

**OFFICE**  
**of the**  
**STATE CORONER**  
**for**  
**WESTERN**  
**AUSTRALIA**

**ANNUAL REPORT**

**2014-2015**



Central Law Courts  
Level 10, 501 Hay Street  
PERTH WA 6000

Telephone: (08) 9425 2900  
Facsimile: (08) 9425 2901

Our Ref : Annual Report

1 October 2015

The Honourable Michael Mischin LLB (Hons) BJuris (Hons) MLC  
Attorney General  
10<sup>th</sup> floor, Dumas House  
2 Havelock Street  
WEST PERTH WA 6005

Dear Attorney

**ANNUAL REPORT 2014-2015**

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, 2015.

Yours sincerely

A handwritten signature in blue ink, appearing to read "R V C Fogliani".

R V C FOGLIANI  
**STATE CORONER**

## Table of Contents

<b>State Coroner's Overview</b>	
Executive Summary of Outcomes	3-4
Structure of the Report	5
Information available to the public	6
The focus over the 2014/15 year: The Backlog of cases & the Legislative Project	7
Report on Inquests that are required by law to be held (mandated inquests):	8-10
(a) Mandated inquests – persons held in care immediately before death	
(b) Mandated inquests – where it appeared the death was caused, or contributed to, by any action of a member of the police force	
(c) Mandated inquests – suspected deaths	
Report on inquests that are held pursuant to an exercise of discretion by the coroner (discretionary inquests)	
The Coronial Counselling Service	10
The Death Prevention Role and the Coronial Ethics Committee	11
A Case Management System	12
Acknowledgements	12
<b>Considerations arising in the 2014/15 year</b>	13
<b>Office Structure</b>	14
Table A	
<b>Registry and Statistics</b>	14-19
Table B – cases received and finalised	
Table C – cases closed	
Table D – deaths reported and cases completed	
Table E – findings on manner of death	
<b>Post Mortem Examinations</b>	20
<b>Objections to Post Mortem Examinations</b>	21-22
Table F	
<b>Coronial Counselling Service Functions</b>	23-24
Table G	
<b>Coronial Ethics Committee Functions</b>	25-26
Table H	
<b>Principal Registrar and Coroner's Registrars</b>	27
<b>Counsel Assisting the Coroner</b>	28
<b>Police Assisting the Coroner</b>	28
<b>Inquests</b>	29-35
Table I – total number of inquests	
Table J – deaths that appeared to be caused, or contributed to, by any action of a member of the police force	
Table K – suspected deaths	
Table L – persons held in care	
Persons held in care – specific reports	36-58

## State Coroner's Overview

### Executive Summary of Outcomes

Under section 8 of the *Coroners Act* 1996 (Coroners Act) one of my functions is to ensure that the State Coronial system is administered and operates efficiently. The outcomes for the office of the State Coroner for 2014/15 reflect a decrease in the backlog within the context of an increasing workload:

- Backlog of cases reduced to 355 as at 30 June 2015. This was due to prioritising the finalisation of investigations over 12 months old wherever possible.
- Of those 355 cases:
  - 105 were backlog inquest cases.
  - The remaining 250 were cases where no further finalisations were possible as at 30 June 2015 because the coroner was awaiting the outcome of further investigations.
- By listing the oldest cases for inquest, the statistics show a greater than usual time to hearing; however, this also reflects that, appropriately, the older matters are being progressed.
- A total of 2021 investigations were finalised in 2014/15:
  - 1975 finalised by administrative finding of which 586 (30%) were backlog cases.
  - 46 finalised by inquest of which 45 (98%) were backlog cases and just over half were mandated inquests.
  - 1390 (69%) of the cases finalised were under 12 months old.
  - 631 (31%) of the cases finalised were over 12 months old.
- The number of inquests finalised decreased from 77 in 2013/14 to 46 in 2014/15. However the 77 included one inquest investigating 10 deaths (Graylands) and one inquest investigating 17 deaths (Christmas Island). Both of those inquests had been heard in the 2012/13 year, but finalised by findings delivered in the 2013/14 year (therefore reported in the latter year).
- The number of total cases on hand over 24 months old reduced to 8.4% in 2014/15 compared to 10% in 2013/14, 9.8% in 2012/13 and 13% in 2011/12. This represents a gradual reduction in aged matters.
- Reports of deaths to the coroner increased to 2192 in 2014/15 compared to 2009 in 2013/14, 2155 in 2012/13 and 1916 in 2011/12. This is to be expected given the population increase.

- The number of cases on hand was 2027 at 30 June 2015 compared to 1891 as at 30 June 2014. This is due to the increase in reportable deaths in 2014/15 as the comparison of cases closed between 2014/15 (being 2021) and 2013/14 (being 2036) remained relatively the same.
- The number of death certificates received in 2014/15 was 908 compared to 683 in 2013/14. These are cases where the coroner has determined that the reported death does not require further investigation and the doctor's death certificate is accepted.
- Counselling Service contacts and referrals increased significantly from 9750 in 2013/14 to 10753 in 2014/15. This reflects the increase in reportable deaths. The increase in 2014/15 also reflects the support provided by the counsellors to the families of the Malaysian Airlines disasters MH370 and MH17.
- The number of objections to the performance of post mortem examinations for the purpose of investigating deaths increased to 279 in 2014/15 compared to 256 in 2013/14.
- Reduction in the number of inquests awaiting hearing between Quarter 1 (Q1) and Quarter 2 (Q2) of 2014/15:
  - In Q1 the backlog of inquest cases reported 124 outstanding.
  - In Q2 the backlog of inquest cases reported 103 outstanding showing a reduction of 21.
  - In addition to closures of inquest cases over the two quarterly reporting periods, the decrease is also occasioned by my review of inquest cases awaiting hearing and the consequential removal, from the inquest list, of a number of cases that were previously being prepared for inquest.
  - The review was occasioned as part of my overall review of practices and procedures since I took up my appointment in January 2014. Other than when the occasion now warrants it, the review of the inquest list in its totality is now complete.
- Under section 27(1) of the Coroners Act, I am required to include a specific report on the death of each person held in care. They are mandated inquests. The specific reports for 2014/15 include a greater proportion of reports in respect of the deaths of children who were the subject of protection orders. This reflects the increase in the focus of counsel assisting staff concentrating on more complex matters for inquest and does not represent an increase in the deaths of children held in care.
- The focus on matters of concern with respect to reportable deaths of children was also evident in two discretionary inquests relating to a total of four deaths where considerations arose regarding parents' preferences for "natural" health solutions over available evidence based medicine. It is my hope that, with these matters having been highlighted, parents will be encouraged to pay close and thoughtful attention to doctors' medical advice and evidence based medicine.

## **Structure of the Report**

The first part of this Report provides statistical and other information on the operations of the Office of the State Coroner in the past financial year ended 30 June 2015 (2014/15).

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

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

Investigations that have not been finalised are not the subject of a specific report. An investigation is finalised when the coroner has made the findings required, if possible, to be made under section 25(1) of the Coroners Act. Generally, in over 95% of cases, an investigation is finalised without holding an inquest. An inquest is part of an investigation.

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

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

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

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

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

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

There were 1975 administrative findings finalised by coroners in the 2014/15 year comprising approximately 97.7% of all reportable deaths investigated for this year. For these matters the coroner makes findings on the evidence before him or her, in chambers. They are not public proceedings. These findings are provided to the deceased's next of kin and they are not published on the Coroner's Court website.

There were 46 Inquests finalised by coroners in the 2014/15 year comprising approximately 2.1% of all reportable deaths investigated for this year. As Inquests are public proceedings, the coroner takes evidence in open court (unless otherwise ordered). The coroner's written findings are published on the Coroner's Court website. Where the coroner has made a recommendation, the written response by the Minister or responsible entity is also published on the website.

## The focus over the 2014/15 year: The Backlog of Coronial Cases and the Legislative Project

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

The backlog is a dynamic figure because cases are constantly being finalised and equally, at the 12 month anniversary, cases are also coming into backlog, on a daily basis. As outlined in the Executive Summary, as at 30 June 2015 the backlog stood at 355.

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

The other significant work for the office over the past financial year has arisen in light of the 113 recommendations made by the Law Reform Commission of Western Australia in its *Review of Coronial Practice in Western Australia*, project no. 100, January 2012. They are recommendations pertaining to the legislation, practices and procedures associated with this Office. The Coroner's Court Legislative Project Reference Committee was established on 23 June 2014 to oversee the process to amend the *Coroners Act 1996* in accordance with the agreed recommendations and to assess additional amendments that are proposed.

The Committee is formed by myself, the Director Magistrates Court and Tribunals and the Director Strategic and Business Development from the Court and Tribunal Services Division of the Department of the Attorney General and is supported by members from the Coroner's Court Legislative Review Project Working Group.

During this year, at my request a Focus Group was set up comprising of myself and members of the Working Group, to consider the detail of the 113 recommendations and to prepare the draft briefing note to the Attorney-General for approval by the Committee. The Focus Group generally met on a weekly basis.

At the time of writing this Report, the Committee has approved the majority of the Focus Group's briefings on the 113 recommendations and a small number await finalisation by the Focus Group for submission to the Committee. The Committee expects to make its submission to the Attorney-General for consideration of the proposed amendments to the *Coroners Act 1996* in early October 2015.

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

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

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

Overall there were 46 investigations finalised by inquest in the past financial year and of those, a total of 26, being approximately 56%, comprised investigations where an inquest was mandated by law.

The 26 mandated inquests were finalised by coroners in the following categories and these are described below:

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

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

A deceased will have been a “person held in care” under the circumstances specified in section 3 of the Coroners Act. They include children the subject of a protection order under the *Children and Community Services Act 2004*, persons in custody under the *Prisons Act 1981* and involuntary patients under the *Mental Health Act 1996*.

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

Under section 27(1) of the Coroners Act, my annual report to you is required to include a specific report on the death of each person held in care. A Table of the investigations into deaths of persons held in care that were finalised by inquest in the past financial year appears at pages 34-35 of this Report. Following that Table, at pages 36-58 are the specific reports on the deaths of each person held in care, arranged in the order in which they appear on the Table.

In the past financial year there were 15 investigations of deaths of persons held in care finalised by inquest. Of those:

- Eight investigations were finalised by inquest in respect of deaths of persons held in custody under the *Prisons Act 1981*;
- Six 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*; and
- One investigation was finalised by inquest in respect of the death of an involuntary patient within the meaning of the *Mental Health Act 1996*.

In respect of all of the 15 investigations of deaths of persons held in care finalised by mandated inquest this past reporting year, the coroner was required under section 25(3) of the Coroners Act to comment on the quality of the supervision, treatment and care of the person while in that care.

There were no adverse comments made by a coroner regarding the quality of the supervision, treatment and care of those deceased persons, save for the investigation into the death of Mr Peter Phillip HUMES (Finding delivered 12 September 2014). The coroner's comments related to the placement of the prisoner in a cell with an obvious ligature point. That is addressed at pages 39-40 of this Report.

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

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

Five concerned police pursuits. One concerned protocols and procedures following a 000 call. In each instance, the coroner found that the death was not caused or contributed to by any action of a member of the police force.

A Table of the six investigations appears at page 32 of this Report.

**(c) Mandated inquests – suspected deaths**

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

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

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

A Table of the five investigations appears at page 33 of this Report.

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

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

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

Of the 46 investigations finalised by inquest in the past financial year, a total of 20, being approximately 44%, comprised investigations where the inquest was discretionary.

A Table of all of the investigations that were finalised by inquest appears at pages 29-31 of this Report. The mandated inquests are marked as such, leaving the remainder on that Table, a total of 20, as the discretionary inquests.

### **The Coronial Counselling Service**

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

Over this reporting year, the Coronial Counselling Service has focussed on its core function which is to ensure, as far as practicable, that persons coming into contact with the coronial system are able to speak with an experienced counsellor who will endeavour to address their questions and concerns and explain the coronial process to them. The service dealt with over 6500 telephone contacts.

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

## **The Death Prevention Role and the Coronial Ethics Committee**

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

Only the coronial findings on inquest are made public, and they comprise less than 3% of all investigations. Following an inquest a coroner may make specific recommendations in connection with the death that may result in practices being changed, for example at hospitals or at workplaces, to assist in preventing similar deaths in the future. This is part of the death prevention role of the coroner.

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

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

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

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

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

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

### **A case management system**

In the last annual report I had stated that the work output of the Coroner's Court of Western Australia would be optimised with the introduction of an electronic case management system.

I am gratified to be informed that the project to implement an electronic case management system for the Coroner's Court is scheduled to commence in 2016/17. Work has already commenced to address the system requirements.

Full implementation will ultimately facilitate the allocation of caseloads to coroners from the time the death is reported, for case management by the same coroner, until completion.

Another benefit includes the efficient retrieval of information for statistical purposes and/or within the context of the death prevention role.

### **Acknowledgements**

I wish to acknowledge the endeavours on the part of Deputy State Coroner Evelyn Vicker, Coroner Barry King and Coroner Sarah Linton to finalise investigations and reduce the backlog.

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

All of the staff members at the Coroner's Court of Western Australia have been exceptionally dedicated to one of the central tasks of the Office, which is to try and find answers for grieving family members and to communicate that with accuracy and sensitivity.

Every member of the police force of Western Australia is contemporaneously a coroner's investigator. The Coroner's Court of Western Australia continued to be well supported by all of the coroner's investigators, including those at the Coronial Investigation Unit, the forensic pathologists and other PathWest staff, and the toxicologists and other ChemCentre staff. I use this opportunity to express my gratitude to the 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 2014/15 Annual Report of the Office of the State Coroner.

R V C FOGLIANI  
**STATE CORONER**

## **Considerations arising in the 2014/15 year**

This is a new section in the Report and provides the State Coroner with the opportunity to highlight issues that touch upon the coroner's death prevention role, by reference to some of the matters that came before the Coroner's Court over the past reporting year.

The themes that emerged arose out of two inquests concerning the tragic deaths of four children and reflected considerations surrounding conventional medicine and natural therapies.

With the growing trend towards a more holistic approach to health matters, and the desire to search for alternative solutions, it is only to be expected that practitioners of conventional medicine may find their advice and judgements increasingly questioned. Where parents' decisions regarding medical services have the likelihood of materially affecting the health and/or even the survival of their children, the importance of forging a strong partnership between clinicians and parents at the earliest possible stage can readily be appreciated. Sometimes, despite all reasonable efforts, that partnership fails to form or breaks down.

The two inquests heard before the Coroner's Court this reporting year reflected tragic consequences of the breakdown in that partnership. The deceased children were deeply loved by their parents, and the clinicians sought to provide the best possible medical solutions under the circumstances. Within that context, the adverse health outcomes were heartrendingly catastrophic.

The evidence reflected the willingness on the part of the medical practitioners to consider and/or incorporate some natural therapies and parents' wishes, but this is always to be balanced against the known outcomes of evidence based medicine. On occasions it will require the application of very fine judgement and considered communication skills, in circumstances where parents are distraught and vulnerable. Even then, outcomes cannot be guaranteed. It is my hope that, with these matters having been highlighted, parents will be encouraged to pay close and thoughtful attention to doctors' medical advice and evidence based medicine.

*[The State Coroner's Finding on the investigation into the death of Tamar STITT and Coroner Linton's Findings on the investigations into the deaths of Baby B, Baby C and Baby P are on the website of the Coroner's Court of Western Australia]*

## Office Structure

The office structure of the Coroner’s Court of Western Australia comprises the State Coroner, Deputy State Coroner and two Coroners supported by 23 full time employees (FTE’s) as shown Table ‘A’ below. Office Manager and Coroner’s Registrar Ms Susan Wilde has capably managed the operations of the Office and has been instrumental in the administration of the files so as to facilitate the reduction of the backlog. Staffing levels were stable over the reporting year.

**Table A**

Coroners and Inquest staff	Management and Registry Staff	Counselling Service
State Coroner	Principal Registrar	Senior Counsellor
Deputy State Coroner	Office Manager	Counsellor
Coroner	Registry Manager	Counsellor
Coroner	Assistant Registry Officer	
Senior Counsel Assisting	Systems Information Officer	
Counsel Assisting	Senior Findings Clerk	
Counsel Assisting	Findings Clerk	
Listings Manager	Customer Service Officer	
Administrator	Customer Service Officer	
Customer Service Officer	Customer Service Officer	
Customer Service Officer	Customer Service Officer	
Customer Service Officer	Customer Service Officer	

## Registry and Statistics

The Registry is the repository of the statistical information concerning the work of the Coroner’s Court of Western Australia.

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

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

caused or contributed to while the person was held in care; that appears to have been caused or contributed to by any action of a member of the Police Force; of a person whose identity is unknown; and/or where the cause of death has not been certified by a doctor in accordance with the *Births, Deaths and Marriages Registration Act 1998*.

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

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

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

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

Registry staff members record the salient details of the coroner's findings, including the deceased's name, date of death, the cause and manner of death and date of the coroner's finding.

With respect to the backlog of coronial cases it will be seen that the backlog reduced from 415 as reported in 2013/14 to 355 in 2014/15. The number of cases about to enter into backlog in any given month is calculated; and the Coroner's Court endeavours to finalise more than that number in an effort to prevent the backlog from increasing.

A total of 2192 reportable deaths were reported to the coroner for full investigation in the past financial year and 2021 cases were completed representing a clearance rate of 92%.

With regard to the 2021 cases completed in the past reporting year the breakdown is as follows:

- 1975 – the number of investigations finalised by administrative finding, of which 586 (30%) were backlog cases, and
- 46 - the number of investigations finalised by inquest, of which 45 (98%) were backlog cases.

At the conclusion of the reporting year, the cases on hand referred to the Coroner's Court of Western Australia for investigation by a coroner amounted to 2027, of which 355 were backlog cases (over 12 months old).

Of those 355 backlog cases, 105 were inquest cases waiting to be heard or pending finalisation by a Coroner.

The following Tables provide an overview of the work of the Office in the 2014/15 year.

**Table B**

<i>CASES RECEIVED</i>	<i>PERTH</i>	<i>COUNTRY</i>	<i>TOTAL</i>
Full Investigation	<b>1593</b>	<b>599</b>	<b>2192</b>
Death Certificates	<b>908</b>	<b>n/a</b>	<b>908</b>

<i>CASES COMPLETED</i>	<i>PERTH</i>	<i>COUNTRY</i>	<i>TOTAL</i>
Finalised by Inquiry	<b>1462</b>	<b>513</b>	<b>1975</b>
Finalised by Inquest	<b>33</b>	<b>13</b>	<b>46</b>
<b>TOTALS</b>	<b>1495</b>	<b>526</b>	<b>2021</b>

<i>BACKLOG</i>	<i>PERTH</i>	<i>COUNTRY</i>	<i>TOTAL</i>
	<b>230</b>	<b>125</b>	<b>355</b>

<i>CASES ON HAND</i>	<i>PERTH</i>	<i>COUNTRY</i>	<i>TOTAL</i>
	<b>1488</b>	<b>539</b>	<b>2027</b>

<i>FINALISATION RATIO</i>			
Finalised by Inquiry		<b>97.72%</b>	<b>1975</b>
Finalised by Inquest		<b>2.28%</b>	<b>46</b>

### Table C

Table C below shows the age of a coronial file when closed calculated from the date of death. It will be seen that 69% (1390) of files were closed in under 12 months and 31% (631) of files were over 12 months old at closure (i.e. backlog files).

<i>TIMELINES</i>	<b>INQUIRY</b>		<b>INQUEST</b>	
	<i>PERTH</i>	<i>COUNTRY</i>	<i>PERTH</i>	<i>COUNTRY</i>
< 3 mths	<b>73</b>	<b>39</b>	<b>0</b>	<b>0</b>
3-6 mths	<b>266</b>	<b>174</b>	<b>0</b>	<b>0</b>
6-12 mths	<b>683</b>	<b>154</b>	<b>1</b>	<b>0</b>
12-18 mths	<b>337</b>	<b>88</b>	<b>4</b>	<b>0</b>
18-24 mths	<b>47</b>	<b>25</b>	<b>4</b>	<b>2</b>
>24 mths	<b>56</b>	<b>33</b>	<b>24</b>	<b>11</b>
<b>TOTALS</b>	<b>1462</b>	<b>513</b>	<b>33</b>	<b>13</b>

## Table D

Table D below shows the total number of deaths reported and cases completed during the 2014/15 year for Perth and Regional WA.

<b>TOTAL NUMBER OF DEATHS REPORTED TO THE CORONER</b>			
<b>Death certificates</b>		<b>908</b>	
<b>Metropolitan deaths</b>	<b>1593</b>		
<b>Regional deaths</b>	<b>599</b>		
<b>Albany</b>	<b>95</b>		
<b>Broome</b>	<b>39</b>		
<b>Bunbury</b>	<b>157</b>		
<b>Carnarvon</b>	<b>37</b>		
<b>Islands</b>	<b>1</b>		
<b>Geraldton</b>	<b>60</b>		
<b>Kalgoorlie</b>	<b>65</b>		
<b>Kununurra</b>	<b>27</b>		
<b>Northam</b>	<b>61</b>		
<b>Port Hedland</b>	<b>57</b>		
<b>TOTAL NUMBER OF REPORTABLE DEATHS</b>	<b>2192</b>	<b>908</b>	
<b>CASES COMPLETED</b>	<b>PERTH</b>	<b>COUNTRY</b>	<b>TOTAL</b>
<b>Finalised by Inquiry</b>	<b>1462</b>	<b>513</b>	<b>1975</b>
<b>Finalised by Inquest</b>	<b>33</b>	<b>13</b>	<b>46</b>
<b>TOTALS</b>	<b>1495</b>	<b>526</b>	<b>2021</b>

## Table E

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

<i>MANNER OF DEATH</i>	<i>2010-2011</i>	<i>2011-2012</i>	<i>2012-2013</i>	<i>2013-2014</i>	<i>2014-2015</i>
<b>Accident</b>	341	684	645	622	580
<b>Misadventure</b>	7	23	19	34	25
<b>Natural Causes</b>	777	881	975	849	915
<b>No Jurisdiction</b>	1	2	7	0	5
<b>Open Finding</b>	66	125	120	125	103
<b>Self Defence</b>	0	1	1	1	0
<b>Suicide</b>	150	404	383	336	340
<b>Unlawful Homicide</b>	45	72	75	69	53
<b>TOTALS</b>	<b>1387</b>	<b>2192</b>	<b>2225</b>	<b>2036</b>	<b>2021</b>

## **Post Mortem Examinations**

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

Under section 34(1) of the Coroners Act, if a coroner reasonably believes that it is necessary for an investigation of a death, the coroner may direct a pathologist or a doctor to perform a post mortem examination on the body. A post mortem examination is a detailed medical examination of the body of a person who has died, undertaken for the purpose of investigating the death.

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

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

## **Objections to Post Mortem Examinations**

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

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

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

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

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

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

## Table F

Table F below shows the number of post mortem examinations and the number of objections received in the 2014/15 year and the outcomes:

Deaths reported to Coroner's Court of Western Australia:

<i>REPORTED DEATHS</i>	
Immediate post mortem	<b>41</b>
No objection to post mortem	<b>1842</b>
Objection to post mortem	<b>279</b>
No post mortem conducted (missing person etc)	<b>30</b>
<b>NUMBER OF REPORTED DEATHS</b>	<b>2192</b>

Outcomes in cases where an objection was initially received:

<i>OBJECTIONS TO POST MORTEMES</i>	
Objection accepted	<b>183</b>
Objection withdrawn	<b>93</b>
Objection withdrawn after coroner overruled	<b>3</b>
Applications to Supreme Court	<b>0</b>
<b>TOTAL OBJECTIONS TO POST MORTEMES</b>	<b>279</b>

## **Coronial Counselling Service Functions**

Any person coming into contact with the coronial system may seek the assistance of the Coronial Counselling Service. The service is attached to the Coroner's Court of Western Australia under section 16 of the Coroners Act. The Coronial Counselling Service is on call from 7:00 am to 6:00 pm every day of the year including public holidays.

There are three coronial counsellors attached to the Coroner's Court of Western Australia, all of whom have qualifications in psychology or social work. Over the past reporting year, senior coronial counsellor Dr Francesca Bell and coronial counsellors Ms Kris Trevaskis and Mr Phil Riseborough have dedicated many hours to talking to persons who come into contact with the Office. They aim to impart clear and accurate information, with compassion. They have a deep understanding of the grieving process.

Coronial counsellors provide information to the next of kin about the progress of their loved one's case through the coronial system. They explain the process and the timelines involved when a senior next of kin objects to a post mortem examination.

Coronial counsellors are able to offer short term counselling in relation to grief, loss, and trauma. Where appropriate they will offer information about referral options.

Coronial counsellors are able to facilitate the viewing of selected case material from the coronial files to assist next of kin to better understand what happened to their loved one. This process involves supporting the next of kin during the viewing as appropriate and being available to answer questions.

Coronial counsellors are able to link people to the court companion service where volunteers are available to explain inquest proceedings and to accompany next of kin to inquests if required. They are able to attend at the State Mortuary to support next of kin if they require that support when viewing their loved one. They will conduct home visits if required and if it is possible.

Part of the remit of the Coronial Counselling Service is to assist in the Disaster Victim Identification process. In March and again in July 2014, two plane disasters meant that this process was activated. Tragedies of such scale require the involvement of many different people from multiple agencies, such as the Western Australia Police, the Australian Federal Police, forensic specialists, and the Department of Foreign Affairs and Trade. The coronial counsellor's role is, above all, to try to minimise any additional trauma to bereaved family members as they are involved in a confronting process at a time when they are shocked and grieving. Additionally, the coronial counsellors assist with the collection of information, they liaise with other agencies to provide the State Coroner with information concerning Western Australian deceased, and they work to support the aims of the other agencies involved. These aims were diligently pursued by the coronial counsellors following the Malaysian Airlines disasters of 2014.

The Coronial Counselling Service is in the process of identifying culturally sensitive counselling services, particularly in regional areas of Western Australia. This endeavour will facilitate access to appropriate care and support for Indigenous people who need to interact with the coronial system or attend an inquest.

At the time of writing this report Ms Trevaskis has retired after many years exceptional service and I acknowledge her efforts.

### Table G

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

<i>TYPE OF SERVICE</i>	<i>2010-2011</i>	<i>2011-2012</i>	<i>2012-2013</i>	<i>2013-2014</i>	<i>2014-2015</i>
Phone, Office/Home Visits	<b>4204</b>	<b>5196</b>	<b>6251</b>	<b>6529</b>	<b>6979</b>
Offers of Service	<b>919</b>	<b>949</b>	<b>933</b>	<b>1092</b>	<b>1377</b>
Mortuary/file viewings	<b>896</b>	<b>1538</b>	<b>1971</b>	<b>2129</b>	<b>2397</b>
<b>TOTAL CONTACTS</b>	<b>6019</b>	<b>7683</b>	<b>9155</b>	<b>9750</b>	<b>10753</b>

For the 2014/2015 year the above categories are explained as follows:

- Phone, Office/Home visits refers to all telephone calls (6734) visits to home addresses (23) and attendances at other offices or attendances by others at the Court (222);
- Offers of Service refers to letters offering counselling (1377); and
- Mortuary/file viewings refers to emails (1007), interoffice liaison (1388) and mortuary contact (2).

## Coronial Ethics Committee Functions

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

Coronial data is confidential. An application for the provision of coronial data must be accompanied by a detailed written submission to the Coronial Ethics Committee. Applications are primarily made for research purposes. The Coronial Ethics Committee meets quarterly (or more frequently, if required) to consider each application, and attempts to strike a balance between family concerns (including privacy, confidentiality, and consent issues), and the benefits of research to the community at large. Once an application has been considered, the Coronial Ethics Committee makes its recommendation to the State Coroner about whether the coronial data sought should be released, and under what conditions.

The membership of the Coronial Ethics Committee aims to draw from a range of representative categories so that a broad cross section of views may be put forward for discussion. The Coroner's Court of Western Australia is well served by the considerable work done by Coronial Ethics Committee members. They make their services available on a voluntary basis in a sensitive area, which has the potential to make a vital contribution to the coroner's death prevention role.

The members of the Coronial Ethics Committee are as follows:

<b>Dr Adrian Charles (until July 2014)</b>	Chairperson, Paediatric Pathologist, Princess Margaret Hospital
<b>Dr Jodi White</b>	Deputy Chairperson, Forensic Pathologist, PathWest
<b>Associate Professor Jennet Harvey</b>	Department of Pathology, UWA
<b>Mr Barry King</b>	Coroner
<b>Mr Jim Fitzgerald</b>	Lay member
<b>Ms Heather Leaney</b>	Lay Member
<b>Ms Debra Zanella (from May 2015)</b>	Member with counselling background
<b>Reverend Brian Carey</b>	Member with a pastoral background
<b>Ms Christine Pitt</b>	Legal Member
<b>Kate Ellson</b>	Secretary, Legal Member, Senior Counsel Assisting

In May 2015, the Coronial Ethics Committee welcomed a new member, Ms Debra Zanella. Ms Zanella comes to the Committee with a strong background in counselling services in the not for profit sector. The Committee gratefully acknowledges her input.

Following Dr Charles' retirement, the Committee met to elect a new Chairperson. At the time of writing this Report, this process is underway.

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

**Table H**

<b>Number of Projects Considered</b>	<b>Number of projects approved</b>	<b>Number of projects not approved</b>
13	13	0
<b>Number of Requests for renewal Considered</b>	<b>Number of Requests for renewal Approved</b>	<b>Number of Requests for renewal Not approved</b>
1	1	0

## Principal Registrar and Coroner's Registrars

The Principal Registrar and the Coroner's Registrars have worked hard to discharge their functions in a timely fashion and when necessary on an urgent basis, in the furtherance of the efficient administration of the coronial system for Western Australia. They have met the challenges of an increasing workload with care and diligence.

Coroner's registrars are appointed under section 12 of the Coroners Act. They have statutory functions under section 13 of the Coroners Act and they exercise the powers or duties of a coroner that are delegated to them by the State Coroner in writing under section 10 of the Coroners Act. There are six coroner's registrars at the Coroner's Court of Western Australia, four of whom exercise delegated functions under section 10 of the Coroners Act, one of whom is the Principal Registrar, Mr Gary Cooper. They exercise their delegations contemporaneously with their other functions.

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

A coroner's registrar's delegated functions under section 10 and statutory functions under section 13 include, but are not limited to, receiving information about a death which a coroner is investigating other than at an inquest, issuing summonses requiring witnesses to attend at inquests, directing that a pathologist or a doctor perform a post mortem examination, authorising the release of the body following the post mortem examination and authorising tissue donations under the *Human Tissue and Transplant Act 1982*. In addition the Principal Registrar and two other coroner's registrars have delegated functions empowering them to restrict access to a place where the death occurred, or where the event which caused or contributed to the death occurred. Of necessity, a coroner's registrar is contactable at any time of the day or night, every day of the year. The Principal Registrar provides mentoring and support to all coroner's registrars.

The Principal Registrar deals with incoming notifications and requests to the Coroner's Court of Western Australia and assesses those incoming matters for referral to the State Coroner where they involve the exercise of non-delegated statutory functions.

The Principal Registrar executes the State Coroner's directions in relation to the conduct of coronial investigations. He performs the role of Business Lead for the Coroner's Court Legislative Review Project.

Over the past reporting year the Principal Registrar took a lead role in co-ordinating the administration of Disaster Victim Identification response for the Malaysian Airlines disasters of 2014 concerning MH370 and MH17.

The Principal Registrar represents the State Coroner at internal and external forums/meetings. On behalf of the State Coroner, he liaises with members of the Western Australia Police, officers from the Department of Health and the office of the Ombudsman, and numerous other government and non-government agencies. He provides education and information sessions to health and legal professionals and other organisations on a regular basis as part of a community education strategy.

## **Counsel Assisting the Coroner**

There are three counsel who assist the coroners with the preparation, management and conduct of inquest hearings. Ms Kate Ellson continued her work as senior counsel assisting for the coroners and as secretary to the Coronial Ethics Committee throughout the past reporting year. She has worked hard to continue the development of the Coroner's Court's call-over system and to facilitate the listing of matters for inquest in a timely way.

Ms Ilona O'Brien and Mr Toby Bishop commenced work as counsel assisting for the coroners in November 2014 and December 2014, respectively. Since commencing their employment, they have both worked hard to ensure matters in their respective practices have been finalised in a timely way.

All three counsel assisting have diligently executed their functions. They have primarily focussed on preparing the backlog inquests for hearing and through their efforts, they have assisted in reducing the number of aged matters awaiting hearing by a coroner.

## **Police Assisting the Coroner**

Sergeant Lyle Housiaux and Senior Constable Eric Langton have served as a critical link between the Office of the State Coroner and the Coronial Investigation Unit of the Western Australia Police.

They provide significant assistance to the coroners in the preparation of matters for inquest, including the gathering of evidence where necessary.

They provide ongoing assistance to coroner's investigators state-wide in relation to practices and procedures for the conduct coronial investigations, thereby contributing to consistency of practice in this area.

Sergeant Housiaux has continued to ably perform the role of assisting the coroner in Court in relation to the conduct a number of inquests throughout the year, thereby assisting with the work flow in this area.

Both police officers through their efforts have made a valuable contribution to the conduct and/or finalisation of a significant number of coronial investigations.

## Inquests

Table I below shows the total number of inquests (**46**) finalised in the 2014/15 reporting year. An inquest is finalised when the coroner signs the inquest finding.

**Table I**

<i>SURNAME OF DECEASED</i>	<i>DATE OF DEATH</i>	<i>DATE OF INQUEST</i>	<i>FINDING</i>	<i>DATE OF FINDING</i>
<b>BEASLEY, Delray</b>	Between 14/06/2010 & 10/07/2010	22/05/2014 & 26/05/2014	Open Finding	08/07/2014
<b>*KING, Michael John</b>	15/03/2013	17/03/2014	Natural Causes	10/07/2014
<b>*WILLIAMS, Adrian Bernard</b>	14/04/2013	10/06/2014	Natural Causes	22/07/2014
<b>DANIEL, Nola Inez</b>	07/01/2010	16, 17 & 19/06/2014	Accident	23/07/2014
<b>VINCENT, Ian Bradley</b>	08/12/2012	15/07/2014	Accident	04/08/2014
<b>#NELSON, Kane Edwin</b>	08/12/2012	15/07/2014	Accident	04/08/2014
<b>LAHENGKING, Daniel</b>	15/08/2009	28-29/05/2014	Open Finding	29/08/2014
<b>^CARTER, Shionah Violet Teneille</b>	15/08/2010	17/06/2014	Unlawful Homicide	12/09/2014
<b>*HUMES, Peter Philip</b>	24/11/2010	30-31/07/2014	Suicide	12/09/2014
<b>^WARE, Benjamin Alfred</b>	14/04/2011	4-5/06/2014	Accident	26/09/2014
<b>CAPORN, Leon</b>	07/07/2010	8-9/09/2014	Accident	02/10/2014
<b>STITT, Tamar Jemima Sabbath</b>	12/11/2009	5-9 & 15/05/2014	Natural Causes	09/10/2014
<b>*HANSON, Gillian</b>	20/06/2010	7-9/07/2014	Natural Causes	17/10/2014
<b>*ETHAN, (Suppression Order on Name)</b>	14/11/2010	10-11/09/2014	Suicide	17/10/2014
<b>*WARD, Francis Robert</b>	08/09/2013	23/09/2014	Accident	22/10/2014

<b>*BABY XAVIER (Suppression Order on Name)</b>	13/04/2012	17/10/2014	Natural Causes	27/10/2014
<b>#MORAN, John Joseph</b>	(unknown)	06/11/2014	Open Finding	07/11/2014
<b>*TS (Suppression Order on Name)</b>	15/10/2010	16-18/09/2014	Natural Causes	18/11/2014
<b>*JAMES, Robert (aka Luckie)</b>	01/02/2013	31/10/2014	Natural Causes	21/11/2014
<b>#TAYLOR, James Patrick</b>	(unknown)	8-10/10/2014	Open Finding	15/12/2014
<b>BC (Suppression Order on Name)</b>	29/06/2010	20-22/5/2014	Natural Causes	17/12/2014
<b>*BETHANY (Suppression Order on Name)</b>	27/02/2012	04/11/2014	Natural Causes	19/12/2014
<b>*BABY W (Suppression Order on Name)</b>	24/09/2011	07/10/2014	Open Finding	19/12/2014
<b>JEFFERY, Gyan Murray</b>	30/09/2011	19-20/11/2014	Open Finding	30/12/2014
<b>*GRUICI, Gheorghe</b>	25/06/2013	11/12/2014	Natural Causes	30/12/2014
<b>^McLEAN, Steven Walter</b>	30/04/2011	21-22/10/2014	Accident	08/01/2015
<b>^WALLAM, Shane Henry</b>	30/04/2011	21-22/10/2014	Accident	08/01/2015
<b>ZELE, Petra</b>	01/06/2010	25/11 – 01/12/2014	Natural Causes	15/01/2015
<b>MORIARTY, Myosotis Julianna</b>	On or about 18/12/2010	12 & 14/01/2015	Misadventure	09/02/2015
<b>TAO, Christopher Ling</b>	10/09/2010	12-16/12/2014	Natural Causes	13/02/2015
<b>*KLAVINS, Valfrids</b>	09/01/2012	03/02/2015	Natural Causes	24/02/2015
<b>DOIG, Peta Susan</b>	04/01/2013	19/01/2015	Natural Causes	26/02/2015
<b>KEARNEY, John Vincent</b>	30/03/2010	7 & 11-13/08/2014	Suicide	26/02/2015

MARSHALL, Tracy Margaret	21/02/2011	22/01/2015	Suicide	26/02/2015
#LEVINGE, Thomas Francis	07/10/2013	03/03/2015	Suicide	17/03/2015
MAHENTHIRAN, Ramaiah	22/07/2013	19/09/2014	Natural Causes	27/03/2015
LANE, Danielle Kiesha	04/01/2012	24-25/03/2015	Misadventure	17/04/2015
TAUAI, Amanda Dana	17/03/2012	24-25/02/2015	Natural Causes	25/05/2015
#LEOPOLDO, Samuel Eya	On or about 17/11/2011	23/01/2015	Accident	26/05/2015
^KING, Justin Aaron	30/09/2011	13-15/04/2015	Accident	02/06/2015
^BEVEN, Luke Ross	13/01/2012	10/02/2015	Unlawful Homicide	05/06/2015
BABY B (Suppression Order on Name)	09/05/2010	30/09 – 10/10/2014	Natural Causes	08/06/2015
BABY C (Suppression Order on Name)	12/02/2010	30/09 – 10/10/2014	Natural Causes	08/06/2015
BABY P (Suppression Order on Name)	03/07/2011	30/09 – 10/10/2014	Natural Causes	08/06/2015
*MKP (Suppression Order on Name)	26/12/2011	29/05/2015	Natural Causes	18/06/2015
*ROBINSON, Shane John	10/06/2011	10/02/2015	Accident	22/06/2015

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

# = Missing person

\* = Person held in care

The balance of the matters listed (20) were discretionary inquests

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

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

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

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

#### Table J

Table J below shows the number of inquests (**6**) finalised in 2014/15 year into deaths that appeared to be caused, or contributed to, by any action of a member of the Police Force.

<i>NAME</i>	<i>DATE OF DEATH</i>	<i>DATE OF INQUEST</i>	<i>FINDING</i>	<i>DATE OF FINDING</i>
<b>CARTER, Shionah Violet Teneille</b>	15/08/2010	17/06/2014	Unlawful Homicide	12/09/2014
<b>WARE, Benjamin Alfred</b>	14/04/2011	4-5/06/2014	Accident	26/09/2014
<b>McLEAN, Steven Walter</b>	30/04/2011	21-22/10/2014	Accident	08/01/2015
<b>WALLAM, Shane Henry</b>	30/04/2011	21-22/10/2014	Accident	08/01/2015
<b>KING, Justin Aaron</b>	30/09/2011	13-15/04/2015	Accident	02/06/2015
<b>BEVEN, Luke Ross</b>	13/01/2012	10/02/2015	Unlawful Homicide	05/06/2015

Five investigations concerned the coroner's independent scrutiny of police pursuits (investigations into the deaths of Messrs Ware, McLean, Wallam, King and Beven). One investigation concerned the coroner's independent scrutiny of compliance with police protocols and procedures following a 000 call (Ms Carter). In each case the coroner found that the police did not cause or contribute to the death.

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

## SUSPECTED DEATHS

Under section 23 of the Coroners Act where a person is missing and the State Coroner has reasonable cause to suspect that the person has died and that the death was a reportable death, the State Coroner may direct that the suspected death of the person be investigated. Where the State Coroner has given such a direction a coroner must hold an inquest into the circumstances of the suspected death of the person, and if the coroner finds that the death of the person has been established beyond all reasonable doubt, into how the death occurred and the cause of the death.

### Table K

Table K below shows the number of inquests **(5)** finalised in 2014/15 year into suspected deaths.

<i>NAME</i>	<i>DATE OF DEATH</i>	<i>DATE OF INQUEST</i>	<i>FINDING</i>	<i>DATE OF FINDING</i>
<b>NELSON, Kane Edwin</b>	08/12/2012	15/07/2014	Accident	04/08/2014
<b>MORAN, John Joseph</b>	(unknown)	06/11/2014	Open Finding	07/11/2014
<b>TAYLOR, James Patrick</b>	(unknown)	8-10/10/2014	Open Finding	15/12/2014
<b>LEVINGE, Thomas Francis</b>	07/10/2013	03/03/2015	Suicide	17/03/2015
<b>LEOPOLDO, Samuel Eya</b>	17/11/2011	23/01/2015	Accident	26/05/2015

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

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

## PERSONS HELD IN CARE

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

- (a) a person under, or escaping from, the control, care or custody of –
  - (i) the CEO as defined in section 3 of the *Children and Community Services Act 2004*;
  - (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;
- (aa) a person for whom the CEO as defined in the *Court Security and Custodial Services Act 1999* is responsible under section 10, 13, 15 or 16 of that Act, whether that person is at a custodial place as defined in that Act, is being moved between custodial places or escapes, or becomes absent, from a custodial place or during movement between custodial places.
- (b) a person admitted to a centre under the *Alcohol and Drug Authority Act 1974*;
- (c) a person who is an involuntary patient within meaning of the *Mental Health Act 1996* or who is apprehended or detained under Part 3 of that Act; or
- (d) a person detained under the *Young Offenders Act 1994*;

Table L below shows the number of inquests **(15)** finalised in 2014/15 into deaths of persons held in care.

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

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

**Table L**

Deaths of persons held in care finalised in the 2014/15 year

<i>NAME</i>	<i>DATE OF DEATH</i>	<i>DATE OF INQUEST</i>	<i>FINDING</i>	<i>DATE OF FINDING</i>
<b>KING, Michael John</b>	15/03/2013	17/03/2014	Natural Causes	10/07/2014
<b>WILLIAMS, Adrian Bernard</b>	14/04/2013	10/06/2014	Natural Causes	22/07/2014
<b>HUMES, Peter Philip</b>	24/11/2010	30-31/07/2014	Suicide	12/09/2014
<b>HANSON, Gillian</b>	20/06/2010	7-9/07/2014	Natural Causes	17/10/2014
<b>ETHAN, (Suppression Order on Name)</b>	14/11/2010	10-11/09/2014	Suicide	17/10/2014
<b>WARD, Francis Robert</b>	08/09/2013	23/09/2014	Accident	22/10/2014
<b>BABY XAVIER (Suppression Order on Name)</b>	13/04/2012	17/10/2014	Natural Causes	27/10/2014
<b>TS (Suppression Order on Name)</b>	15/10/2010	16-18/09/2014	Natural Causes	18/11/2014
<b>JAMES, Robert (aka Luckie)</b>	01/02/2013	31/10/2014	Natural Causes	21/11/2014
<b>BETHANY (Suppression Order on Name)</b>	27/02/2012	04/11/2014	Natural Causes	19/12/2014
<b>BABY W (Suppression Order on Name)</b>	24/09/2011	07/10/2014	Open Finding	19/12/2014
<b>GRUICI, Gheorghe</b>	25/06/2013	11/12/2014	Natural Causes	30/12/2014
<b>KLAVINS, Valfrids</b>	09/01/2012	03/02/2015	Natural Causes	24/02/2015
<b>MKP (Suppression Order on Name)</b>	26/12/2011	29/05/2015	Natural Causes	18/06/2015
<b>ROBINSON, Shane John</b>	10/06/2011	10/02/2015	Accident	22/06/2015

## PERSONS HELD IN CARE - SPECIFIC REPORTS

**Michael John KING**

***Inquest held in Perth 17 March 2014, investigation finalised 10 July 2014***

Mr Michael John King (the deceased) died on 15 March 2013 at Fremantle Hospital. The cause of death was ischaemic heart disease in association with coronary arteriosclerosis. The State Coroner found the manner of death was natural causes. The deceased was 48 years old.

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

The deceased had been in custody for various offences since 1986. At the time of his death he was obese and he had a complex medical history which included significant pre-existing heart disease, high cholesterol, asthma and diabetes. He was a smoker and had commenced abusing alcohol at a young age. He had a mild intellectual deficit. He was assessed for, but not ever diagnosed with, a mental illness.

The deceased was a difficult prisoner to supervise and to treat. He displayed aggression towards other prisoners, and due to behavioural issues, on a number of occasions he was deemed unsuitable to take part in group therapeutic treatment. He was volatile and he had limited behavioural control.

Over the period of his incarceration, he was transferred to a number of prisons and concern had been expressed by his family about the continuity of his medical treatment in light of transfers.

The State Coroner explored the deceased's supervision, treatment and care in the various prisons, taking into account his physical and mental health requirements, and found that it was appropriate and reasonable. There was nothing to suggest that the deceased's transfers were as a result of anything other than properly considered decisions, and some of them were necessitated by the deceased's own problematic behaviours. The State Coroner did not express any concerns regarding the deceased's continuity of care within the context of the number of prison transfers.

The State Coroner found that the deceased was frequently non-compliant with his medications and on occasion refused to attend medical appointments. Proper and reasonable efforts were made to counsel the deceased as to the consequences to his health and to encourage him to take his medications and attend medical appointments and medical parades. She was satisfied that despite his intellectual deficit, the deceased

understood there was a need to take his medications, for the sake of his health, but that on many occasions he made an informed decision not to take them.

In the week prior to his death the deceased received essential daily medications on four occasions. On the afternoon of 15 May 2013 the deceased was preparing for a visit at the Hakea Prison Visitors Centre when he became dizzy and unstable on his feet. The alert was initiated. The deceased became unresponsive and CPR was commenced. SJA paramedics took over the resuscitation attempts and the deceased was taken to Fremantle Hospital, where CPR was continued. The deceased died later that day at Fremantle Hospital, of a heart attack arising on the back of significant pre-existing heart disease.

The State Coroner did not make any recommendations.

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

**Adrian Bernard WILLIAMS**

**Inquest held in Perth 10 June 2014, investigation finalised 22 July 2014**

Mr Adrian Bernard Williams (the deceased) died on 14 April 2013 at Royal Perth Hospital. The cause of death was pneumonia in a man with underlying advanced metastatic cancer and chronic airways disease. The coroner found the manner of death was natural causes. The deceased was 63 years old.

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

The deceased had a history of severe chronic obstructive airways disease, ischaemic heart disease, lung and liver cancer and non-Hodgkin's lymphoma. On 7 March 2013 the deceased was registered as a Phase 2 terminally ill prisoner as death was considered imminent. He continued to receive treatment for his conditions.

Prior to the deceased's death he was receiving palliative chemotherapy on a three weekly basis and oxygen three to four times a day for emphysema.

The deceased was transported from the Casuarina Prison infirmary to Royal Perth Hospital on 4 April 2013 with acute respiratory distress. His condition deteriorated until he died there on 14 April 2013.

The Coroner was satisfied that the quality of the supervision, treatment and care of the deceased while in custody was appropriate.

The Coroner did not make any recommendations.

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

**Peter Philip HUMES**

**Inquest held in Perth 30-31 July 2014, investigation finalised 12 September 2014**

Mr Peter Philip Humes (the deceased) died on 24 November 2010 at Hakea Prison. The cause of death was ligature compression of the neck (hanging). The coroner found the manner of death was suicide. The deceased was 38 years old.

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

In late October 2010 the deceased was arrested on an outstanding bench warrant and remanded in custody to await his next court appearance. He was interviewed by a prison officer and a nurse on his admission into Hakea and, based upon his answers and the information available at that time, neither person formed the view the deceased was at risk of self-harm or suicide at that time.

The deceased was seen by a doctor on 5 November 2010 thirteen days after having been admitted to prison. The deceased reported feeling agitated and having difficulty getting to sleep. The doctor prescribed the deceased some medication that is generally used to treat depression but in lower doses acts as a sedative, to treat the deceased's agitation. Some blood tests and a later medical review were also arranged. The doctor concluded the deceased was not suicidal.

On 10 November 2010 the deceased was spoken to by prison security staff in relation to a telephone call he had made, that was to be referred to police and might lead to further charges being laid against him. He attended court on 16 November 2010 in relation to his existing charges and was again remanded in custody to a further date in December 2010.

On 23 November 2010 the deceased was visited by a paralegal from the Aboriginal Legal Service. They were missing some of the relevant material relating to his charges, so no discussion was had about the likely outcome of the proceedings at that time. Arrangements were made to visit him the following week when the rest of the material had been obtained.

The deceased spoke to his parents later that afternoon and early evening and he appeared his usual self.

The deceased died sometime between 10.50 pm on 23 November and 4.50 am on 24 November 2010 while locked down in his cell. He had been allocated a cell mate until two days before, but after that cell mate was moved he occupied the cell alone.

He was found by prison officers at approximately 4.50 am hanging from the bar of a window grille by a ligature made out of fabric and tied around his neck. Efforts to resuscitate him were unsuccessful.

The inquest focussed primarily on whether there had been any signs prior to that evening that the deceased was at risk of self-harm or suicide. Other than some reports that the deceased seemed a little 'down', none of the people who had been in contact with the deceased leading up to his death reported seeing any behaviour that might have signalled the deceased was having suicidal thoughts.

In commenting on the quality of the deceased's supervision, treatment and care, the coroner said that the most concerning aspect of the deceased's care and supervision was his placement in a cell with an obvious ligature point, namely window bars.

Evidence was heard about the steps taken by the Department of Corrective Services to minimise the risk of suicide by hanging in the prison environment since the deceased's death, including modifying the window grille to remove the obvious ligature hanging point. Therefore, the coroner did not make any recommendations.

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

**Gillian HANSON**

**Inquest held in Bunbury Court House 7-9 July 2014, investigation finalised 17 October 2014**

Ms Gillian Hanson (the deceased) died on 20 June 2010 at Bunbury Regional Hospital. The cause of death was hyponatremia. The Deputy State Coroner found the manner of death was natural causes. The deceased was 62 years old.

Immediately before death the deceased was a "person held in care" under the *Coroners Act 1996* because she was an involuntary patient under the *Mental Health Act 1996*. The deceased was residing as a patient at the Bunbury Regional Hospital Psychiatric Unit at the time of death.

The deceased was admitted as an involuntary patient to the Psychiatric Unit at Bunbury Regional Hospital on the afternoon of Friday 18 June 2010 following her refusal to allow Community Mental Health workers to administer her regular medication. She died the following Sunday while still an involuntary in-patient, following the reinstatement of her essential medication.

The inquest focused on the quality of the supervision, treatment and care the deceased received while an involuntary patient.

The Deputy State Coroner found that the deceased had suffered with mental health issues for much of her life and had managed her condition with the assistance of treatment and medication. She was generally managed in the community by a Mental Health Team but on occasions her condition deteriorated to the extent she required hospital admission to stabilise her medication. In the past this had frequently been as a voluntary patient.

On 16 June 2010 the deceased became suspicious when her regular Community Mental Health Nurse did not visit her home to review her and provide her with depo medication because he was on leave. She refused to be medicated. Her mental state deteriorated.

On the afternoon of the 18 June 2010 the deceased's Community Mental Health Team visited her and when they were unable to persuade her to take her medication her psychiatrist believed it was necessary she be provided with an involuntary hospital admission for the weekend.

The deceased was admitted as an involuntary patient to Bunbury Regional Hospital Psychiatric Unit that afternoon, with assistance from the police. The deceased was medically assessed by the Psychiatric Medical Officer on ward but was extremely agitated and un-cooperative. A physical examination was not performed due to a concern it would distress her unnecessarily. She did not appear to the psychiatric medical officer to be in need of urgent medical review.

On the morning of Saturday 19 June 2010 the deceased was assessed by the Consultant Psychiatrist and found to be still uncooperative. He confirmed her involuntary status. He assessed her as suffering from chronic schizophrenia with worsening symptoms and a lack of insight as to her need for medication. The Psychiatrist asked for routine blood and urine investigations as soon as the deceased became cooperative enough for those to be instigated without causing excessive distress. Following that examination she was provided with her routine medications which included SSRI Escitalopram and her other regular medication.

Throughout the rest of the day the deceased was monitored as she would allow by the mental health nurses. That evening she was found to be drinking excessively and vomited. This can be seen with psychotic episodes.

At approximately 1.00 am on the morning of the 20 June 2010 the deceased was located unresponsive on the floor of her room. Full resuscitation was commenced but was not successful. Immediately prior to resuscitation a blood sample was taken before the commencement of IV fluid therapy.

The analysis of results of that blood test recorded a sodium level of 114mmls per litre, consistently described by all practitioners as very low and a level at which serious symptoms of hyponatremia would be apparent quite quickly.

It is clear on the whole of the evidence that although hyponatremia is a recognised side effect of some SSRI's, and other medications, including some anti-psychotics, it is a relatively rare, although recognised side effect. While the Consultant Psychiatrists were not aware of a recorded death related to hyponatremia and those medicated for mental health issues, they all believed it had been a contributor to the death of the deceased in this case, in conjunction with her excessive drinking of water, nausea and vomiting.

The Deputy State Coroner found that there was no issue with the supervision, treatment and care the deceased received while an involuntary inpatient in the Bunbury Regional Hospital Psychiatric Unit.

The Deputy State Coroner made a recommendation in respect of elevating awareness for medical practitioners of the potential for SSRI medications to contribute to hyponatremia in those medicated for psychosis.

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

**Ethan (Subject to Suppression Order)**

**Inquest held in Perth 10-11 September 2014, investigation finalised 17 October 2014**

Ethan [name suppressed] (the deceased) died on the morning of 14 November 2010. The cause of death was as a result of ligature compression of the neck (hanging). The Deputy State Coroner found the manner of death was suicide. The deceased was 15 years old.

Immediately before death the deceased was a “person held in care” under the *Coroners Act 1996* because he was subject to a protection order pursuant to the *Children and Community Services Act 2004*.

The deceased child had a dysfunctional infancy and was taken into care at two years of age. He then spent two years at a childrens’ home before being placed in foster care where he remained until his foster father found him suspended from a tree in the rear garden of his foster home on the 15 November 2010.

The inquest heard evidence from a psychologist with the Department of Child Protection and Family Support and an independent psychiatrist specialising in paediatric development. Their combined evidence indicated the deceased child was likely to have suffered cumulative harm in early childhood which would disorganise his neural growth and spread, and cause strong consolidation of neural pathways associated with a flight/fight or fear response. Also, evidence was heard that chronically high levels of stress hormones in the infant brain leads to permanent increases in a child’s stress hormone production which predisposes a child to hyper vigilance, hyper arousal, impulsivity and poor behaviour control. These factors are relevant when considering a child’s later learning and educational experiences. This type of compromised brain development produces adolescent children less equipped to manage daily life stressors and demands.

The deceased child was likely to have suffered frontal executive system difficulties as a result of being in an abusive and neglectful environment at critical times in his brain’s development. While the deceased child should have been removed from the inappropriate environment immediately and placed in an appropriate environment, it was not always possible to do that, especially when looking at the availability of suitable placements. In this case the deceased child did not receive a suitable placement until after four years of age by which time much damage would have been incurred. In addition, even after his appropriate placement with his foster parents there were some difficulties during his early years in that placement related to inappropriate biological family contact.

By the time the deceased child was in his teens he was subject to normative adolescent brain changes which can cause poor decision making in an emotional context, on top of his already acquired difficulties.

Any foster placement was going to be difficult for all concerned no matter how supportive and strong that environment was. It was the combined view of the experts the deceased child's placement with his foster parents had been an excellent placement, and they had managed very well as a family, taking into account the normal adolescent problems superimposed upon his dysfunctional childhood development.

The expert psychiatrist indicated she believed any child who had a history of disadvantage is at increased vulnerability to suicidal ideation and completed suicide, especially when compounded by a lack of impulse control.

The Deputy State Coroner found the Department for Child Protection and Family Support placed the deceased in a safe, protective, loving and supportive environment after four years of age. Consequently, it was found he obtained the best possible supervision, treatment and care. Despite this the deceased remained vulnerable to a lack of impulse control around times of normal adolescent stress. Tragically, the deceased overreacted to a boundary setting situation and hanged himself.

The Deputy State Coroner did not make any recommendations.

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

**Francis Robert WARD**

***Inquest held in Perth 23 September 2014, investigation finalised 22 October 2014***

Mr Francis Robert Ward (the deceased) died on 8 September 2013 at Rockingham General Hospital. The cause of death was pneumonia in a man with traumatic brain injury. The Deputy State Coroner found the manner of death was accident. The deceased was 90 years old.

Immediately before death the deceased was a “person held in care” under the *Coroners Act 1996* because he was a sentenced prisoner and pursuant to the *Prisons Act 1981* he was in the custody of the Chief Executive Officer of the Department of Corrective Services. He was serving his sentence at Casuarina Prison.

The Coroner found the deceased had a number of co-morbid medical conditions and was at a high risk for mechanical falls. He was assessed as a falls risk by the nursing staff at Casuarina Prison and immediately prior to his death had been placed in the Casuarina Infirmary.

On 13 June 2013 the deceased suffered the first fall which appeared to initiate his terminal decline. He incurred a small right frontal subdual haematoma which was appropriately treated. On 17 August 2013 he had another fall and developed signs of a more extensive bleed. He was transferred to RPH where it was found he had a large acute subdural haemorrhage overlying a prior subacute/chronic subdural collection. Due to his age and frailty he was not a suitable candidate for neurosurgical intervention and was treated conservatively. He was returned to Casuarina Infirmary for palliative care until an alternative facility could be found to provide him with the high level of care he needed. On 20 August 2013 the deceased was classified as a phase two terminally ill prisoner because it was considered death was imminent.

On 6 September 2013 the deceased was in the process of being transferred to RPH for review but deteriorated on route and was taken to Rockingham General Hospital where he remained until his death on the 8 September 2013.

The Deputy State Coroner was satisfied that the deceased’s supervision, treatment and care were adequate and reasonable in all the circumstances.

The Deputy State Coroner did not make any recommendations.

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

***Baby Xavier (Subject to Suppression Order)***

***Inquest held in Perth 17 October 2014, investigation finalised 27 October 2014***

Baby Xavier [name suppressed] (the deceased) died on 13 April 2012. The cause of death was unascertained. The coroner found the manner of death was natural causes. The deceased was eight weeks old.

Immediately before death the deceased was a “person held in care” under the *Coroners Act 1996* because he was subject to a protection order pursuant to the *Children and Community Services Act 2004*.

The deceased was in the care of an experienced and responsible foster mother who had taken him to a holiday park for a few days with her young daughter and another foster child. The foster mother had put the deceased in a porta-cot to sleep and later found him not breathing and unresponsive. Paramedics took the deceased to Busselton District Hospital but he could not be revived.

A forensic pathologist conducted a post mortem but was unable to find a cause of death.

The coroner found that the care provided to the deceased was reasonable and appropriate. In particular, he ruled out co-sleeping and an unsafe sleeping environment as likely contributors to the death.

The coroner did not make any recommendations.

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

***TS (Subject to Suppression Order)***

***Inquest held in Perth 16-18 September 2014, investigation finalised 18 November 2014***

TS [name suppressed] (the deceased) died on 15 October 2010. The cause of death was unascertained but consistent with epileptic seizure. The coroner found the manner of death was natural causes. The deceased was 10 years old.

Immediately before death the deceased was a "person held in care" because he was subject to a protection order pursuant to the *Children and Community Services Act 2004*.

The deceased was reported to have begun having seizures in either 2007 or 2008. Around the same time the deceased's mother asserted that he had been diagnosed with ADHD and prescribed a drug containing clonidine for his ADHD, which also helped to control the seizures. When the prescription ran out, the deceased's mother began giving the deceased clonidine medication obtained from her own prescription. She later began giving the same medication to the deceased's sister on the basis she believed the deceased's sister also had ADHD.

On 24 April 2009 the deceased was taken to hospital after having more seizures at home. No seizures were witnessed at the hospital so he was discharged and further investigations were ordered. In May 2009 an EEG was performed that was reported as abnormal and suggestive of a susceptibility to epilepsy. Further investigations were recommended. However, other than an assessment in September 2009 (when the deceased was found not to meet the criteria for ADHD) no other appointments were attended, despite some follow up by the hospital. As a result, no formal diagnosis of epilepsy was made.

In March 2010 the Department for Child Protection and Family Support (the Department) was notified of concerns relating to the deceased's sister being administered clonidine inappropriately. Discussions were had with the deceased's parents about the need to cease the use of clonidine for both children, with the deceased needing to be weaned from the medication in a controlled manner. Nevertheless, on 9 April 2010 the deceased's sister was admitted to hospital with symptoms suggestive of clonidine overdose. In the end, both children were hospitalised in relation to their clonidine usage and were then taken into the provisional care of the Department. The deceased and his sister were placed in the care of their maternal grandparents with regular medical review. No evidence of seizure activity was noted during this time.

On 23 September 2010 a 2 year protection order was granted and the children remained in the care of their grandparents thereafter. The deceased appeared to be well looked after by his grandparents in a caring, loving and safe environment.

On 11 October 2010 the deceased had his final hospital medical review and was considered to be well and did not require regular medical follow-up.

On 14 October 2010 the deceased appeared to be normal and did not complain of being unwell. He went to bed at approximately 9.00 pm. The next morning he was discovered lying unresponsive in his bed. The deceased's grandparents commenced cardiopulmonary resuscitation until the ambulance paramedics arrived. Paramedics conducted observations of the deceased and certified life extinct.

Following a post mortem examination the forensic pathologist concluded that he was unable to identify a structural cause for the death and as such the cause of death was given as "unascertained". However, having excluded any structural cause and taking into account the deceased's previous history of seizures, the forensic pathologist formed the opinion that the appropriate cause of death was "unascertained (consistent with epileptic seizure). Alternatively, some pathologists use the term "SUDEP" or "sudden unexpected death in epilepsy". Additional evidence given at the inquest from Dr Walsh, a paediatric neurologist, supported the forensic pathologist's original opinion that the death was a SUDEP death, with Dr Walsh identifying a particular form of epilepsy as the likely cause of the seizure. He based his opinion on the available medical history.

On the basis of the expert medical evidence, the coroner concluded that while the preferred approach would have been to conduct further investigations in 2008 and onwards and explore the possibility of giving medication to the deceased to control his seizures, it could not be said that his death would have been prevented if this had been done. The coroner concluded that while considerable research has been conducted into SUDEP, it is still the case no complete solution has been found to prevent it.

The coroner was satisfied that there was nothing that the Department did or failed to do that contributed to the deceased's death.

The coroner did not make any recommendations.

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

**Robert JAMES (aka Philip Kevin LUCKIE and Robert John COUGHLIN  
Inquest held in Perth 31 October 2014, investigation finalised 21 November 2014**

Mr Robert James (the deceased) died on 1 February 2013 at Royal Perth Hospital. The cause of death was early bronchopneumonia in a man receiving palliative medical care for liver failure due to cirrhosis. The coroner found the manner of death was natural causes. The deceased was 45 years old.

Immediately before death the deceased was a “person held in care” under section 3 of the *Coroners Act 1996* because he was a sentenced prisoner and pursuant to the *Prisons Act 1981* he was in the custody of the Chief Executive Officer of the Department of Corrective Services. He was serving his sentence at the Walpole Work Camp.

The deceased was a long-term intravenous drug user. He was diagnosed with hepatitis C early in his life, which he contracted from a contaminated needle he had used. The infection proved resistant to treatment and he developed cirrhosis of the liver. He was suffering from that condition at the time he was imprisoned in 2010.

Medical progress notes record a general deterioration in the deceased’s health during his prison term. He was transferred to hospital on 51 separate occasions for appointments, emergencies and planned admissions. On 24 January 2013 the deceased was admitted to Royal Perth Hospital for the last time with a serious infection. He developed renal failure. The deceased was informed by doctors his prognosis was poor and he requested that he be classified as “Not for Resuscitation”.

On 1 February 2013 the deceased’s condition deteriorated further and he died that evening.

The coroner commented that there was no issue with the deceased’s supervision during his incarceration and that the quality of his treatment and care was appropriate and of a very high standard.

The coroner was satisfied that there was nothing that the Department for Corrective Services did or failed to do that contributed to the deceased’s death.

The coroner did not make any recommendations.

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

***Bethany (Subject to Suppression Order)***

***Inquest held in Perth 4 November 2014, investigation finalised 19 December 2014***

Bethany [name suppressed] (the deceased) died on 27 February 2012. The cause of death was consistent with epilepsy. The Deputy State Coroner found the manner of death was natural causes. The deceased was five years old.

Immediately before death the deceased was a “person held in care” under section 3 of the *Coroners Act 1996* because she was subject to a protection order pursuant to the *Children and Community Services Act 2004*.

The deceased child had been severely disabled from birth and required a high level of full time care for all aspects of daily living, including mobility, eating and hygiene. She was cared for by her grandmother and extended family with input from various government and not for profit organisations.

Due to the high level of care needed by the deceased child, as the child developed, her grandmother became one of the few who could interpret her needs with accuracy. This led to great dependency on her grandmother and the need for respite. On the periods of respite Bethany frequently suffered periods of difficulty due to being away from her grandmother’s care.

Ultimately Bethany, who had not been expected to survive her infancy, suffered a seizure on 27 February 2012, while at home and died. The Deputy State Coroner found that the Department for Child Protection and Family Support through the placement with Bethany’s grandmother, had provided Bethany with exceptional supervision, treatment and care.

The Deputy State Coroner did not make any recommendations.

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

***Baby W (Subject to Suppression Order)***

***Inquest held in Perth 7 October 2014, investigation finalised 19 December 2014***

Baby W [name suppressed] (the deceased) died on 24 September 2011. The cause of death was unascertained and the Deputy State Coroner could not determine a manner of death. This resulted in an Open Finding. The deceased was nine weeks and six days old.

Immediately before death the deceased was a person held in care under the *Coroners Act 1996* because he was subject to a protection order pursuant to the *Children and Community Services Act 2004*.

Baby W was taken into care due to his parents inability to look after him. His mother suffered serious health problems and both his biological parents led a dysfunctional and itinerant life style which could have caused Baby W serious developmental problems. Initially the Care and Protection Order was limited in the hope his parents would eventually be able to care for him but this did not occur prior to his death.

The foster placement provided for Baby W via Yorganop Association Inc. provided him with a happy, responsive, loving and nurturing environment. The placement was culturally appropriate and Baby W responded well to that environment and developed appropriate developmental for age progress and a much more settled sleep pattern.

Yorganop provides long term and short term foster placements for infants requiring culturally appropriate placements and as part of the training provided to Yorganop carers the issue of safe sleep practices is considered. All Yorganop carers need to be appropriately accredited by the Department for its placements.

On 24 September 2011 Baby W's foster carer had a family gathering at her home and at the end of the day, when taking the children inside, she noticed he had developed a slightly runny nose. He was provided with a dose of children's Panadol after feeding and before sleep. Baby W fell asleep in his carer's arms and once he was settled she placed him in his bassinet in his snuggle blanket. He was placed on his tummy with his face turned to the left. Baby W's carer was happy she had established a consistent sleep routine for Baby W. There was nothing about his presentation when she put him to sleep to cause her concern. She left the room and did not re-enter until the morning when she discovered him deceased in the bassinet face down.

A post mortem examination was unable to establish a cause of death for Baby W. It seems likely on the whole of the evidence his ability to breathe freely and effectively was to some extent compromised, possibly by his positioning on his tummy, and perhaps by a very mild respiratory deficiency due to a mild infection. There was no evidence he was not well cared for and the forensic pathologist considered the level of Panadol appropriate for the treating of a mild infection. The Deputy State Coroner considered infections tendered to elevate respiration due to an additional need for oxygen. A partially occluded airway may have compromised that effective respiration by a restriction in available oxygen and/or an elevation in the carbon dioxide level known as re-breathing. Once unresponsive as the result of the respiratory deficiency the potential for further occlusion of the airways, as the face relaxes into the adjoining surfaces, increased.

Other than a likely compromised airway there appeared to be little explanation for Baby W's death.

The Deputy State Coroner was satisfied the supervision, treatment and care of Baby W was of a good standard, noting that he was placed in a loving and caring environment. However, she raised a caution for carers to remember safe sleep guidelines for infants too small to maintain their own airways when placed in a position which may compromise their ability to breathe freely while they are not old enough to protect themselves by movement.

The Deputy State Coroner did not make any recommendations.

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

***Gheorghe GRUICI***

***Inquest held in Perth 11 December 2014, investigation finalised 30 December 2014***

Mr Gheorghe Gruici (the deceased) died on 25 June 2013 at Royal Perth Hospital. The cause of death was organ failure in an elderly man receiving terminal palliative care for renal failure, a chest infection and infective endocarditis. The coroner found the manner of death was natural causes. The deceased was 72 years old.

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

The deceased was in prison from 9 October 1997 until he died. Early in his incarceration the deceased frequently attended the prison medical centre complaining of “all-over pain” comprising headaches and pain in the legs, neck and abdomen. He also experienced hallucinations and delusions. His condition deteriorated further over time.

In January 2013 blood tests showed that the deceased had chronic renal failure, which was managed thereafter at the Royal Perth Hospital renal clinic. On 22 March 2013 the deceased was transferred to the Casuarina Prison infirmary due to the need for 24 hour nursing care. On 18 June 2013 he was transferred to Royal Perth Hospital where he remained until he died on 25 June 2013.

The coroner found that the deceased died on 25 June 2013 from organ failure in an elderly man receiving terminal palliative care for renal failure, a chest infection and infective endocarditis. The Coroner found that death occurred by way of natural causes.

The coroner found that the department’s care of the deceased was complicated by his serious mental illness, but that the deceased was provided with suitable treatment and care from departmental medical staff and through referrals to specialists and hospitals. The coroner found that during the deceased’s last days he was given appropriate palliative care until he died.

The coroner did not make any recommendations.

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

**Valfrids KLAVINS**

***Inquest held in Perth 3 February 2015, investigation finalised 24 February 2015***

Mr Valfrids Klavins (the deceased) died on 9 January 2012 at Sir Charles Gairdner Hospital. The cause of death was complications of mesothelioma. The coroner found the manner of death was natural causes. The deceased was 66 years old.

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

The deceased’s final period of imprisonment was from 1996 and from August 2006 he was incarcerated at Acacia Prison. In 2011 he was diagnosed with mesothelioma, possibly from previous exposure to asbestos.

On 16 December 2011 the deceased was registered as a phase two terminally ill prisoner, indicating that death was imminent.

On 30 December 2011 the deceased was transferred from the Acacia Prison Medical Centre to Swan Districts Hospital and from there to Sir Charles Gairdner Hospital, where he was treated palliatively until he died on 9 January 2012.

The coroner found that the quality of supervision, treatment and care of the deceased while in custody was appropriate.

The coroner did not make any recommendations.

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

***MKP (Subject to Suppression Order)***

***Inquest held in Perth 29 May 2015, investigation finalised 18 June 2015***

MKP [name suppressed] (the deceased) died on 26 December 2011. The cause of death was consistent with seizure disorder in association with long standing hypoxic ischaemic encephalopathy (known severe cerebral palsy). The Deputy State Coroner found the manner of death was natural causes. The deceased was 15 years old.

Immediately before death the deceased was a person held in care under the *Coroners Act 1996* because she was subject to a protection order pursuant to the *Children and Community Services Act 2004*.

The deceased had been severely disabled from birth with Level 5 Cerebral Palsy which significantly affected her ability to function independently. Her medical care was provided by a multi-disciplinary team who catered for her many medical difficulties and her every day care was provided by her foster carers in conjunction with a combination of services provided by the Cerebral Palsy Association and the Disability Services Commission working in conjunction with the Department for Child Protection and Family Support (the Department) and Princess Margaret Hospital.

Initially the deceased had been cared for by her biological mother but it became apparent the deceased child's care could not be supported in that environment. She was placed in Lady Lawley Cottages whilst a long term placement was sought. Her ultimate placement with her foster carers from the age of 5, until her death, was an extraordinarily constructive placement for a child with the deceased's difficulties. She was provided with a family environment and cared for unstintingly by her foster parents and their family in conjunction with the above services.

Unfortunately in the months before her death the deceased's ability to physically self protect herself from further respiratory depression was impaired due to her growth and the mechanical impairment of her already compromised respiratory drive. As she grew, so did the mechanical restrictions on her respiratory drive increase, due to her growth. Shortly before her death she required a period of hospitalisation to assist with her increasingly drowsy state and her paediatric consultant realised her respiratory depression would increase. She wished to implement a care plan to assist her carer family should an emergency arise. Whilst a general meeting was planned for all those associated with the deceased child's care it had not been held before a medical emergency arose on the Christmas night of 25 December 2011 and the deceased died, probably as a result of a seizure.

The Deputy State Coroner found it likely the deceased's respiratory depression contributed to whatever circumstances surrounded her death and her propensity to suffer seizures, especially at the time of increased respiratory need.

The Deputy State Coroner considered the deceased's placement with her foster family was optimal. The family's dedication to the deceased's care, stimulation and physical input was extraordinary. The Deputy State Coroner concluded by finding there was no doubt the supervision, treatment and care of the deceased by her foster family and foster mother in particular, following her placement with them, was exceptional and allowed the Department to ensure her supervision, treatment and care were outstanding.

The Deputy State Coroner did not make any recommendations.

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

**Shane John ROBINSON**

**Inquest held in Perth 10 February 2015, investigation finalised 22 June 2015**

Mr Shane John Robinson (the deceased) died on 10 June 2011 at Casuarina Prison. The cause of death was multiple drug toxicity. The coroner found the manner of death was accident. The deceased was 29 years old.

Immediately before death the deceased was a person held in care pursuant to the *Prisons Act 1981* because he was sentenced prisoner serving his sentence at Casuarina Prison operated by the Department of Corrective Services.

At an early age the deceased began to use illicit drugs and came to the attention of the law. The deceased engaged in drug rehabilitation but after the suicide of his father the deceased relapsed into heavy drug use. His behaviour became erratic and volatile and he continued to commit criminal offences, eventually serving a number of prison terms. After being released on parole in November 2006 the deceased committed further offences, his parole was suspended and he was taken back into custody in March 2007. The deceased was denied release on parole in June 2010 and remained in custody until his death.

In June 2009 the deceased was diagnosed with Crohn's disease following investigation for progressive anaemia. He was treated with a variety of medications that were not effective, and eventually underwent bowel surgery in August 2010. Problems developed following the surgery and further surgery was recommended but the deceased declined to have the procedure.

The deceased's medical management in prison was also complicated by his history of polysubstance abuse, making it difficult for the doctors to determine real need versus drug-seeking behaviour. Nevertheless, he was prescribed various medications to manage his chronic pain and other medical complaints.

In the last months of his life the deceased's health deteriorated significantly, and he was seen to be very unwell, but he declined to be housed in the prison infirmary. He received regular medication, including daily methadone, and spent most of his day in his cell.

On 8 May 2011 the deceased was taken to hospital with chest pain, but no cardiac cause could be identified so he was discharged the following day.

On 17 May 2011 the deceased was hospitalised for exacerbation of his Crohn's disease, which led to a new drug being trialled to manage his symptoms. He was discharged on 26 May 2011 on the new drug regime. His second dose of the new medication was given on 8 June 2011.

On 10 June 2011 the deceased was found in an unresponsive state in his cell shortly after an early morning cell check. He could not be revived, despite cardiopulmonary resuscitation being attempted.

Following a post mortem examination, which including toxicological analysis, the forensic pathologist formed the opinion the cause of death was multiple drug toxicity. Some of the drugs found in the deceased's system were consistent with what were prescribed to him, and some were not. In the view of an expert pharmacologist, the most likely explanation was that the deceased took his prescribed medication on 9 June 2001 and then took some additional prescription medication he had obtained illicitly. There was no evidence he had any thoughts of self-harm or suicide at that time.

The deceased's mother raised a number of concerns in respect to the care of the deceased and these issues were explored during the inquest by the Coroner. At the conclusion the Coroner was satisfied the deceased received a high standard of medical care, at a minimum as good as what he would have expected to receive if he was not incarcerated.

The source of the non-prescribed drugs was unable to be identified although there was anecdotal evidence of the deceased having purchased medication from other prisoners in the past. Evidence was heard that the Department of Corrective Services takes all reasonable steps to minimise the trade in drugs in the prison environment but its efforts are not foolproof when faced with the will to circumvent the systems.

The coroner was satisfied that the deceased received a high standard of medical care, at a minimum as good as what he would have expected to receive if he was not incarcerated. Further, that there was nothing that the Department of Corrective Services did or failed to do that contributed to the deceased's death.

The coroner determined that the deceased died as a result of multiple drug toxicity and death arose way by way of accident.

The coroner did not make any recommendations.

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