many occasions since 1997 without any action being taken by the Department.

In his report of 21 May 1999 Mr Chivell noted that there were limitations to the counselling service then being provided, particularly in respect of country people, and he recommended that the extent of the services be improved.

That recommendation was supported by me and in my response which was tabled in Parliament I advised:

> "It is difficult to provide adequate counselling services to country regions in a context where there are only two counsellors attached to the Coroner's Court and both of those counsellors are stationed in Perth."

This issue was also addressed by the Law Reform Commission of Western Australia in its report on Aboriginal Custody Laws. Recommendation 77.1 of the final report was:

> "That resourcing for expansion of the coronial counselling service in rural areas be investigated."

In responding to that recommendation I advised the acting Executive Director, Court and Tribunal Services, that in order to accommodate this recommendation it would be essential that the extra counsellor should be available.

In spite of a comprehensive business case being presented to the Department in respect of the provision of coronial counsellors and a number of recommendations having been made over the last decade, it appears that the Department has no intention of addressing this issue and I can only infer that the Department allocates a very low priority to this matter.

Possible Need to Cancel or Postpone Indefinitely Inquest Hearings

In order for an inquest hearing to go ahead it is necessary for there to be counsel assisting as well as a coroner. Counsel assisting liaises with witnesses, questions witnesses in court and produces exhibits etc.

The present allocation of counsel assisting to the Coroner's Court is only 0.8 FTE.

In addition to the allocated position of counsel assisting, the Coroner's Court relies on briefing an independent counsel from the

Bar.

In the past the Coroner's Court has been able to rely on the assistance of two police officers although increasingly the responsibilities of those officers in liaising with police in respect of the approximate 2,000 investigations conducted by police in coronial cases limits their availability to assist with inquest hearings. It has also been a recent proposal by Western Australian Police to withdraw at least one of those police officers from the Coroner's Court, although this proposal is still subject to negotiation and discussion.

In my letter to the Director General dated 2 October 2007 I advised that in respect of the legal briefing fees, at present only $65,000 was allocated and that an additional $50,000 was urgently required. In addition I advised that considering that counsel assisting is expected to monitor all deaths in custody, conduct complex inquest hearings and handle cases where there may be criticism of police involvement, the entire resource situation is unsatisfactory.

In her response of 29 October 2007 the Director General made the following observation in respect of legal briefing fees:

> "The level of funding for legal briefing fees is subject to the same constraints and funding priorities as those applied to all other items in the department's budget. While an increase from $65K to $115K appears to be an extremely small amount, it can only be funded by re-allocation of existing departmental resources or as a result of a successful business case to government. To date, neither of these mechanisms has achieved the priority required to justify the allocation of additional funds at the expense of something else".

In respect of the proposal relating to counsel assisting, the Director General advised as follows:

> "I understand that counsel assisting services are provided by a permanent part-time position and the level of funding is based upon providing a level of resource that is affordable within the department's overall allocation. Any increases in this need to be made in light of timeliness and quality assessments in finalising cases along with other Court and Tribunal Services priorities. I foresee the department canvassing this issue as part of future submissions to the State Budget process."

It is clear from a review of outstanding matters that there are a number of lengthy and difficult inquest hearings which will require the involvement of counsel assisting, both within the office and briefed from the independent Bar, which should be listed for hearing in 2008/2009.

While funding has recently been made available for a second part-time counsel assisting until 30 June 2008, there has been no recurrent allocation for this purpose.

Computerisation

The Coroner's Court is the only court in Western Australia which does not have access to a comprehensive computer system for file management.

This is a matter which has repeatedly been raised with the Department and an undertaking was originally given to provide such a system in 1998.

On 21 May 1999 a review of the *Coroner's Act 1996* and its application was conducted by Mr Wayne Chivell, the then State Coroner for South Australia. The review had been foreshadowed by the Attorney General in his second reading speech. In that review Mr Chivell noted that the Coroner's Court did not have access to a comprehensive computer system and at para 3.10.7 of his report he recommended that the Ministry of Justice should consider installation of such a system. In a response to that recommendation prepared by me and forwarded to the Attorney General for tabling in Parliament on 5 November 1999 I observed in this context -

> "It is understood that the Coroner's Court is to be provided with a comprehensive computer system in the near future and that this system will be part of the GENISYS System currently being implemented throughout the court system in Western Australia."

On 23 September 1999 the Executive Director, Court Services, Mr Richard Foster wrote to me advising that the installation of the "Ministry Standard Operating Systems" within the Coroner's Court was scheduled for completion that financial year." He advised that tenders had been called for the installation of a land line with the Ministry mainframe and the Court, cabling within the Court and hardware. He stated, however, that once the development of the GENISYS System had been finalised, an installation schedule for sites would be prepared which would include the Coroner's Court.

That system was never installed and has since become obsolete. The current system of ICMS has also not been provided to the Coroner's Court.

The present situation is that while some limited file management functions can be performed using the National Coronial Information System which is available to the Coroner's Court, there is still no adequate computer system available.

The implications of the failure to provide the Coroner's Court with a computer system include:

- there are large numbers of file movements and hard copy documents must be viewed by a range of staff involved in different activities;
- staff cannot provide immediate advice to families contacting the Coroner's Court when files are being used by other staff members or are being viewed by other family members;
- The Registry Book and other important records are handwritten;
- There is an increasing demand for statistics from the Court which causes considerable pressure on staff as most statistics can only be obtained through manual searches; *and*
- it is not possible to adequately monitor ongoing investigations or to ensure that unnecessary delays are identified.

A very recent development has been that the National Coronial Information System, a national system available to the Court, may be extended to provide a basic computer system for file management etc for the Coroner's Court. If this takes place it will finally enable the Court to adequately monitor progress of files.

The reason for the lack of provision of resources

To a right thinking person provided with information about these matters it may seem difficult to understand why these obvious resourcing issues have never been addressed. It would seem obvious that, for example, two coronial counsellors could not adequately provide a 24 hour, 365 day a year service and that they could not provide an adequate service to country Western Australia while situated in Perth and flooded with work. It would also appear self-evident that one part-time person as counsel assisting could not possibly adequately provide the functions of monitoring all deaths in custody, conducting complex inquest hearings and handling cases where there is criticism of police involvement (which are current requirements of the position). In addition, it would appear obvious that the Administrator of the Coroner's Court could not perform the multiplicity of tasks referred to above and that there will inevitably be problems associated with such extensive multi-tasking.

All these matters have been repeatedly raised with the Department with some limited success.

In respect of the Registry duties, there has been temporary provision of a trainee officer and a person temporarily seconded to the Court who is working out of a different office.

In respect of the other matters referred to above, however, it appears that there is no intention by the Department to take any action in the near future.

There is soon to be a review of coronial practice in Western Australia and on 4 November 2007 the Attorney General provided the Law Reform Commission of Western Australia with a reference to review and report on the jurisdiction and practices of the coronial system including the operation of the *Coroner's Act 1996*. Unfortunately it is clear that such a review will not be completed in the relatively near future and in the interim the problems referred to will continue to get worse. In my view there is no reason to wait for the completion of the Law Reform Commission's review to address these obvious issues relating to the Coroner's Court.

In addition to the Law Reform Commission review and as a preliminary basis for its investigations a review is soon to be conducted into the operation of the Court by the State Coroner for Queensland, Mr Michael Barnes. This review will address practical issues faced by the Court and should be completed well before the final report of the Law Reform Commission. Such a review is required by section 57 of the *Coroners Act 1996* to be carried out as soon as practicable after every fifth anniversary of the commencement of the Act and is overdue.

A possible reason for the Department's obvious unwillingness to address these various issues appears to be a complete misunderstanding by the Court Services Section of the Department of the budget of the Coroner's Court.

In advising the Director General in respect of my concerns expressed to her in my letter of 2 October 2007, the Executive Director, Court and Tribunal Services, provided the following advice in a memorandum dated 16 October 2007:

> "I refer to the attached letter dated 2 October 2007 from Alastair Hope State Coroner regarding the budget submission for the Coroner's Court that has been put forward in the 2008/09 budget process. The submission has not received a priority ranking amongst other submissions through both the Courts Executive Group and Heads of Jurisdiction.
>
> It is important that you are aware that there has been much dialogue in recent years on the funding concerns and pressures within the Coroner's Court. The Coroner has written to the Director General of this Department and Executive Director, Court and Tribunal Services (CTS) on a number of occasions. Many of the previous concerns have been addressed.
>
> More recently (in 2006/07), the Coroner's Court exceeded its budget by $0.5 mil with the reasons and drivers being unclear. ... It is considered

> that many of these budget over-runs were avoidable and, before a significant injection of funding should occur, the Coroner's Court has been asked to attempt to reduce expenditure. This situation will be closely monitored in the 1st quarter and mid-year budget reviews."

In the context of the comments contained in this memorandum it is not surprising that the Director General has offered limited support for the budget submission in question.

In my view the comments contained in this response to the budget submission are misleading and based on a very poor understanding of the Coroner's Court budget. Of particular significant is the fact that by far the largest component of the $0.5 million referred to in the memorandum was increased body removal costs of government contractors, costs over which the Coroner's Court had no control as for each contract the lowest tender was accepted.

Unfortunately, in order to appreciate my contention that these claims are without merit, it is necessary to have some appreciation of the Coroner's Court budget.

It is important to note that the budget for the Court is not settled by court staff but is an allocation made by the Department.

The first important matter to note in respect to the Coroner's Court budget is the fact that only about 20% of the budget relates to costs associated with the Court itself and 80% are costs over which the Coroner's Court has very little control or influence but are related to death investigation.

The Department's budget figures for the Coroner's Court for the year ended 30 June 2007 which are referred to in the Executive Director's letter reveal that of the total operating expenses of $6,568,582, $5,280,729 was expended on four main items, namely, Forensic Pathology costs, Toxicology costs Body Removal Costs and rental.

The main item in respect of which there was a substantial variance between the budgeted figure and the actual figure was in respect of the body removals. The break-up of the costs referred to in the budget documentation was as follows:

1	Body Removals (including chaplain fees)	$1,099,051
2	Forensic Pathology	2,749,498
3	Toxicology	1,122,873
4	Rental	309,307
5	All other items including staff salaries, cleaning, equipment, travelling expenses, witness fees, transcribing costs etc.	1,287,853
	Total	**$6,568,582**

It should be noted that even in respect of the various items referred to at 5 above, the Coroner's Court has limited control in respect of many of the expenses incurred, some of which are incurred in country regions or by the head office of the Department without consultation with the Court. In respect to the reference to "chaplain fees" at item 1, the budget papers refer to a charge for "chaplain fees" of $13,795. These costs were in fact body removal costs which were incorrectly coded by staff at a country court.

The main items of body removal, forensic pathology and toxicology merit explanation.

Body Removals

This item is of particular importance in this context as 60% of the amount by which the Coroner's Court exceeded its "budget" referred to in the letter from the Executive Director, Court and Tribunal Services, to the Director General relates to this item.

Once a death becomes a Coroner's case, the Coroner takes control of the body and usually it is necessary for the body to be taken from the death scene to a mortuary. On average 1,450 bodies are transported to the State Mortuary each year for post mortem examination.

There are 126 body removal contracts operated by 25 contractors throughout the State. Contracts are awarded after a tender process. The tenders vary significantly depending on the location covered by the contract.

The contracts were put up for tender in the third quarter of 2006 and in the case of 60 contracts only 1 tender was received. The contracts were duly awarded to the sole tender in each case. On average, compared with the previous contract, the price of the provision of body removal services has risen by 37%.

The following table shows the costs of providing body removals of the last 3 years:

	Allocated Budget	**Actual Budget**	***Variance***
2004/2005	$720,000	$760,253	*$40,253*
2005/2006	$720,600	$816,095	*$95,495*
2006/2007	$741,600	$1,035,816	*$294,216*

It should be noted that in spite of the fact that the actual budget has exceeded the allocated budget in each year, the budget for the next year has never taken account of the actual variations. In spite of the fact that this situation has been pointed out repeatedly by staff at the Coroner's Court, the allocated budget has been set with no regard to past actual budgets. In a context where in the year 2005/2006 the actual budget was $816,095 there could have been no realistic expectation that in the year 2006/2007 an allocated budge of $741,600 would be met. There was no realistic expectation that the tender process would result in a reduced cost for body movements or that there would be a substantial reduction in the number of deaths in the State.

While this item is included in the Coroner's Court "budget" in Western Australia, in a number of States this item is costed to police who attend death scenes and are in many ways better placed to monitor the contracts.

Forensic Pathology Services

This is the largest item in the Coroner's Court budget at $2,749,498. This item was previously budgeted to the Department of Health, but budget responsibility for forensic services was shifted in the 2005/06 budget year.

At that stage a budget transfer figure of $2,320,000 was provided.

This contrasted with the PathWest estimate for the financial year in respect of this service of $2,752,314. The allocated figure was, therefore, inadequate to provide for provision of pathology services at the then current level. The transfer of funding for this item to the Coroner's Court took place following extensive discussion between the Department of Health and the then Department of Justice. At all stages I expressed reservations in respect of the funding transfer and noted, for example, that at various times when the Department of Health had raised this issue with the Department of Justice in the past, the proposed

allocation of funding for the transfer had varied and that the amount suggested as being required in 1996 was substantially higher than the amount which was suggested in 2000.

On 5 September 2005 the Acting Executive Director, Court Services, made the following observation in respect of this item:

> "It is important to note that Pathwest has recently been subsumed into the Metropolitan Health Service and hence will remain a function of the health system. The Department of Justice will not be administering or 'running' Pathwest, but will be paying for any services delivered by this organisation to the department."

The situation, therefore, is that although the Coroner's Court budget is required to fund provision of forensic pathology services, the Coroner's Court is not involved in "running" this service or administering it and is simply involved in paying for services delivered by the organisation.

While it is obvious that the Coroner's Court cannot effectively monitor what is effectively a health service provided by doctors at a hospital remote from the Coroner's Court, payment of this item remains a major consideration for the Coroner's Court and I have been required on a number of occasions to take action in an effort to ensure that adequate funding is provided for this service.

I should hasten to emphasise that I am not critical of the funding requirement of the forensic pathology services and note that the forensic pathologists in Western Australia perform approximately one-third more post mortem examinations each than forensic pathologists in other States such as Victoria.

Toxicology Services

Toxicology services are provided in respect of all sudden deaths by the Chemistry Centre. The costs in respect to this service were the subject of a transfer of funding which was similar to that in respect of forensic pathology services and the amount transferred was subsequently found to be insufficient as a result of which the Coroner's Court was required to provide additional funding each year from within its current budget for this item.

This cost is of importance in this context as apart from the increased cost of body removals, it is the item in respect of which there was greatest variance between the budget allocated and actual costs and comprises a significant portion of the amount referred to in the Executive Director's letter to the Director General.

The actual cost of toxicology services was $1,122,873 which was $37,617 higher than the budgeted figure of $1,085,256. The reason for the variance was that no account was taken of increased costs when setting a budget in respect of this item. The actual cost for toxicology services for the previous year was $1,084,871.

The budgeted figure was set arbitrarily without any account being taken of the real costs incurred or even CPI increases. A "budget" which did not provide for any additional expenditure in respect of these costs over the actual expenditure for the previous year was clearly not realistic.

Conclusion

It would appear from the correspondence relating to budgetary issues that a major factor in the inadequate resourcing of the Coroner's Court results from a perception that the Coroner's Court has been exceeding its budget by a significant amount each year.

The inclusion of the costs for body removals, pathology and toxicology services in the Coroner's Court budget has achieved the bizarre result of causing the Western Australian Coroner's Court to have a higher cost per finalisation than other Coroner's Courts of Australia for the purposes of the ROGS expenditure and cost per finalisation calculations none of which have all of these items within their budgets (most also do not even include counsel briefing fees which in some cases have been extremely high). This is in spite of the fact that this Court is, by most objective standards, clearly one of the most poorly resourced, if not the most poorly resourced, in Australia.

These additions to the budget have a further impact on the ROGS calculations as the Corporate and Court Services overhead apportionment is based on the percentage of the Coroner's Court "actual" expenditure. This produces a result which allocates costs of those services for these items, most of which involve no corporate involvement. The allocation of corporate overheads greatly exceeds the actual cost of the court's salaries wages and allowances and is clearly disproportionate to the services actually provided.

As explained above the major cost items within the Coroner's Court budget are the costs of body removals, pathology, toxicology and rental.

The Coroner's Court has no control in relation to these items, in respect of which each year in spite of input from this office unrealistic budgets are set.

As a general rule it can be anticipated that each year the cost of all of these items will increase and unless realistic budgets are set it is clear that there will be a variation between the budgeted figures and the actual figures.

Until it is recognised by the Department that the Coroner's Court has no control over these items and while the Coroner's Court continues to be disadvantaged as a result of these variations, there appears to be little realistic chance that important resource issues will be addressed and in that context I cannot have confidence that I can comply with my statutory obligations.

It is most unfortunate that these resource issues have been allowed to cause serious problems for the Coroner's Court, particularly when the costs involved are relatively small and form a small percentage of the total costs incurred.

It is also regrettable that, as noted in the Executive Director's letter to the Director General, it has been necessary for me to write to the Director General and Executive Director, Court and Tribunal Services, on many occasions in respect of resourcing issues which has adversely impacted on the time available to me to perform my other duties of investigating sudden deaths and conducting inquest hearings.

I do wish, however, to acknowledge the efforts of the Executive Manager, Specialist Courts and Tribunals, who has advocated on behalf of the Court in recent negotiations relating to staff and other issues and recognise that the minor gains which have been achieved have been largely through his considerable efforts.

Involvement of Relatives

The *Coroners Act 1996* involves relatives of deceased persons in the coronial process to a far greater extent than previously was the case.

The Act requires a Coroner to provide information to one of the deceased person's next of kin about the coronial process in every case where the Coroner has jurisdiction to investigate the death.

In practice the information is contained in a brochure which is provided by a police officer who is also required to explain the brochure. A police officer is further required to record details about the provision of the information on a mortuary admission form which is viewed by the Coroner or a delegate prior to any decision being made about whether or not a post mortem should be conducted.

During the year 1 July 2006 - 30 June 2007 a total of 2,341 deaths were referred to the Coroners Court. In 559 cases a death certificate was issued at an early stage and the body was not taken to the mortuary. Of the remaining 1,782 cases, a total of 117 objections were made to the conducting of a post mortem examination.

In the majority of cases the objection was accepted and no internal post mortem examination was conducted.

In a number of cases the objection was subsequently withdrawn, either immediately or when a Coroner had overruled the objection. In some cases it appears that while family members were at first concerned about a post mortem examination, later the family members realised that it would be important to know the cause of death with reasonable certainty.

Where objections are made, every effort is taken to attempt to ascertain the extent to which a cause of death can be determined without an internal post mortem examination.

It is a rare case in which there are no external factors which would give some insight into a likely cause of death.

The following charts detail statistics relating to objections to post mortem examinations for the year. The cases where a death certificate was issued by a doctor and the body did not reach the mortuary have not been included.

Deaths Referred to the Coroners Court from 1 July 2006 - 31 December, 2006

	Jul	Aug	Sept	Oct	Nov	Dec	*Total*
Death Certificate issued although the body was admitted to the Mortuary	**14**	**20**	**16**	**17**	**15**	**8**	**90**
Immediate post mortem ordered (usually these are homicide cases)	**0**	**4**	**4**	**3**	**2**	**2**	**15**
No post mortem because body missing etc.	**0**	**0**	**0**	**0**	**1**	**2**	**3**
No objection to post mortem examination	**133**	**96**	**117**	**123**	**102**	**118**	**689**
Objection received by the Coroners Court	**10**	**16**	**7**	**15**	**8**	**5**	**61**
TOTAL NUMBER OF DEATHS	**157**	**136**	**144**	**158**	**128**	**135**	**858**

Developments in Cases where an Objection was initially received

	Jul	Aug	Sept	Oct	Nov	Dec	*Total*
Objection withdrawn prior to a ruling being given by a Coroner	**2**	**3**	**2**	**4**	**4**	**2**	**17**
Objection accepted by a Coroner and no post mortem ordered	**8**	**13**	**4**	**10**	**3**	**2**	**40**
Objection over-ruled by a Coroner	**0**	**0**	**1**	**1**	**1**	**1**	**4**
TOTAL	**10**	**16**	**7**	**5**	**8**	**5**	**61**

Deaths Referred to the Coroners Court from 1 January 2007 - 30 June 2007

	Jan	Feb	Mar	Apr	May	Jun	*Total*
Death Certificate issued although the body was admitted to the Mortuary	**22**	**5**	**12**	**7**	**9**	**15**	**70**
Immediate post mortem ordered (usually these are homicide cases)	**3**	**1**	**2**	**1**	**3**	**3**	**13**
No post mortem because body missing etc.	**0**	**0**	**3**	**2**	**0**	**2**	**7**
No objection to post mortem examination	**138**	**108**	**149**	**109**	**142**	**132**	**778**
Objection received by the Coroners Court	**13**	**9**	**8**	**10**	**8**	**8**	**56**
TOTAL NUMBER OF DEATHS	**176**	**123**	**174**	**129**	**162**	**160**	**924**

Developments in Cases where an Objection was initially received

	Jan	Feb	Mar	Apr	May	Jun	*Total*
Objection withdrawn prior to a ruling being given by a Coroner	**2**	**2**	**2**	**4**	**4**	**2**	**16**
Objection accepted by a Coroner and no post mortem ordered	**11**	**6**	**5**	**6**	**3**	**6**	**37**
Objection over-ruled by a Coroner	**0**	**1**	**1**	**0**	**1**	**0**	**3**
TOTAL	**13**	**9**	**8**	**10**	**8**	**8**	**56**

It can be seen from the above charts that of the total number of deaths referred to the Coroners Court there were relatively few objections to the conducting of post mortem examinations.

In the majority of cases where an objection was received the decision which was ultimately made was in accordance with the wishes of the family. There were a total of 117 objections of which 33 were withdrawn prior to a ruling being given by a Coroner and 77 were accepted by a Coroner and no post mortem examinations were ordered. In only 7 cases where an objection had been received did a Coroner order that a post mortem examination should be conducted.

In the vast majority of cases relatives of deceased persons who died suddenly during the year appreciated the importance of a thorough examination of the circumstances of the deaths. In many cases the results of the post mortem examinations provided important information for family members who would otherwise have been left with many unanswered questions surrounding the deaths.

Counselling Service

REFERRALS - CORONIAL COUNSELLING SERVICE
1 July, 2006 – 30 June, 2007

TOTAL NEW CONTACTS
(letters to Next of Kin or referral from clients, other agencies or police)

1,903

The figure of 1,903 is not accurate as data was lost from the Coronial Counsellors' Database between 6 November and 7 February. It is believed that all recorded figures should be approximately one third increased to realistically estimate the actual numbers involved.

Counselling			
Phone	Office	Home	Other
948	94	32	126

Family Members	Non-Family
853	265

Coronial Ethics Committee

The Committee attempts to strike a balance between family concerns (including privacy, confidentiality and consent issues), and the possible benefits of research to the community at large. The Committee then makes recommendations to the State Coroner to assist him to decide whether to approve a project or to allow access to coronial records.

The considerable efforts of the Ethics Committee during the year are very much appreciated by the Coroner's Court particularly when it is considered that the Committee works on a voluntary basis and all members fit Committee work into otherwise very busy schedules

Mrs Felicity Zempilas has resumed her position as the Secretary of the Committee upon her return from leave.

The members of the Committee are as follows:

Dr Adrian Charles	*Chairperson* Paediatric Pathologist, Princess Margaret Hospital
Associate Professor Jennet Harvey	Department of Pathology, UWA
Mrs Felicity Zempilas	*Secretary* Lawyer, Coroner's Office
Ms Evelyn Vicker	Deputy State Coroner
Dr Jodi White	Forensic Pathologist, PathCentre
Ms Martine Pitt	Executive Director, Communicare
Mr Jim Fitzgerald	Lay member
Ms Heather Leaney	Lay member
Mr Neville Collard	Aboriginal member

The Committee has addressed the following projects during the last financial year as indicated in the table below.

Number of Projects Considered	Number of projects approved	Number of projects not approved
11	10	1

Counsel to Assist Coroners

In February 2007 Mrs Felicity Zempilas resumed her position as Counsel Assisting the State Coroner and has ongoing responsibility for all deaths in police and prison custody as well as other more complex matters.

In addition the Police Service continues to provide assistance to the Coroner's Court in the form of two police officers who act as officers assisting, namely Sergeant Peter Harbison and Sergeant Geoff Sorrell. These officers bring a wealth of experience and relevant knowledge to the task.

In a number of more lengthy inquests Mr Dominic Mulligan was retained as counsel assisting. Mr Mulligan was the first counsel assisting appointed at the Coroner's Court in 1997-1998 and he now practices as a Barrister in private practice.

Inquests

A chart follows detailing the Inquests conducted during the year.

It should be noted that in respect of the cases which are not Inquested, each of these cases is investigated and in every case findings are made by a Coroner and a Record of Investigation into Death document is completed detailing the results of the investigations which have been conducted.

INQUESTS FOR THE YEAR 1 JULY, 2006 - 30 JUNE, 2007

NAME	DATE OF DEATH	DATE OF INQUEST	CORONER	COURT SITTING	FINDING	DATE OF FINDING
WALSH Cathryn Mary	8/9/2001	7-8/6/2006	Deputy	Perth	Accident	21/7/2006
TUCKER Ian Robert	16/3/2004	19-20/6/2006	Deputy	Perth	Natural Causes	18/8/2006
TYSON Neil	6/8/2004	26-28/6/2006	State	Perth	Accident	9/8/2006
STONE Alistair Samuel Irvine	Between 1992-1993	11/7/2006	State	Perth	Open Finding	28/7/2006
BEDFORD Desmond Wayne	8/3/2004	11-13/7/2006 and 8-9/8/2006	Deputy	Kununurra	Accident	4/10/2006
STEELE Norman Eric Keith	24/5/2004	18-19/7/2006 And 17/8/2006	State	Merredin And Perth	Natural Causes	5/12/2006
CRANE Charles Rutherford Nelson	8/5/2003	31/7-4/8/2006	State	Perth	Open Finding	6/9/2006
PLUNKETT David John RANKIN Kim FURNESS Raymond Bernard GAMMOND David Roy	8/11/2003	14-16/8/2006	State	Kununurra	Accident	18/8/2006
WELLSTEAD James Franklyn	14/7/2004	15/8/2006	Deputy	Perth	Accident	19/9/2006
QUILLIAM Peter QUILLIAM Norma	30/8/2004	23/8/2006	State	Kununurra	Accident	24/8/2006
TIBERIO-CERLENCO Inaam Ahmad	30/4/2004	22-23/8/2006	Deputy	Perth	Accident	13/10/2006
*HARWIG Jade Aunia	26/3/2004	30-31/8/2006	Deputy	Busselton	Suicide	13/10/2006
ALVES-VEIRA Rodney James	8/10/2005	5/9/2006	State	Perth	Accident	5/9/2006
APPELBEE Kurt Anthony	9/3/2003	25/8/2006 And 5-7/9/2006	Deputy	Perth And Bunbury	Accident	16/11/2006
LIEDEL Karl Antony Walter	15/5/1998	12-15/9/2006	Deputy	Perth	Accident	2/11/2006
REID Dylan Michael BRODALA Leon Joseph	13/2/2005	13-14/9/2006	State	Albany	Accident	14/9/2006
POULTON Kylie Louise	8/6/2004	26-28/9/2006 And 13/11/2006	Deputy	Perth	Suicide	17/11/2006
BARKER Caroline Ann	31/3/2003	17-19/10/2006	Deputy	Perth	Unlawful Homicide	2/2/2007
PEWHAIRANGI Bussy Tautuhi	29/5/2004	26/10/2006	State	Esperance	Accident	26/10/2006
FLYNN Kevin Michael Lawrence	28/4/2005	30-31/10/2006	State	Busselton	Open Finding	7/11/2006
STANNARD Matthew John	24/8/2003	6-8/11/2006	Deputy	Bunbury	Suicide	17/11/2006
*MARTIN Noel Davis	1/11/2004	5-7/12/2006	Deputy	Albany	Suicide	25/1/2007
STURT Olive Sandra	2/7/2005	11-14/12/2006 And 1/3/2007 And 8/3/2007	State	Kununurra And Perth	Natural Causes	23/3/2007
BROOK Mark Simon Patrick	27/5/2005	18-19/12/2006	Deputy	Perth	Suicide	1/2/2007
GARTSIDE Andrew David	8/9/2005	16/1/2007	State	Perth	Accident	16/1/2007
BOLTON Wayne Karl	9/3/2005	16/1/2007	State	Perth	Unlawful Homicide	16/1/2007
TEDESCHI Gabrielle Mia					Suicide	Not completed
PRICE Taylor Jamie	15/1/2005	14-15/2/2007	State	Perth	Accident	28/2/2007
HOWIESON John Raymond	15/1/2005	27-28/2/2007 And 1/3/2007	Deputy	Port Hedland	Suicide	23/3/2007

NAME	DATE OF DEATH	DATE OF INQUEST	CORONER	COURT SITTING	FINDING	DATE OF FINDING
NEBRO Donald Arthur	13/5/2005	6-7/3/2007	Deputy	Kalgoorlie	Suicide	27/3/2007
CUNNINGHAM Mark Edward	n/a	7/3/2007	State	Perth	Death not established beyond all reasonable doubt	26/3/2007
HESARI Ali			State	Perth		
HASLUCK Norman John	9/1/2004	13/3/2007 And 3/4/2007	Deputy		Accident	2/5/2007
BATES Leslie Michael	13/12/2003	20/3/2007	State	Perth	Accident	28/3/2007
ZAK Romauld Todd					Suicide	
RASMUSSEN Rachel Anne	17/6/2003	11-12/4/2007 And 14-16/5/2007	State	Perth	Misadventure	8/6/2007
FRITH Sheila Margaret	6/7/2005	23-24/4/2007	Deputy	Perth	Accident	14/5/2007
ROBSON Emma Louise	29/9/2004	9-11/5/2007	State	Albany	Natural Causes	11/5/2007
THOMASON James	9/4/2005	22/5/2007	State	Perth	Suicide	27/6/2007
STOLL Thomas	25/4/2006	22/5/2007	State	Perth	Open Finding	29/6/2007
TSILICOCHYSSOS Nickolas	6/7/2003	22/5/2007	State	Perth	Accident	27/6/2007
MOSS Sharon Beverley	17/2/2005	29/5/2007	State	Perth	Natural Causes	8/6/2007
*MOURISH Jack Richard	14/9/2004	13-15/6/2007 And 20-22/6/2007	State	Perth	Natural Causes	

*Indicates Death in Custody

Deaths In Custody

An important function of the Coronial System is to ensure that deaths in custody are thoroughly examined. Section 22 of the *Coroners Act 1996* provides that an Inquest must be held into all deaths in custody.

Pursuant to section 27 of the *Coroners Act 1996* the State Coroner is required to provide a specific report on the death of each person held in care. The following contains reports on Inquests held during the year into deaths in care together with charts detailing the position of all deaths in care during the year.

Inquests – Persons Under Care of a Member of the Police Service

The definition of a ***"person held in care"*** includes the case of a person under, or escaping from, the control, care or custody of a member of the Police Service. Section 22(1)(b) of the Act provides that a Coroner who has jurisdiction to investigate a death must hold an Inquest if it appears that the death was caused, or contributed to, by any action by a member of the Police Service.

In this context while there were no inquests where it was found that section 22(1)(b) applied, at least four relevant inquests have either been listed or completed at the time of writing which will be reported on for the 2007-2008 year.

Inquests – Deaths In Care – Ministry of Justice (now the Department for Corrective Services)

During the year 3 Inquests were conducted into the deaths of persons who died while in the custody of the Department of Justice, now the Department for Corrective Services.

The following chart details the position in respect of all deaths in care since January 2004 where the deceased was either in prison custody or there was police involvement.

Date of Death	Date of Inquest	Name of Deceased	Custody	Place of Death	Finding
4/4/04	11/2/05	CHAPMAN Allan	Prison	Hakea Prison Murdoch Community Hospice	Natural Causes
24/7/04	30/5/06	BARNARD Peter	Acacia Prison	RPH	Natural Causes
2/9/04	27/2-2/3/06	DONALDSON Leon John	Prison	Casuarina Prison	Suicide
14/9/04	13-15/6/07 And 20-22/6/07	MOURISH Jack	Prison	Hakea Prison	Natural Causes
17/10/04		WONGAWOL Phillip	Prison	RPH Acacia Prison	
25/10/04	30/5/06	HIGGINS Rodney Scott	Prison	RPH Casuarina Prison	Natural Causes
1/11/04	5-7/12/06	MARTIN Noel	Prison	Albany Regional Prison	Suicide
26/12/04		AXFORD Michael John	Prison	RPH	
21/5/05		HICKS Lawrence	Prison	Nickol Bay Hospital Karratha	
10/7/05		WHEELOCK Laurence Noel	Prison Parole	Carnarvon	
3/9/05		HENDERSON Gordon James	Prison	Casuarina Prison	
7/10/05		BIRNIE David John	Prison	Casuarina Prison	
19/10/05		TRIMMER Billy	Prison	Wyndham Work Camp	
1/5/2006		PARRE Donald Edwin	Prison	Albany Regional	
19/5/2006		ROCHFORD Simon	Prison	Albany Regional	
12/6/2006		ZUPEC John	Karnet Prison	Fremantle Hospital	
2/8/2006		BROWN Robert Geoffrey	Prison	Bethesda Hospital	
8/9/2006		HANSON Colin	Police	In police presence Kalgoorlie	
17/9/2006		WRIGHT Ryan Anthony	Police	In police presenc Nollamarae	
26/9/2006		VAN ZYL Alexander Carl	Police	In police presence Margaret River	
3/12/2006		BRIGGS Lenny Mark John	Prison	Casuarina Prison	
27/4/07		NUNDLE Lee James	Prison	Wooroloo	
21/6/2007		VOJINOVIC Slavko	Police	Police chase Thomas Rd Armadale	

A brief summary of the three inquested death in custody cases follows –

Jade Aunia Harwig

Jade Aunia Harwig (the deceased) was a 24 year old female who died on 26 March 2004 at 5 Nixon Crescent, Margaret River, as a result of ligature compression of the neck (hanging).

At the time of her death the deceased was subject to a Work Release Order, having been released from Bandyup Women's Prison on 18 February 2004, while serving a sentence of four years imprisonment for the crime of armed robbery.

On the night of 26 March 2004 the deceased was found by her sister hanging by an electrical extension cord from a wooden beam at the rear of the address where she was residing.

The Deputy State Coroner concluded that the deceased's decision to take her life was made impulsively in circumstances where she had been drinking, had recently used drugs, was depressed about the time it was taking to readjust and was still dealing with guilt and sadness over the death of her boyfriend.

The Deputy State Coroner found that the deceased was adequately managed during her Work Release Order but express concern in respect of a failure, while she was in custody at Bandyup Prison, for the Prison Counselling Services to ensure that a follow up appointment recommended for the week of 8 April 2003 took place. The Deputy State Coroner made the following recommendation in that context.

I RECOMMEND, WHERE A PRISONER DECLINES A FOLLOW UP APPOINTMENT A RECORD IS MADE OF THIS FOR FUTURE REFERENCE.

Noel Davis Martin

Noel Davis Martin (the deceased) was a 67 year old male who died on 1 November 2004 at Cell C2, Unit 1, Albany Regional Prison as a result of ligature compression of the neck (hanging).

The deceased died during his first period in custody and he had suffered cancer of the bowel while in the community for which he

had been treated in the past. At the time of his admission into custody he suspected he may have had a recurrence of his medical problems. Investigations confirmed a cancer of a different type. Shortly before his death by hanging he was advised that he would require further treatment while in custody.

The Deputy State Coroner found that the deceased had a plan to take his own life at a stage when he believed that his quality of life would no longer be sustainable.

The Deputy State Coroner found that the death arose by way of Suicide.

In comments on the Supervision, Treatment and Care of the deceased the Deputy State Coroner expressed some concerns in respect the limited information available to Prison Management as oppose to the Health Services in respect of the deceased's diagnosis of cancer and planned treatment.

The Deputy State Coroner also expressed concern in respect of evidence that there is no separate mental health budgeting for prisons and that all mental health resourcing comes out of the Health Services budget.

In the context of the above concern the Deputy State Coroner made the following recommendations –

I RECOMMEND A POSITION WITHIN A PRISON SUCH AS THE ASPM BE NOMINATED TO RECEIVE ALL RELEVANT AND SIGNIFICANT INFORMATION ABOUT A PRISONER TO HELP THEM FORM A VIEW AS TO WHETHER OR NOT THE STATUS QUO WITH RESPECT TO THEIR WELL BEING MAY HAVE BEEN AFFECTED AT ANY ONE TIME. IT SHOULD BE THE CASE ANY OF THE WELFARE PEOPLE IN THE PRISON ENVIRONMENT CAN APPROACH THE ASPM AND ADVISE HIM OF A CHANGE WITH RESPECT TO ANY PRISONER.

I RECOMMEND THE CONFIDENTIALITY WAIVER FORMS SIGNED BY PRISONERS FOR THE OBTAINING OF MEDICAL INFORMATION WITH RESPECT TO THEIR WELFARE HAVE AN ADDITIONAL PART INDICATING THEY ARE AWARE THAT INFORMATION MAY BE PROVIDED TO THE ASPM FOR THE PURPOSES OF THE OVERALL SECURITY AND MANAGEMENT OF THE PRISON.

I RECOMMEND THERE BE FUNDING FOR ADEQUATE MENTAL HEALTH RESOURCING TO ALL PRISONS OVER AND ABOVE THAT OF HEALTH SERVICES.

Jack Richard Mourish

Jack Richard Mourish (the deceased) was a sentenced prisoner housed at Hakea Prison, Nicholson Road, Canning Vale who died on 14 September 2004 at the age of 37 years.

The deceased had been kicking a football with another prisoner when he collapsed. Resuscitation attempts were commenced and an ambulance was called for. Resuscitation efforts ceased while the deceased was still at the prison.

A post mortem examination revealed that the cause of death was ischaemic heart disease.

Toxicology analysis of blood taken from the deceased revealed that he had recently consumed cannabis. It was also determined that he had taken buprenorphine (also marketed as Subutex) which had not been prescribed for him.

The State Coroner found that the death arose by way of natural causes but made a number of comments on the quality of the supervision, treatment and care of the deceased while in custody.

The State Coroner commented on the fact that when the deceased died suddenly and unexpectedly as a result of his serious heart disease, the investigation which followed revealed what was described at the inquest as a "snap shot" of drug use in the prison.

Of particular concern was the fact that the deceased appeared to have regularly used illicit drugs and medications which were not prescribed for him while in prison.

The investigation into the circumstances of the death revealed a wide range of drugs and items connected with bringing drugs into prison or drug use. The State Coroner expressed concern that the WA Police do not appear to allocate sufficient priority to preventing the bringing of illicit drugs into the prison system and made the following recommendation in that regard.

Recommendation No. 1

I RECOMMEND THAT WA POLICE REVIEW THE PRIORITIES PRESENTLY ALLOCATED TO STRATEGIES DESIGNED TO PREVENT THE SUPPLYING OF DRUGS INTO PRISONS AND WORK WITH THE DEPARTMENT OF CORRECTIVE SERVICES WITH A VIEW TO PLAYING AN IMPORTANT ROLE IN APPREHENDING AND PROSECUTING OFFENDERS BRINGING DRUGS INTO PRISONS SO AS TO REDUCE THIS ENDEMIC PROBLEM.

The State Coroner noted that a factor in the relatively low priority apparently given to this issue by WA Police was the fact that the quantities of drugs involved are relatively small and so any penalties imposed on offenders are relatively light. In that context the State Coroner made the following recommendation –

Recommendation No. 2

I RECOMMEND THAT CONSIDERATION SHOULD BE GIVEN TO AMENDING THE MISUSE OF DRUGS ACT 1981 –

- **SO AS TO PROVIDE THAT A PERSON IN POSSESSION OF A PROHIBITED DRUG OR PLANT IN THE CARPARK OF A PRISON SHOULD BE PRESUMED TO HAVE THE INTENTION OF SELLING OR SUPPLYING THAT PROHIBITED DRUG TO A PRISONER; AND**

- **PROVIDING THAT IT SHOULD BE A CIRCUMSTANCE OF AGGRAVATION TO A CRIME OF SUPPLYING A PROHIBITED DRUG OR PROHIBITED PLANT WHEN THE RECIPIENT OF THE DRUG OR PLANT IS AT THE TIME IN CUSTODY.**

The State Coroner noted that there are considerable risks associated with the practice of prisoners consuming prescription medications which have not been prescribed for them and while that the Department has put in place strategies to address this problem, expressed the view that this issue requires ongoing attention and in that context made a further recommendation –

Recommendation No. 3

I RECOMMEND THAT THE DEPARTMENT OF CORRECTIVE SERVICES TAKE STEPS TO ENSURE THAT THE POSSIBLE RISKS TO PRISONERS ASSOCIATED WITH USING OTHER PERSONS' MEDICATIONS ARE HIGHLIGHTED AND THAT ALL PRISONERS FOUND TO BE MISUSING MEDICATIONS IN THIS WAY SHOULD BE COUNSELLED IN STRONG TERMS AS TO THE DANGERS ASSOCIATED WITH THE PRACTICE.

In the context of health issues identified at the inquest the State Coroner made the following recommendations –

Recommendation No. 4

I RECOMMEND THAT THE DEPARTMENT OF CORRECTIVE SERVICES REVIEW ITS PROCEDURES TO ENSURE THAT MIDDLE AGED ABORIGINAL MEN COMPLAINING OF CHEST PAINS ARE ALLOCATED ADEQUATE PRIORITY WITHIN THE SYSTEM AND ARE COUNSELLED AS TO THE POTENTIAL RISK OF SUDDEN DEATH IN THE EVENT THAT THEY ARE NOT COMPLIANT WITH EFFORTS TO DIAGNOSE THEIR CONDITION AND, IF THEIR PROBLEM IS IDENTIFIED AS BEING OF CARDIAC CAUSE, AGGRESSIVE MANAGEMENT OF THEIR CONDITION.

Recommendation No. 5

I FURTHER RECOMMEND THAT CONSIDERATION SHOULD BE GIVEN TO PROVISION OF IMPROVED EDUCATION TO PRISONERS IN RESPECT OF HEALTH ISSUES AS PART OF THE ONGOING PROCESS OF UPSKILLING PRISONERS FOR THEIR EVENTUAL RETURN TO THE COMMUNITY.

In this case the deceased collapsed on a grassed area between units and a number of prisoners were able to view his body at the scene until it was removed. In that context the State Coroner made the following recommendation –

Recommendation No. 6

I RECOMMEND THAT IN EACH PRISON IN WESTERN AUSTRALIA ACTION SHOULD BE TAKEN TO IDENTIFY ITEMS WHICH COULD BE USED TO SCREEN A BODY FROM PRISONERS IN THE EVENT THAT A DEATH OCCURS IN AN OPEN AREA IN A PRISON.

The State Coroner noted that although the Department's Policy Directive 30 required staff to complete a specific Death in Custody Report Form, this form was not used by Hakea staff after the death of the deceased and the standard Incident Form was used.

The purpose of the specific form is to ensure that a report is obtained from prison officers shortly after a death in custody which addresses issues relating to the deceased before the death which may have had a bearing on the death. It was noted that in spite of past recommendations made by coroners the correct forms were still not routinely used.

In the above context the State Coroner made the following recommendation –

Recommendation No. 7

I RECOMMEND THAT THE DEPARTMENT OF CORRECTIVE SERVICES REVIEW PROCEDURES TO ENSURE THAT PRISON SUPERINTENDENTS ARE AWARE OF POLICY DIRECTIVE 30 AND COMPLY WITH THAT POLICY.

Deaths Referred to the Coroners Court
1 July 2006 – 30 June 2007

A total of 2,341 deaths were referred to the coronial system during the year.

Of these deaths, in 717 cases death certificates were ultimately issued by doctors. In many cases there were initial problems experienced in locating a treating doctor or a treating doctor had initial reservations about signing a certificate which were ultimately resolved.

In the Perth area there were 1,143 Coroner's cases and in the country regions there were 481 Coroner's cases a total of 1,624 cases.

Coroner's cases are 'reportable deaths' as defined in section 3 of the *Coroners Act 1996*. In every Coroner's case the body is in the possession of the Coroner until released for burial or cremation. In all Coroner's cases an investigation takes place and either on the basis of that investigation or following an Inquest subsequent to the investigation, a Coroner completes findings as to the identity of the deceased, how the death occurred and the cause of death.

Statistics relating to the manner and cause of deaths referred to the Coroner for investigation are detailed below. In a number of cases a Finding by a Coroner had not been made at the time of compilation of the statistics, but an apparent manner and cause of death has been provisionally determined from the circumstances in which the body was found and from other information available.

Deaths referred to a Coroner for investigation for the Metropolitan area

1 July, 2006 - 30 June, 2007

Natural		634
Suicides		209
Accidents		145
Traffic		117
Homicide		14
Open		3
Misadventure		0
Inconclusive		5
	TOTAL	**1143**

Deaths referred to a Coroner for investigation for the Country area

1 July, 2006 - 30 June, 2007

Natural		220
Suicides		74
Accidents		62
Traffic		95
Homicide		8
Open		10
Inconclusive		1
Misadventure		0
Missing Persons		2
	TOTAL	**481**