

**OFFICE
OF
THE
STATE
CORONER**

ANNUAL REPORT

2011-2012



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30 June 2012

Our Ref : A-1

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Attorney General
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WEST PERTH WA 6005

Dear Minister

In accordance with Section 27 of the *Coroners Act 1996* I hereby submit for your information and presentation to each House of Parliament the report of the Office of the State Coroner for the year ending 30 June, 2012.

The *Coroners Act 1996* was proclaimed on 7 April, 1997 and this is the 16th annual report of a State Coroner pursuant to that Act.

Yours sincerely

Alastair Hope
STATE CORONER

Table of Contents

State Coroner’s Overview	4
Principal Registrar’s Overview	10
Counselling Service.....	15
Coronial Ethics Committee	16
Counsel To Assist Coroners.....	18
Inquests	19
Sandra Mccarty; Pia Bosso; Sandra Kokalis; Deborah Gruber and Carmelo Vinciullo (Operation Lantana)	22
Christmas Island Tragedy.....	24
Mark Anthony Fryer	36
Shaun Michael Ian Price.....	37
Ashton Michael Sunfly; Mitchell Nanala, Lewis John Kalions; Jason Milner and Liam Tchooga (Balgo Community Deaths)	38
David Peter Ellery.....	51
Josephine Wilma Troy.....	57
Shar Rose Benfield	59
Ricardo Maderia Da Silva.....	63
Simon James Brazier	68
Andrew Ian Allan	69
David James Lee.....	70
Deaths In Care.....	73
Involuntary Patients Within The Meaning Of The Mental Health Act 1996.....	73
Warwick Andrew Ashdown	73
Deaths possibly caused or contributed to by actions of members of the Police Service.....	81
Shaun Ryan Cronin	81
Matthew Tjoe.....	82
Victoria Sumabat Shepherd.....	85
Elliott Peter Watt.....	85
Benjamin David Daly	87
Andrew Richard Collard.....	92
Inquests – Deaths In Care – Department For Corrective Services	94
Brian William Edwards.....	96
Declan John Brennan.....	96
Christopher Peter Barnes (Aka Moore)	105
Bruce Jason Garrett	109
Freedom of Information Act Direction to Police acting as Coroner’s Investigators	94



State Coroner's Overview

The year 2011-2012 commenced very badly for the Coroner's Court, but finished on a very positive basis as a result of additional funding being committed for the court in March 2012.

The extreme problems for the Coroner's Court and great stress and excessive workloads for staff described in the Annual Report of 2010-2011 continued into the start of 2011-2012. The two full-time coroners were involved in the mega inquests, the Christmas Island inquest and Operation Lantana inquest, for a significant portion of the year. For much of that time there were no coroners available to do the day-to-day work of the office during normal business hours.

Cases which would normally be finalised by way of administrative findings were not being completed in sufficient numbers to limit the backlog. The worst position was reached in the first quarter of the financial year when the number of backlog cases (cases over 12 months old) rose to 951. While that number was slightly reduced in the second quarter of the year, the position continued to be dire until the decision of government to provide additional funding which took place in late March.

The position in respect of cases identified as requiring a public inquest was also similarly extremely serious and by the second quarter of the year over 126 of these cases were in backlog.

The position changed dramatically in March 2012 when the Treasurer and Attorney General, the Hon Christian Porter MLA, advised me that a decision had been made to provide an additional \$509,000 for the 2011-2012 year and \$1,015,000 for the 2012-2013 year to the Coroner's Office. The decision was confirmed by letter dated 16 March 2012 in advance of finalisation of the budget process.

While expressed to be non-recurrent this was new funding for the Coroner's Office and the commitment was made in anticipation of a comprehensive review being conducted of the needs of the Coroner's Court expected to take place in the latter part of 2012.

This funding was in addition to continuation of the ongoing provision of non-recurrent funding, some of which has been provided in that form for almost a decade, but in respect of which about \$300,000 to \$400,000 was first provided in 2009-2010.

The new funding was allocated to provide for:

- 2 additional coroners;
- 1 principal registrar; and
- 4 administrative support staff.

The allocation for the current financial year was made to allow the Coroner's Court to commence employing coroners immediately prior to finalisation of the 2012-2013 budget.

Immediate action was taken to take advantage of this important development. Mr Dominic Mulligan, who had recently been appointed to assist with completion of administrative findings, was appointed to act as a coroner until 30 June 2013.



In respect of the other coroner's position, and the ability to access significant funding in the remaining 3 months of the year, steps were taken to appoint two people as coroners, Mr Barry King and Mr Peter Collins.

As there was money to continue with only one of those positions from 30 June 2012 until 30 June 2013, in order to ensure that both persons would have an opportunity to conduct inquest hearings as well as complete administrative findings, each person was appointed for a further six months of that 12 month period. In other words, each person was appointed as a coroner for a period of approximately 8 ½ months.

In respect of Mr Mulligan, he has a wealth of experience as counsel both in New Zealand and in Australia. He was the first counsel assisting appointed for the Coroner's Court in 1997 and after that time, while working in private practice and as a barrister, has been retained as counsel assisting for a number of important inquests. He has appeared in 78 inquests in Western Australia as counsel assisting. These inquests include the inquest into the explosion on HMAS Westralia, the Jandakot plane crash inquest, the inquest into numerous deaths by way of suicide in the Kimberley and the inquest into the Borabbin bushfire deaths.

In the case of Mr Collins, at the time of his appointment he was the Director of Legal Services for the Aboriginal Legal Service of Western Australia. Mr Collins brings to the position of coroner a wealth of experience as an advocate in Queensland, the Northern Territory and Western Australia. Prior to his appointment he was responsible for the Aboriginal Legal Service of Western Australia's statewide legal service and the professional supervision of 40 lawyers and 20 court officers.

Mr King was employed as Assistant Crown Counsel and Senior Assistant Crown/State Counsel with the State Solicitor's Office in Perth. He has appeared as counsel in various jurisdictions including the WA Coroner's Court and, in the context of proposed future changes to the Coroner's Act 1996, has relevant experience having been instructing officer on behalf of the Attorney General in relation to a number of important Bills.

These coroners bring to the role experience and skills relevant, not only to the immediate tasks which they will be expected to perform, but also of benefit in the implementation of anticipated changes to coronial practice in Western Australia.

In respect of the Principal Registrar position, Mr Gary Cooper, the manager of the Coroner's Court, has been temporarily appointed to that position. Mr Cooper brings to the position a wealth of administrative experience and is also a qualified legal practitioner with considerable experience and expertise in the coronial jurisdiction.

Importantly as Principal Registrar Mr Cooper will be in the position to represent the Coroner's Court in its interaction with many different departments and organisations within Western Australia, interstate and overseas.

The importance of this new position was highlighted shortly after its creation when following the Christmas Island disasters of 21 June 2012 and 27 June 2012 Mr Cooper was required to represent the Coroner's Court in negotiations with a number of different Commonwealth departments, the High Commissioner for Pakistan and others in relation to a range of issues relating to the deaths.



The additional administrative support staff are of fundamental importance to the ongoing running of the office and, in the context of inquest preparation and management, an important position created was that of Listings Manager, a position which will involve responsibility for monitoring listing of inquests, the preparation of matters for inquest hearing, issuing of subpoenas, arranging the accommodation for witnesses and the wide range of tasks which must be performed for an inquisitorial court to prepare matters for hearing and for hearings to proceed efficiently.

The creation of those positions had an immediate and dramatic impact on the functioning of the Coroner's Court. The backlog of cases which had been 951 in the first quarter of the year was reduced to 572 by the close of the financial year.

At the time of writing this report in August 2012, I can report that by the close of July 2012 this number was further reduced to 538.

In the context of the improved resourcing and functioning of the Coroner's Court I anticipate that the total number of backlog cases will continue to decrease although it is not within the power of the Coroner's Court to complete all of the matters within a 12 month period. There are, for example, a number of cases where investigations of deaths are conducted over a period in excess of 12 months for a range of reasons and there are a number of cases where finalisation is delayed for reasons wholly outside the control of the Coroner's Court, such as the need to complete criminal proceedings or delays which result from the investigation of issues raised by family members or others after initial investigations have been completed.

In respect of the outstanding matters to be inquested, it is expected that a substantial reduction of the backlog will take much longer to be effected. Considerable changes have, however, already taken place to ensure that procedures in the office will enable earlier preparation of matters for inquest hearing, closer interaction between counsel assisting and coroners, more streamlined investigations and the ability to organise more regular and structured inquest sittings.

Law Reform Commission Report and Strategic Review

In January 2012 the Law Reform Commission of Western Australia released its final report on the Review of Coronial Practice in Western Australia. The final report contained 113 recommendations relating to a wide range of different issues. Recommendation 5 proposed that a strategic review of the Office of the State Coroner should be conducted by a suitably qualified and independent person or persons at the earliest opportunity.

With a view to complying with that recommendation and section 57 of the *Coroner's Act 1996*, which requires the Attorney General to carry out a review of the operations of the Act every five years, AOT Consulting was retained by the Department of the Attorney General in May 2012.

AOT Consulting representatives have met with Coroner's Court staff on numerous occasions and their report is anticipated later this calendar year.

In respect of the Law Reform Commission Report, while I was disappointed with a number of conclusions and recommendations which appear to have been based on misinformation or a lack of understanding of what is a complex system, the report helpfully addressed a very wide range of different topics, many of which urgently require attention.



While a number of the recommendations addressed deficiencies which have already been corrected or which will be addressed as a result of the additional resourcing which government has provided, assuming that resourcing is to be ongoing, there are a number of important decisions which need to be made as a consequence of the recommendations.

A concern of the Law Reform Commission reflected in recommendations 102 and 103 was that there is a need for coroners to be more directive and to take a more active role in determining whether or not there should be internal post mortem examinations.

The increase in the number of full time coroners will enable greater input to take place from coroners at the early stage of investigations and it is anticipated that as a consequence of this there will be a significant reduction in the number of internal post mortem examinations conducted. It is proposed to implement changes in this regard in a structured way in the very near future.

Additional Christmas Island Cases

It is with concern that I note that there have been other cases of boats sinking and bodies being taken to Christmas Island in addition to the case of the sinking of SIEV 221 with 50 resulting deaths which was inquested during the 2011/2012 year.

There is an outstanding case in relation to SIEV 69 which sank in the Indian Ocean on 1 November 2009 with 40 persons on board. 27 of those persons were ultimately rescued by occupants of a passing ship and fishing vessel. The body of one deceased person was recovered and the remaining 12 persons are missing, believed to be dead.

In respect of that one person, as a result of the body being taken to Christmas Island, the WA Coroner's Court has jurisdiction.

On 21 June 2012 the sinking of another asylum seeker boat was reported, believed to have taken place approximately 200 nautical miles off Christmas Island.

It was believed that there were about 220 persons on the boat, 110 of whom were rescued. The bodies of 17 deceased persons were located and transferred to Christmas Island. The WA Coroner's Court has jurisdiction in respect of those 17 deaths.

On 27 June 2012 another boat carrying asylum seekers sank at a location approximately 102 nautical miles north of Christmas Island.

Information received indicates that there were 133 persons on board, 125 were rescued and the body of one deceased person was recovered. The remaining 7 persons are missing, believed to be dead.

The WA Coroner's Court has jurisdiction in respect of the deceased person whose body was recovered and was repatriated to Christmas Island.



In respect of each of these cases it has been necessary to endeavour to identify the bodies and for an investigation to be conducted. In respect to the 21 June 2012 tragedy the identification process is still ongoing. Identification of bodies in disasters such as these is a difficult and resource intensive activity, which involves comparison of difficult to obtain ante mortem information with post mortem information, some of which is sought from overseas.

While the Commonwealth has provided funding for the investigation of these deaths and for the coronial process, these cases impose a significant burden on coroner's staff, police and forensic pathologists who would otherwise be performing duties relating to deaths in Western Australia.

In this context I wish to recognise the excellent work of WA Police officers whose response to each of the tragedies has been extremely professional. The expertise in WA Police for handling these difficult cases is now at a high level.

2011-2012 achievements include -

- ✚ reduced backlog files from 846 to 572;
- ✚ case finalisations increased from 1,365 to 2,193;
- ✚ temporary appointment of additional staff; *and*
- ✚ implementation of changes to improve backlog of inquest files.

2012-2013 priorities include -

- ✚ continue with efforts to reduce the numbers of all backlog files;
- ✚ update and improve the website;
- ✚ implement procedures to increase the input of coroners in the early coronial processes and reduce the numbers of internal post mortem examinations being conducted;
- ✚ enhance the educative function of the court;
- ✚ address deficiencies identified by the Law Reform Commission;
- ✚ implement changes following the strategic review and section 57 review; *and*
- ✚ put in place an efficient structure to make best use of improved resourcing.

Staff

Staff at the Coroner's Court have worked extremely hard in the difficult circumstances described at the beginning of this report to keep the system going. It should be recognized that for staff the delays associated with the backlog were particularly difficult and frustrating.

All staff have responded extremely positively to proposed changes and worked to ensure that the additional resources provided during the year would be used effectively. I am mindful of the fact that the Coroner's Court has been very fortunate in its staff and recognize that in this very small office every person has the desire to provide the best service possible in the circumstances.

I would also like to acknowledge the efforts of staff who provide a service in the country regions for their hard work throughout the year.

I thank the Deputy State Coroner and Coroners Mulligan, Collins and King for their ongoing support.



The Funding Decision

In the context of the additional funding of \$509,000 for the 2011-2012 year and \$1,015,000 for the 2012-2013 year I wish to recognize the very positive support which the Coroner's Court received from the former Treasurer and Attorney General, the Honourable Christian Porter MLA.

I recognize that this support for the court has come at a time when there are many competing demands for government funding.



Principal Registrar's Overview

I am pleased to present my first report as the inaugural Principal Registrar of the Coroner's Court. First, I would like to welcome Sue Wilde, who took over from me as Office Manager in May 2012. Since her arrival Sue has made a positive impact on the office and has started to implement changes which will influence our future direction and achievements.

The year 2011/12 has been a busy and eventful year for the court especially since January, with the publication of the Law Reform Commission's (LRC) final report on the *Review of Coronial Practice in WA*.

The LRC's discussion paper published in June 2011, aimed at assisting the public to understand both the legislative and practical operations of the jurisdiction, including the need to reduce delay in the coronial process; the need to promote public confidence in the coronial system, and the need to enhance the role and support of families in the coronial process. The final report collated all the feedback stemming from the discussion paper which resulted in 133 recommendations made with regard to procedural and legislative matters which I am sure will lead to change and innovation in coronial law and practice in the future.

Recommendation 5 of the final report proposed an independent strategic review of the Coroner's Office *...to be conducted by a suitably qualified independent person or persons at the earliest opportunity.*" I am pleased to report the review commenced in May 2012, and will include, but is not limited to:

1. an evaluation of administrative systems and processes;
2. an evaluation of infrastructure and human resourcing needs;
3. a review of the functions and supervision of administrative staff within the Office of the State Coroner;
4. a review of the office's risk management plans;
5. consideration of the implementation of administrative, policy and procedural recommendations of the Law Reform Commission of Western Australia; and
6. the development of a strategic plan for the efficient and effective delivery of coronial services and consultations with relevant stakeholders.

The review will be completed during the second week of August 2012, and will involve consultation with coroners, staff, key stakeholders and others involved in the coronial process. It is envisaged the review will lead to sweeping changes in the way we conduct our core business and deliver services. It is too early to anticipate outcome of the independent review, however, the final report is eagerly awaited.

In tandem to the review, in May 2012, Government provided \$1.5m in additional funding provisionally until the end of June 2013. The additional funding provided for the appointment of two additional coroners and five support staff, which included the creation of three new positions namely; the Principal Registrar, Findings Clerk and Listings Manager. The office is now comprised; 4 coroners and 24 staff, which since August 2009, is a 100% increase in resources.



The Work of the Office 2011/12

The year got off to a relatively slow start as far as finalisations were concerned but it is pleasing to report that since May 2012, the provision of additional resources has made a significant impact on the court's backlog of cases (i.e. cases over 12 months old) which has reduced by 274 cases compared with the same time last year. The focus for 2012/13 will be to reduce the backlog of cases even further and improve the timeliness of file completions.

The total number of cases referred for investigation and the number of reportable deaths referred to the Coroner's Court was 2,679. This is decrease of 64 deaths over the previous financial year (2010-2011).

The number of deaths ultimately determined to be reportable also decreased, from 1,996 to 1,916. In reportable death cases it is necessary for the coroner investigating the death to make findings pursuant to section 25 of the Coroners Act 1996.

The number of cases completed was substantially higher than the number of deaths reported with a record number 2,192 cases being finalised. The number of cases finalised by Inquest increased from 40 to 98. A case in this context refers to the investigation of the death of an individual.

At the conclusion of the financial year the cases on hand referred to a coroner amounted to 2,013 of which 572 were over 12 months old.

The tables below show an overview of the work of the office in 2011/12.

CASES RECEIVED	Perth	Country	TOTAL
Full Investigation	1398	518	1916
Death Certificates	763	n/a	763

CASES COMPLETED	Perth	Country	TOTAL
Finalised by Inquiry	1599	495	2094
Finalised by Inquest	30	68*	98
TOTALS	1629	563	2192

* 50 of these cases relate to the Inquest held by the State Coroner into Christmas Island boat disaster.

BACKLOG	Perth	Country	TOTAL
Backlog	448	122	572

CASES ON HAND	Perth	Country	TOTAL
	1603	410	2013

FINALISATION RATIO		
Finalised by Inquiry	95.53%	(2094)
Finalised by Inquest	4.47%	(98)



The table below shows the age of a file at the time of closure. It will be seen that 41.7% (916) of files were closed in under 12 months and 58.3% were over 12 months old (i.e. backlog files).

TIMELINES	INQUIRY		INQUEST	
	Perth	Country	Perth	Country
< 3 mths	7	77	0	0
3-6 mths	130	172	0	0
6-12 mths	375	155	0	0
12-18 mths	588	44	0	51
18-24 mths	306	13	3	3
> 24 mths	193	34	27	14
TOTALS	1599	495	30	68

The above figures are pleasing and show significant reductions/increases (compared with 2010/11) in terms of:

- Backlog files - reduced from 846 to 572;
- Cases on Hand - reduced from 2,312 to 2,021.
- Case finalisations - increased from 1,365 to 2,193 in 2011/12.

A total of 2,679 deaths were referred to the coronial system during the year. Of these deaths, in 763 cases death certificates were ultimately issued by doctors. In a significant number of cases there were initial problems experienced in locating a treating doctor or a treating doctor had initial reservations about signing a certificate which were ultimately resolved.

In the Perth area there were 1,398 Coroner's cases and in the country regions there were 518 Coroner's cases, a total of 1,916 cases.

Coroner's cases are 'reportable deaths' as defined in section 3 of the *Coroners Act 1996*. In every coroner's case the body is under the control of the Coroner until released for burial or cremation. In all coroners' cases an investigation takes place and either on the basis of that investigation or following an Inquest subsequent to the investigation, a Coroner completes findings as to the identity of the deceased, how the death occurred and the cause of death. Statistics relating to the manner of deaths referred for investigation and completed by a Perth or country Coroner are detailed below.

Manner of Death	2008/09	2009/10	2010/11	2011/12
Accident	469	563	338	682
Misadventure	6	10	7	22
Natural Causes	928	887	776	875
Open Finding	68	79	47	145
Self Defence	1	0	0	1
Suicide	288	337	150	399
Unlawful Homicide	50	49	45	68
Totals	1,810	1,925	1,363	2,192



Involvement of Relatives

The *Coroners Act 1996* involves relatives of deceased persons in the coronial process. The Act requires a Coroner to provide information to one of the deceased person's next of kin about the coronial process in every case where the Coroner has jurisdiction to investigate the death.

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

During the year 1 July 2011 - 30 June 2012 a total of 2,678 deaths were referred to the Coroners Court. In 763 cases a death certificate was ultimately issued. Of the remaining 1,916 cases a total of 200 objections were made to the conducting of a post mortem examination.

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

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

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

The following tables detail statistics relating to objections to post mortem examinations for the year. The cases where a death certificate was issued by a doctor have *not* been included.

Deaths Referred to the Coroner's Court

Reported Deaths	
Immediate post mortem	41
No objection to post mortem	1690
Objection to post mortem	200
No post mortem conducted (missing person etc.)	26
Number of Reported Deaths	1916



Developments in cases where an Objection was initially received

Objections to Post Mortems	
Objection accepted	132
Objection withdrawn	66
Objection over-ruled	1
Objection withdrawn after coroner over-ruled	1
Applications to Supreme Court	0
Total Objections to Post Mortems	200

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

In the majority of cases where an objection was received the decision which was ultimately made was in accordance with the wishes of the family. There were a total of 200 objections of which 66 were withdrawn prior to a ruling being given by a coroner and 132 were accepted by a Coroner and no post mortem examinations were ordered. In only 1 case where an objection had been received did a coroner order that a post mortem examination should be conducted, and in 1 other case an objection was withdrawn after over-ruling by a coroner.

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

Conclusion

2011/12 was an extremely busy year for the Coroner's Court. Inquest matters of the magnitude of the Christmas Island boat disaster pushed the resources and capacity of the court to the limit causing other equally important inquest matters to be delayed. This was an unfortunate but necessary consequence because the State Coroner was obliged to investigate the disaster on behalf of the Commonwealth.

The provision of additional resources albeit on a temporary basis clearly demonstrates that significant improvements were achieved. It would be remiss not to mention the tremendous effort made by everyone at the office over the past year. I am very fortunate and immensely proud to work with a group of remarkable and dedicated people who provide unique services to families trying to cope with the death of a loved one.



Counselling Service

As recommended in the Law Reform Commission Report, the Coronial Counselling Service in the past financial year has taken on a higher community profile in the area of education and training. This has involved providing training within the Department of the Attorney General as well as with key stakeholders and various community agencies within Western Australia.

Following on from a successful state wide Suicide Prevention Symposium earlier in 2011 at which the State Coroner was the Keynote speaker, the Counselling Service instigated and developed a series of coronial education seminars for members of the Australian Funeral Directors Association. These seminars held throughout 2012 have included a regional conference in Esperance, two metropolitan area presentations and a coronial multidisciplinary presentation at the State Mortuary.

In the area of Disaster Victim Identification ongoing training continues to be provided to the Police Operatives Course at the WA Police Academy as well as refresher training to the counsellors involved in Phase 3 ante mortem information collection. Within the Department, a presentation and facilitated discussion to the 2012 Regional Court Managers Conference on the impact of coronial work in a regional setting, was also held. Other coronial education and training sessions have been provided to non government sector agencies such as Anglicare as well as tertiary education institutions.

On a national level, the Coronial Counselling Service contributes to the bereavement education community with the Senior Coronial Counsellor being on the Management Committee of the Australian Centre for Grief and Bereavement. This organisation is based in Victoria and provides education, training, research and professional service options for grief and trauma counsellors throughout Australia. Through this involvement an invitation was extended to attend the 26th annual meeting of the International Work Group on Death, Dying and Bereavement, held in Melbourne in October 2011. This international group provides leadership and support to those involved in bereavement services and education. They conduct regular meetings at which leaders in the field can work and study together. This forum provided an international opportunity to highlight and discuss the unique role and work of the coronial counsellors within the Office of the State Coroner of Western Australia.

REFERRALS - CORONIAL COUNSELLING SERVICE

1 July 2011 - 30 June 2012

Total New Contacts (Including client self referrals, police and community agencies)	Counselling Provided (Phone, Office and Home)	Letters Sent for Offers of Support	Other Services (Liaison, referral and file viewings)
7,683	5,196	949	1538



Coronial Ethics Committee

The Coronial Ethics Committee was set up under the Coroners Act 1996 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.

The Committee requires a detailed written submission in relation to requests for Coronial data. The Committee meets at least quarterly to consider each request, 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 Committee makes recommendations to the State Coroner about whether the information should be released and under what conditions.

The Coroner's Court is very grateful for the considerable work done by Ethics Committee members. A large volume of material is often required to be read before each meeting, and the Committee members give up their time to prepare for meetings and to attend them. The members of the Committee are people with many other commitments and they are very generous to participate in the Committee's work on a voluntary basis.

The members of the Committee are as follows:

Dr Adrian Charles	Chairperson Pediatric Pathologist, Princess Margaret Hospital
Associate Professor Jennet Harvey	Department of Pathology, UWA
Ms Evelyn Vicker	Deputy State Coroner
Dr Jodi White	Forensic Pathologist, PathCentre
Ms Martine Pitt (until March 2012)	Executive Director, Communicare
Mr Jim Fitzgerald	Lay member
Ms Heather Leaney	Lay member
Reverend Brian Carey (from February 2012)	Member with a pastoral background
Ms Christine Pitt (from February 2012)	Lay member
Kate Ellson (from January 2012)	Secretary Counsel Assisting the State Coroner
Dr Celia Kemp (until January 2012)	



This financial year, the Committee met five times this financial year and has addressed the following projects as indicated in the table below.

Number of Projects Considered	Number of projects approved	Number of projects not approved
9	8	0

The Committee also considered several informal requests for information and applications to renew the approval for existing projects.

Ms Martine Pitt is no longer on the Committee and the State Coroner thanked her for her service.

In her place, the Committee is very pleased to welcome the Reverend Brian Carey as a member with a pastoral background. Reverend Carey has a history of being involved in discussions about the ethical use of human tissue and will be a valuable member to the Committee. Likewise, the Committee welcomed Ms Christine Pittman to the committee as a lay member. Ms Pittman has a long history in social work and will provide a valuable perspective to the Committee's work.

The Committee requires significant secretarial support, which is provided by Counsel Assisting the State Coroner. Additional administrative support is provided by Court officers. This necessarily takes time away from inquest work as these staff members would otherwise be working on the preparation of files for inquests and appearing at inquests.

During this financial year Ms Melanie Smith, Counsel Assisting the State Coroner, assisted the Committee as its Secretary in the absence of Dr Kemp. From 1 July 2011 until 10 October 2011, Ms Smith spent a large number of hours assisting the Committee with its work. The Committee is very grateful for Ms Smith's assistance during that period.

From the beginning of 2012, Counsel Assisting the State Coroner, Ms Kate Ellson replaced Dr Celia Kemp as Secretary to the Committee. In the six months Ms Ellson has had the role, and not including the work done at and after the Committee's June 2012 meeting, Ms Ellson has spent approximately twenty-three hours of her time doing Committee work.

In order to reduce the impact of the Committee's work on inquest work, and in order to provide the Committee with some much needed administrative support, efforts are being made to incorporate some of the duties of the Secretary into an administrative officer's role. Once implemented, this will be of valuable assistance to both the Committee and to the Court.



Counsel to Assist Coroners

Dr Celia Kemp, Senior Counsel Assisting, after a considerable period of sick leave returned to the office in July 2011 to complete and assist the Deputy State Coroner with the inquest hearing into the five deaths relating to cerium deaths. Dr Kemp resigned on 27 January 2012 to take up a position in Victoria.

Ms Kate Ellson commenced to work on a 12 month contract as counsel assisting in January 2012. Ms Ellson has worked hard to prepare files for listing of inquest hearings as well as competently carry out her role as Secretary to the Ethics Committee.

Currently the in-house-counsel assisting comprise—

-  Mr Jeremy Johnston
-  Ms Melanie Smith
-  Ms Kate Ellson

WA Police Assistance

WA Police continued to provide support to the Coroner's Court in the form of two officers who worked in the office and provided an extremely important service in monitoring the quality of police investigative briefs and liaising with WA Police as well as on occasions assisting in inquest hearings.

Sergeant Housiaux worked in the court during the year and he was assisted for part of the year by Sergeant Robert Pope.



Inquests

A chart follows detailing the Inquests conducted during the year.

Name Of Deceased	Date Of Death	Date Of Inquest	Number Of Sitting Days	Coroner	Court Sitting	Finding	Date Of Finding
OPERATION LANTANA Sandra McCARTY Pia BOSSO Sandra KOKALIS Deborah GRUBER Carmelo VINCIULLO	25/5/2005 26/5/2005 27/5/2005 28/5/2005 1/7/2005	29/8 - 7/10/2011	30	Deputy	Perth	Open Finding Open Finding Open Finding Open Finding Natural Causes	30/6/2012
XMAS ISLAND TRAGEDY	15/12/2010	31/1/2011 16/2/2011 30/3/2011 17/5-3/6/2011 11-15/7/2011 25-29/7/2011 5-13/9/2011	31	State	Perth Christmas Isl Perth Perth	Open Findings	23/2/2012
WALDEN Athenia Hana	11/5/2008	7/2/2011 23-28/3/2011	1 5	State# Packington	Perth	Misadventure	8/11/2011
~ ARNOLD Luke David	28/12/2008	1/3/2011	1	Deputy	Perth	Accident	3/10/2011
BUNGLE BUNGLES Christian CATARGIU Jessica COUSINS Whitney PINNEY Sarah THOMAS	14/9/2008	12-14/4/2011	3	Deputy	Kununurra	Accident	3/20/2011
FRYER Mark Anthony	20/10/2008	3-5/5/2011	3	Deputy	Perth	Homicide	24/11/11
PRICE Shaun Michael Ian	7/6/2008	3-6/5/2011	4	Packington	Albany	Unlawful Homicide	18/11/11
KUCHEL Boyd Timothy	13/6/2007	15/4/2011 23-26/5/2011	1 4	State# Packington	Perth (D/H) Perth (Inquest)	Misadventure	2/3/2012
* NEBRO Daniel Rowley	3/7/2009	2/6/2011	1	Packington	Bunbury		
* MORATO Henrique Gregory	9/10/2008	7-8/6/2011	2	Packington	Perth		
* DOYLE Blake Michael	25/11/2009	9-10/6/2011	2	Packington	Perth		
* NEUMANN Karl	24/9/2009	11/6/2011	1	Packington	Perth		



Name Of Deceased	Date Of Death	Date Of Inquest	Number Of Sitting Days	Coroner	Court Sitting	Finding	Date Of Finding
CRONIN Shaun Ryan	9/8/2004	12/7/2011	1	Deputy	Perth	Accident	11/10/2011
TJOE Matthew	2/11/2009	14/7/2011	1	Deputy	Perth	Unlawful Homicide	24/10/11
SHEPHERD Victoria Sumabat	24/1/2009	19/7/2011	1	Deputy	Perth	Accident	11/10/11
BALGO DEATHS SUNFLY Ashton Michael NANALA Mitchell KALIONS Lewis John MILNER Jason TCHOOGA Liam	17/6/2008 27/2/2009 27/6/2009 23/4/2009 29/6/2010	2/8/2011 3-4/8/2011 8-10/8/2011	1 2 3	State	Balgo Kununurra Perth	Suicide Suicide Suicide Suicide Accident	21/10/11
EDWARDS Brian William	12/2/2010	23/9/2011	1	Mulligan	Perth	Natural Causes	24/1/2012
ASHDOWN Warwick Andrew	12/10/2007	3-14/10/2011	10	State	Perth	Misadventure	23/11/2011
* BRENNAN Declan John	28/4/2008	17-19/10/2011 31/10/2011	4	Deputy	Perth	Suicide	12/1/2012
ELLERY David Peter	31/7/2007	1-4/11/2011	4	Mulligan	Perth	Suicide	30/3/2012
HODGSON Kathleen	6/3/2006	2-4/11/2011	3	Deputy	Perth	Misadventure	27/2/2012
DALY Benjamin David	16/11/2008	28/11/2011	1	State	Perth	Suicide	2/12/2011
TROY Josephine Wilma	14/2/2006	5-8/12/2011 16-19/1/2012	8	Deputy	Perth	Natural Causes	9/3/2012
PICKETT Andrea		19/12/2011 11-19/6/2012	8	State	Perth	Unlawful Homicide	28/6/2012
* MOORE (aka BARNES) Christopher Peter	18/12/2000	20-21/12/2011	2	Mulligan	Perth	Accident	21/6/2012
BENFIELD Shar Rose	24/6/2008	25-27/1/2012 23-24/1/2012	5	Mulligan	Perth Kalgoorlie	Open Finding	18/4/2012
EGAN Bevan Paul	7/6/2007	23-24/1/2012 27/1/2012	3	Deputy	Perth	Accident	30/6/2012
PICKERING Cozette Elizabeth Mary PICKERING Rhys Michael PICKERING Shayden David	6/4/2007	27-31/1/2012 1-3/2/2012	8	Deputy	Perth	Misadventure	30/6/2012



Name Of Deceased	Date Of Death	Date Of Inquest	Number Of Sitting Days	Coroner	Court Sitting	Finding	Date Of Finding
DA SILVA Ricardo Madeira	24/4/2010	30/1/2012 1/2/2012	2	State	Perth	Accident	7/2/2012
BRAZIER Simon James	30/3/2005	10/2/2012	1	Mulligan	Perth	Open Finding	10/2/2012
WATT Elliott Peter	22/12/2008	13-16/2/2012	4	State	Perth	Suicide	20/3/2012
COLLARD Andrew Richard	4/7/2010	27-28/2/2012 15/3/2012	3	Mulligan	Perth	Accident	24/4/2012
LITTLE Sharinka Patricia	20/3/2008	12-16/3/2012	5	State	Perth	Misadventure	5/4/2012
* GARRETT Bruce Jason	2/10/2010	3/4/2012	1	Deputy	Perth	Natural Causes	31/5/2012
TURNER Trent	13/3/2009	18-19/4/2012	2	Deputy	Perth	Accident	20/6/2012
MORGAN Myrtle	3/9/2006	30/4/2012 1-2/5/2012	3	King	Perth	Accident	22/5/2012
ALLAN Andrew Ian	17/9/2010	9-11/5/2012	2	Deputy	Perth	Natural Causes	18/5/2012
LEE David James	15/7/2007	14-18/5/2012 21/5/2012	6	Mulligan	Perth Port Hedland	Misadventure	6/6/2012
JAMIESON Sandy	19/1/2010	21-23/5/2012 Adj sine die	3	Deputy	Perth		
KEOGH Kellie Anne	10/11/2008	5/6/2012 Adj sine die	1	Collins	Perth		
HENDERSON-STEWART Brody Andrew	28/3/2007	12-15/6/2012	3	Deputy	Perth		

Mr Hope heard 14 Inquests 69 sitting days
Ms Vicker heard 21 Inquests 77 sitting days
Mr Packington heard 7 Inquests 19 sitting days
Mr Mulligan heard 7 Inquests 22 sitting days
Mr King heard 1 Inquest 3 sitting days
Mr Collins heard 1 Inquest 1 sitting day

In-house Counsel

Dr Celia Kemp – 6 [ceased January 2012]
Jeremy Johnston - 12
Melanie Smith - 11
Kate Ellson -3 [commenced February 2012]

Briefed Barrister

Dominic Mulligan – 10
Marco Tedeschi – 1
Anthony Willinge – 2

Total Inquests heard 49

Number of Sitting Days 191

Note : In this context the number of inquests heard refers to the number of hearings. In some cases more than one death was investigated at a single inquest. There were 98 deaths investigated by inquest in 49 hearings. Findings are required to be made in relation to each death.



The following is a brief summary of a number of inquest findings.

**Sandra McCARTY; Pia BOSSO; Sandra KOKALIS; Deborah GRUBER
and Carmelo VINCIULLO (Operation Lantana)**

This inquest was conducted to examine the circumstances of five deaths, in Western Australia in 2005, of people suffering end stage incurable cancer administered an intravenous (IV) High pH Cancer Therapy devised by Dr Helfried Sartori (Sartori). The treatment used a range of substances including caesium, DMSO (an industrial solvent) and Laetrile (also called B17 although it is not a vitamin, or Amygdalin), all of which are potentially toxic.

'The treatment' as referred to in the finding refers to the substances given, the clinical conditions and manner in which it was undertaken.

Seven people were administered the IV therapy by the Kathi Preston Memorial Health Centre (KPMHC/Perth), some of whom had prior oral treatments containing caesium, and, one of whom had received prior IV Laetrile in Mexico. The treatment offered in May was for a course of 12 days.

Sandra McCarty, Pia Bosso, Sandra Kokalis, Deborah Gruber and Antonio Ranieri all commenced IV therapy on 14 May 2005.

Carmelo Vinciullo and Daryl Green commenced IV therapy on 20 May 2005.

Sandra McCarty died on 25 May 2005

Pia Bosso died on 26 May 2005

Sandra Kokalis died on 27 May 2005

Deborah Gruber died on 28 May 2005

Carmelo Vinciullo ceased treatment on 25 May 2005 because he was in so much pain he could not continue. He died on 1 July 2005 of his cancer. It had not been cured.

While it was accepted all six cancer patients who died in 2005 had serious, end stage cancer, one of the issues of concern was whether the treatment accelerated any of their deaths and, of some significance, whether or not they had been misled into expecting a cure for their cancer which ultimately caused them to die in very distressing circumstances, rather than prolonging either their quantity and/or quality of life.

The Deputy State Coroner formed the view the IV treatment did accelerate the deaths of the four women who died over the four days 25-28 May 2005; and she speculated Carmelo Vinciullo would have died during treatment had he not withdrawn from any further treatment by KPMHC on 25 May 2005.

One of the frauds perpetrated by way of the information and consent documents provided to prospective patients was the distribution of a version of Sartori's 1984 published study with respect to "his treatment." Aside from the fact the 1984 publication drew criticism for its original content, the version provided to prospective patients had been altered from the original. The published paper referred to oral caesium chloride and other preparations; while the treatment to which the patients consented, and was referred to in the altered documents they received, used IV preparations and substances not covered in the 1984 paper.



While the Deputy State Coroner unreservedly supported the proposition patients have a right to choose their treatment, she believed that choice must be appropriately informed. The four women who died, and those who had families involved with the treatment, were given serious misinformation about the risks involved with the treatment itself. As a result they were not prepared for imminent death, and did not have the opportunity to say and do the things they may have done had they been able to accept they might die.

In addition the treatment caused serious suffering, which was exacerbated by the setting in which it was provided and instructions given to participants.

The Deputy State Coroner considered one of the most important outcomes from the inquest was to attempt to provide independent information to the public so those considering Sartoir's High pH therapy in the future could be properly informed about its danger. There is no evidence this particular treatment had any real benefit at all to patients. There is considerable evidence it is dangerous and has a serious risk of accelerating death.

She made the following recommendations:-

Comments

Some of the products and compounds used by KPMHC in May 2005, are not scheduled, or controlled in any way, due to the fact they have not been considered for human administration. There have been no clinical experimental trials utilising the substances which would have warranted their consideration for human therapies.

There are some schemes at a Commonwealth level, and Schedules at a State level which do allow people access to substances not approved for use in human administration in Australia, but recognised as being substances people may believe have a beneficial effect. B17 is one example.

I accept people should be able to pursue therapies they may reasonably feel could assist them. However, difficulty in accessing some questionable products may lead to appropriate questioning as to the efficacy of those products as experimental "*medicines*".

It does seem caesium chloride and some caesium salts are considered for unproven therapies. In light of the serious concerns raised at the inquest as to the consequences of their use, I am of the view it would be sensible to restrict or control their procurement in some way.

It may be useful for the TGA at a Commonwealth Level, and the Committees advising the Scheduling of Poisons at a State level, to consider the list of substances utilised in this therapy at page 207/08 of this finding to determine whether or not some of those should require restricted access.

I recommend a form of restricted access for caesium chloride and other caesium salts in the same way as has been provided for Laetrile (B17).

I recommend any Visa application for entry into Australia by Sartori be closely scrutinised by the Department of Immigration & Citizenship (DIAC).

I recommend the data available from the operation of KPMHC in Perth be comprehensively evaluated by relevant experts to provide education and information to medical health practitioners as to the effects of administration of these substances."



The Deputy State Coroner also referred the two Australian Registered Nurses and the Australian Registered Doctor involved in the treatment to the Australian Health Practitioner Regulation Agency (AHPRA) and referred the matter to the DPP for his determination as to whether an offence has been committed, and whether it would be in the public interest to pursue those contributing to those deaths on those dates.

CHRISTMAS ISLAND TRAGEDY

The State Coroner conducted an inquest into the circumstances of a tragedy which took place at Christmas Island on 15 December 2010 at Perth Coroner's Court over 31 sitting days. The finding was delivered on 23 February 2012.

The inquest was into the 30 deaths of -

1. Fatemeh BAGHAIE (aka) Fatama BAGHAE /BAGHA'E or Fatmeh BAQAIE
2. Khedier EIDAN MADHI (aka) Khodair MAHDI
3. Khoshqhadam AMINI
4. Hassan SHAHVARI
5. Ali KHEDIER EIDAN (aka) Ali EDAN
6. Afssaneh ABDULLAHI- MEHER
7. Haifa BAWY (aka) Haifa MOHAMMED or Haifae AHMED MOHAMMAD
8. Mehran ZAREH
9. Fawzeya BAWY (aka) Fawziyah MOHAMMED
10. Fatemeh TAYARI (aka) Fatemeh TAYYARI
11. Mahan SHAHVARI
12. Shekooh TAROMI NEJAD SHEERAZY (aka) Shekooh TAROMINEJAD SHIRAZI
13. Mariam SHAHVARI (aka) Nazanin SHAHVARI
14. Ahmed Oday AL KHAFAJI
15. Nasrollah AKBARI (aka) Nasrala AKBARI or Nasralah AKBARI or Nasroallah AKBARI
16. Mariam Fakri Kadum AL KHAFAJI (aka) Mariam Oday AL KHAFAJI
17. Maryam ZAREH
18. Elmira KHORSHIDI (aka) Shakiba KHORSHIDI or Shakiby KHOORSHIDY
19. Javed SHIRVANI
20. Soha ZAREH (aka) Soho ZAREH
21. Sam Hussain HUSSAINI (aka) Sayed Sam HUSSAINI
22. Zahra Median IBRIHIMI (aka) Zahra'a IBRAHIMI
23. Khalil BEHZADPOUR (aka) Khalil BEHZADPOOR
24. Abbas AKHONDY (aka) Abbas AKHONDI SHIVYARY
25. Mehrdad KARBARI
26. Malektaj KARIMI (aka) Malaktaj KARIMI
27. Reza GANDOMI
28. Kobra DAVARY YEKTA (aka) Kubra DAVARIYAKTH
29. Oday Rashed Mohammed Hassan ALSALMAN
30. Farhad AKHLAGHI SHAIKHDOOST (aka) Farhed AKHLAGHI SHAIKHDOOST



The inquest was into the suspected deaths of –

1. Nahaye Ahmad Mohammed BAWY (aka) Nehayah MOHAMMED, or Nehaya BAWY, or Nihaya Ahmed MUHAMMED
2. Esraa Eidan MAHDI (aka) Asra EIDAN or Isra KUDAIR or Assraaa KHEIDER EIDAN
3. Siamak KHORSHIDI (aka) Shahin KHORSHIDI or Shaheen SYAMACK, or Seyamak, Siyamak
4. Koorosh KHORSHIDI
5. Zaman Ali HESNAWI (aka) Ali ZAMAN, or Zaman Ali DAWAS or Zaman ALI AL HASSNY
6. Maryam HOSSEINI (aka) Mariam HUSSAINI, Hussine
7. Nazar ELEBRAHEMI (aka) Medin NAZAR or Nizar Medlan IBRIHIMI
8. Kamran ABDOLLAHI MEHR (aka) Kamvan ABDOLLAH MEHEN or Camran, or Komron KHURSHIDI
9. Abbas Ody Rashed SALMAN (aka) Abbas AL SALAN or Abbas ALI
10. Hana Sabz ZADEE (aka) Hana SABZ-ZADAH or Hana SABZOZADA
11. Mahsa AKBARI
12. Mohammad Reza SARDARI (aka) Mohammad Reza or Mohammad Reza SARDEARI
13. Ali Al KHAFAGY (aka) Ali Aly KHAFAJI or Ali Oday KHAFAJI or Ali Fakri Kadum
14. Abdul Amir SADATI (aka) Abdul Amir SAADATI KHASEH or PASHA or Amir SADATI
15. Kathm BEDIRI (aka) Kathem RAHI AL BRAIRI or Kadum RAHI
16. Somieh ARAM (aka) Somaieha ARAM or Somayeh ARAM
17. Hossein ABDOLLAHI KOUSHKI (aka) Hossein KOOSHKI ABDOLLAHI, Hussain
18. Hossein NABATI (aka) Hossein NABAATI
19. Naser HOSSEINI (aka) Seyyed Naser, Nasser
20. Abouzar HASANZADEH (aka) Abuza HASSAN ZADEH Abozahar



The above photograph shows SIEV 221 immediately before it was forced onto the cliff



The Executive Summary to the reasons was as follows –

These 50 deaths were inquested in one inquest pursuant to section 40 of the *Coroners Act 1996 (WA) (CI)*.

All 50 deaths took place in the coastal sea of the territory of Christmas Island and the relevant coronial legislation applicable is the *Coroners Act 1996 (WA) (CI)* (the Act).

Of the 50 who died, the bodies of 30 of those persons were recovered and subsequently those persons were all identified. In each case based on the account of forensic pathologists I was satisfied that the cause of death was consistent with immersion (drowning).

In respect of the other 20 persons who died, in each case the evidence established beyond all reasonable doubt the identity of those persons and the fact that they are deceased. In respect of those persons as the bodies were not located it was not possible to determine with precision the causes of death, but I was satisfied that the deaths resulted from drowning or injuries suffered as a result of impact with the shore or debris in the ocean.

On Wednesday 15 December 2010 between 6:40am and 7am Christmas Island time Suspected Irregular Entry Vessel (SIEV 221) crashed on the rocky shoreline of Christmas Island and sank. At the time it was the monsoon season at Christmas Island and sea conditions were very rough, particularly near the coast.

The vessel, the engine of which had failed, was driven repeatedly by the ocean onto the low cliffs on the shoreline and was then swamped by waves and backwash causing it to sink. On the boat at the time there were 92 persons, 89 passengers and 3 crew. The passengers were mostly from Iran and Iraq and were seeking to enter Australia.

At one stage when the vessel struck the low cliffs one passenger was able to jump from the vessel onto the rocky shore and he survived. 41 persons were saved from the ocean by naval and customs officers in rigid-hulled inflatable boats (RHIBS) which had been launched from the naval vessel, HMAS Pirie, and tenders which had been launched from the customs vessel, ACV Triton.

The success of those involved in saving survivors from the ocean was due in no small part to the very considerable contribution made by Christmas Island residents who threw lifejackets to persons in the water. Without those lifejackets many more would have perished.

The residents also provided considerable assistance by acting as spotters, pointing out to those in the rescue vessels the locations of survivors in the water.

The bravery of those involved in the rescue efforts, both navy and customs personnel and local people, was exceptional.

The tragedy involved the largest loss of human life in a maritime incident in Australian territorial waters during peace time in 115 years.

Suppression Orders

Suppression orders were made in respect of the publication of the names and other identifying information relating to the passengers of SIEV 221 and other asylum seeker witnesses at the inquest.

A suppression order was also made that there be no report of the inquest or any part of the inquest which would identify or tend to identify either the alleged organisers or crew of SIEV 221.



The latter suppression order will continue until the completion of the trials of the alleged crew and organiser. That suppression order was made as a result of concerns expressed relating to possible prejudice of criminal trials and in that context reference to the behaviour of those involved in organising the journey and the crew of SIEV 221 was limited at the inquest and has not been dealt with in great detail in these reasons.

The “People Smugglers”

In respect of individuals categorised as “people smugglers” or as “organisers of the venture” it appeared clear from the evidence at the inquest that the actions of those persons contributed to the deaths. Those persons provided the passengers with a vessel which was not suitable for the journey across open seas in the monsoon season to Christmas Island. They did not provide enough lifejackets or other emergency safety equipment. The boat was overloaded and the person who appears to have been acting as captain left part of the way through the voyage and the remaining crew appear to have been inadequately trained or qualified for such a journey. These are just a few of the many safety deficiencies in the approach taken by these persons to the safety of the passengers and crew.

The passengers on SIEV 221 appear to have been lied to by a person or persons involved in organising the journey about the quality of the boat which was to be used, the number of lifejackets which would be available and other matters bearing on the hazards associated with the journey.

The Arrival of SIEV 221 at Christmas Island

On the early morning of 15 December 2010 there was almost no surveillance being conducted of the ocean to the north and north-west of Christmas Island.

The first sightings of SIEV 221 were made by individuals on the island coincidentally looking out to sea at the time.

It appears that the first sighting of the boat was by a resident who lived on an address on Gaze Road. According to her evidence she first saw the boat at about 5:20am.

At about 5:40am on that morning a customs officer staying at the Mango Tree Lodge walked out on the balcony of the room he was occupying and saw SIEV 221.

That customs officer contacted the customs on-call officer by telephone at 5:46am and advised him of the situation.

In the area of the Island near Flying Fish Cove conditions were particularly severe that morning. For vessels travelling from Rocky Point towards Flying Fish Cove there was an area where the deep sea ocean swells struck the cliffs of the Island and backwashed back out to sea. A combination of backwash and on coming swell created what was described by a number of witnesses as a “washing machine affect” making this water very hard to navigate and unpredictable. It was at this location that SIEV 221 was driven onto the rocky cliffs and sank.

It appears that SIEV 221 had travelled in a generally north to south direction from Indonesia to Christmas Island until it approached the shore close to the Mango Tree Lodge where it was first seen. SIEV 221 then travelled in a westerly direction towards Rocky Point and then south to the area near the Golden Bosun Tavern where it sank.

The decision to turn the boat to the west into the weather was a fatal one in the circumstances. Had the boat travelled to the east, it is possible that it would have reached the relatively sheltered waters near Ethel Beach and the disaster may not have happened.



In Flying Fish Cove on that morning conditions were extremely severe and there was no real possibility that asylum seekers on the boat could have been offloaded there safely. It appears, therefore, that from the moment when the decision was made for the boat to travel in a westerly direction all on board were in great peril and faced possible death.

This fact was appreciated by a number of the residents of Christmas Island who saw SIEV 221 on its journey to Flying Fish Cove. A number of these residents contacted 000 and described what they had seen. A number of these calls were made shortly before 6am or shortly afterwards.

It appears that SIEV 221 was first observed to approach Christmas Island at between 5:20am and 5:40am, the disastrous decision to turn to the west took place at about 5:55am and the boat then travelled to Rocky Point and then to the location where it sank.

Emergency Calls Made by Asylum Seekers

A number of emergency calls were made from SIEV 221 to the emergency number 991 which were redirected to 000. These calls were made by asylum seekers using mobile telephones.

Three calls were successfully transferred to the WA Police Call Centre and they were logged at between about 5:50am and 6:05am. It is clear the makers of the calls were extremely distressed and that their grasp of the English language was limited. It is also clear that the police officers who took the calls struggled to understand what was being said and experienced difficulty in obtaining information which could be acted upon.

While the immediate response to the calls appeared to demonstrate some inexperience on the part of the operator, senior officers at the Police Operations Centre became involved quickly and appropriate responses were made within a short period of time.

The calls came through at about the same time as emergency calls made by residents on Christmas Island which were received by the AFP On Call Officer.

The emergency calls from SIEV 221 were not made sufficiently early in the course of events to significantly advantage those involved in the subsequent rescue operation. If the calls had been made an hour earlier, for example, they may have resulted in an earlier response.

The Responsibility for Intercepting SIEVs

The responsibility for intercepting SIEVs entering any of Australia's contiguous zones rested with Border Protection Command.

Border Protection Command was comprised of consolidated assets and resources from the Australian Customs Service and Defence.

The Commander of Border Protection Command was Rear Admiral Timothy Barrett.

At the time Border Protection Command regularly deployed an asset to Christmas Island. At the time of the tragedy HMAS Pirie was the Christmas Island response vessel. This was usually the only asset at Christmas Island conducting surveillance on behalf of Border Protection Command.

At the time of the incident there were two assets allocated to Border Protection Command at Christmas Island, HMAS Pirie and ACV Triton, but these were to the east of Christmas Island for reasons discussed herein and could not provide effective surveillance of the north and north-west of Christmas Island.



While it was accepted by Rear Admiral Barrett that Border Protection Command was responsible for surveillance for SIEVs he expressed the view that –

I am unaware of any Government policy that requires BPC [Border Protection Command] to conduct surveillance in any part of the Australian Search and Rescue Region for the purpose of providing safety monitoring of vessels during sea passage.

In the context of the priority allocated to intercepting vessels such as SIEV 221 Rear Admiral Barrett made the following observation –

The reality is that in the event of a SIEV landing without being intercepted, the consequences from a border security perspective, and the difficulty in recovering the situation, are significantly less for a Christmas Island arrival than for a mainland arrival.

The above observation was clearly correct. Christmas Island is a small island surrounded by large areas of ocean and there would have been no possibility that asylum seekers from a SIEV, if they landed without being intercepted, would avoid detection. In addition it was obvious that asylum seekers intending to travel to Christmas Island were not wishing to avoid detection.

While it clearly would have been preferable if action could have been taken to intercept SIEV 221 prior to the stage when its engines failed and disaster was inevitable, at the time of its arrival the assets available to Border Protection Command, HMAS Pirie and ACV Triton, were involved in the performance of the core functions of Border Protection Command and were not available to conduct surveillance to the north of the Island.

It is noted that until the early hours of 15 December 2010 Border Protection Command had received no information which would suggest that an immediate response was required to prevent a possible tragedy on that morning or at all.

Available intelligence to Border Protection Command provided no direct information to the effect that imminent arrival of a SIEV was expected during the period of the evening of 14 December 2010 into the morning of 15 December 2010.

In that context the threat level for an arrival at the time was considered to be “medium”.

ACV Triton

In respect of ACV Triton, that vessel is chartered by Australian Customs and Border Protection Service to patrol Australia’s northern waters.

On 15 December 2010 it was only by coincidence that ACV Triton was at Christmas Island. At the time ACV Triton had on board 108 detainees who were being transported from the vicinity of Ashmore Islands to Christmas Island.

ACV Triton had arrived at Christmas Island on 13 December 2010 but due to prevailing weather conditions had been unable to offload the detainees being transported.

On the morning of 15 December 2010 ACV Triton was taking shelter to the east of the Island, a decision having been made that the 108 detainees on board should not be offloaded until the weather conditions improved.



HMAS Pirie

At the time of the tragedy HMAS Pirie was the Border Protection Command Christmas Island response vessel.

HMAS Pirie is an Armidale class patrol boat. The Commanding Officer of HMAS Pirie was Lieutenant Commander Mitchell Livingstone.

On 14 December 2010 HMAS Pirie had been involved with the apprehension of another SIEV, SIEV 220. SIEV 220 had been escorted to the east of Christmas Island by HMAS Pirie and ACV Triton.

The occupants of SIEV 220, 8 asylum seekers and 3 crew, were transferred directly from the SIEV to Ethel Beach boat ramp on the evening of 14 December 2010 using HMAS Pirie's RHIBS.

Throughout the night of 14 December 2010 and the early morning of 15 December 2010 HMAS Pirie was monitoring SIEV 220 on which there were 4 members from the HMAS Pirie (a steaming party). The plan was to wait for conditions to ease so that SIEV 220 could be destroyed at sea.

There was no available mooring so the boarding party from HMAS Pirie on SIEV 220 were endeavouring to keep it from crashing on the Island or drifting out to sea.

In the early hours of the morning of 15 December 2010 HMAS Pirie was travelling in a north-south direction, altering course each 10 minutes, over a distance of approximately 1 mile, at a distance of approximately 1 mile from the coast of Christmas Island in the vicinity of Ethel Beach.

ACV Triton was also the lee of Christmas Island, further to the south, so that the two vessels would be a safe distance apart.

Radar Surveillance

There was no effective radar surveillance being conducted north of Christmas Island at the time when SIEV 221 arrived.

The Jindalee Operational Radar Network (JORN) was not turned on at the time when SIEV 221 was wrecked and was never designed as a surveillance tool for detecting small wooden boats such as SIEV 221.

At the time of the incident Border Protection Command had commenced a process to trial a land based radar system but that system was not operational. It is doubtful whether that type of radar system would have been capable of detecting SIEV 221 on the morning of 15 December 2010.

Surveillance – Summary

While surveillance to the north of Christmas Island was a priority of Border Protection Command, the priority was not such that it was considered appropriate to allocate a second vessel to conduct surveillance when HMAS Pirie was unavailable or to put in place other means of effective surveillance which would have required significant additional resources. In the context of the functions of Border Protection Command, arrangements put in place for surveillance were reasonable.



The Emergency Response

In respect of the response to the emergency, while there were some delays in HMAS Pirie and ACV Triton and their small boats arriving at the scene of the disaster, it is important to note the fact that 41 persons were saved from the ocean by naval and customs officers who all risked their lives in doing so.

There was no guarantee at the time that the vessels, HMAS Pirie and ACV Triton, would have been available and able to assist. If, for example, ACV Triton had not been at Christmas Island, there would have been more deaths. If neither vessel had been able to assist it is likely that there would have only been one survivor, the passenger who was able to jump from the vessel to the rocky shore.

While there were a number of delays in the response from 5:46am, when the Customs on-call officer was advised of the arrival of SIEV 221, until about 7am, when the RHIBs from the HMAS Pirie arrived at the scene, the reasons for those delays resulted from the position in which HMAS Pirie and ACV Triton were placed at the time when the disaster took place.

I am satisfied that Lieutenant Commander Livingstone on HMAS Pirie and Andrew Stammers, Master of the ACV Triton, acted as promptly and efficiently as they could in the circumstances. The officers on the RHIBs and tenders demonstrated great courage and resourcefulness in the circumstances and I have nothing but praise for them.

The Christmas Island Emergency at Sea Response Capability

On 15 December 2010 there were no vessels from Christmas Island involved in the rescue efforts, all of the rescue vessels involved came from HMAS Pirie and ACV Triton. In the circumstances as they existed at the time there was no realistic possibility that any vessels from the Island could have participated in the rescue efforts. This was because of two factors –

- (a) the sea state at the time, which was extreme; and
- (b) the fact that there were no vessels on the Island capable of a rescue response in bad weather.

The agency with primary responsibility for an immediate search and rescue response in the area of the tragedy was the Australian Federal Police (AFP).

At the time of the tragedy the search and rescue vessel provided to the AFP for use on Christmas Island was a LeisureCat, the "Colin Winchester".

At the time of the tragedy that vessel was out of survey and believed to be unsafe for use in bad weather.

On the Island at the time there was a Volunteer Marine Rescue Service (VMRS) provided by local volunteers, the Commander of which at the time was Greg Riley.

It was clear from the evidence at the inquest that these volunteers were dedicated and committed people. I have great admiration for the contribution to marine safety provided by VMRS volunteers.

Responsibility for providing vessels for use by the VMRS rested with the Commonwealth. The vessel provided to the VMRS was a LeisureCat vessel, similar to the vessel provided to the AFP, namely the "Sea Eye".



At the time of the tragedy that vessel was also out of survey and was believed to be unsafe for use in bad weather.

There were no other vessels on Christmas Island on 15 December 2010 which were capable of taking part in a rescue operation in difficult conditions and so on that morning there was no capability for an emergency response in rough seas.

At the inquest the circumstances which resulted in there being no vessels on the Island capable of a rescue response in bad weather were explored. This involved reviewing the circumstances from the time of purchase of the LeisureCat vessels the "Colin Winchester" and "Sea Eye". These were purchased by the AFP with funding provided by the Department of Regional Australia.

The evidence revealed that –

1. In respect of the purchase of the vessel for the VMRS, at the time when the decision was made to purchase the LeisureCat, earlier documentation which related to recommendations made by the Fire and Emergency Services Authority of Western Australia (FESA) which had set up the VMRS and had ongoing interactions with the Department of Regional Australia were somehow not considered and the views of the intended users of the vessel were not taken into account.
2. The contract for purchase of the vessels was entered into with a named company when the name of that company had changed years earlier.
3. Problems were experienced with the LeisureCat vessels sent to Christmas Island virtually from the outset and on their arrival the Harbour Master placed the "Sea Eye" into quarantine as he was concerned that the vessel had not been built according to the United Shipping Laws (USL) Code.
4. On arrival the "Sea Eye" was damaged and relevant documentation was not available and was difficult to obtain.
5. On 11 August 2010 the "Colin Winchester" was comprehensively inspected by an Australian Maritime Safety Authority (AMSA) Inspector and a significant number of deficiencies were noted in a marine surveyor's report of that date.
6. An almost identical marine surveyor's report of deficiencies was also provided by AMSA in respect of the "Sea Eye" dated 12 August 2010 following inspection of that vessel.
7. The reports required the defects to be corrected by 11 November 2010 and 12 November 2010 respectively. Those defects were not corrected and the vessels were not replaced.
8. Concerns had been raised in respect of the stability of both vessels as it was believed they were overweight.
9. In September 2010 Sergeant Swann was directed by AFP Management that he was not to use the vessel, the "Colin Winchester".
10. In respect of the VMRS vessel, the "Sea Eye", as a result of the problems relating to that vessel Mr Riley, the Commander, had advised Sergeant Swann by letter dated 1 December 2010 that the VMRS was unable to provide a dedicated, viable marine rescue service.

The fact that neither the AFP nor the VMRS had access to a suitable vessel which could be used in rescue operations in bad weather and that there was no viable marine rescue service on the island was extremely unsatisfactory and unsafe. That this situation was allowed to exist for over four months leading up to the tragedy and afterwards at a time when the monsoon season was approaching and then during the monsoon season was particularly unsatisfactory and unsafe.



In addition it appeared that on 15 December 2010 the AFP on Christmas was not well prepared in respect of its role as a search and rescue authority in a number of respects.

Claims that information had been provided of the pending arrival of SIEV 221

After the inquest had commenced information was provided to the effect that identified detainees claimed that they had provided actionable information to persons in authority which could have enabled an earlier response to take place resulting in the tragedy either being avoided altogether or the number of deaths being reduced.

The detainee whose Department of Immigration and Citizenship (DIAC) number is OTF 018 claimed that he had told a guard at the Christmas Island Detention Centre of the impending arrival of SIEV 221 hours before it arrived.

In his statements OTF 018 claimed that a number of fellow detainees were involved in reporting the imminent arrival of the boat to a Serco employee. The most prominent among these were a detainee whose DIAC number was ZUC 001 (the alleged translator of OTF 018's account) and a detainee whose DIAC number was OTF 016 (OTF 018's room mate).

These allegations were investigated in great detail by police and at the inquest. It became clear that the account of OTF 018 and the accounts of those who gave evidence and provided information supporting that account were false. The accounts were a fabrication, inconsistent with the objective evidence.

The only account by any person in authority provided to the inquest which would suggest that an advance warning had been received of the arrival SIEV 221 was provided in a statement by an employee of MSS who had been employed as a fly-in fly-out contractor to Serco on Christmas Island.

The account of this witness in evidence was significantly different from the account given in his statement and was not credible. In any event, based on the witness' evidence at the inquest, the information which he claimed to have received and communicated was not credible information which ought to have been passed on or which would have been likely to have been acted upon.

On 5 September 2011 information was provided that a young woman, who had been a detainee on Christmas Island at the time of the wreck of SIEV 221, had told employees of Serco and DIAC that SIEV 221 was on the way from Indonesia before it arrived and specifically that she had done so on the night before the wreck.

This person was referred to at the inquest as MS 1 and was an Iranian national who had arrived on Christmas Island on 13 October 2010.

Extensive investigations were conducted into the allegations made by MS 1, but ultimately no oral evidence was called at the inquest in relation to those allegations. No party at the inquest submitted that it would have been helpful to receive oral evidence in relation to the issues. It appeared abundantly clear from objective evidence obtained by police investigators that the claims were unfounded.

It appeared, therefore, that there was no reliable, actionable information available to any persons in authority to the effect that SIEV 221 or any other similar vessel was expected to arrive at Christmas Island on the early morning of 15 December 2010.



Conclusions

The evidence revealed that individuals categorised at the inquest as “people smugglers” or as “organisers of the venture” contributed to the deaths. To a lesser extent it could be said that the crew, in being involved in transporting passengers of SIEV 221 to Christmas Island and by their decision making and steering of SIEV 221, also contributed to the circumstances which resulted in the deaths.

In the context of pending criminal prosecutions it is not appropriate for me to consider whether a verdict of unlawful homicide or a verdict of accident would be appropriate. In those circumstances I have made an Open Finding as to how the deaths arose.

Comments

A number of comments including recommendations have been made based largely on the recommendations of Sergeant Adam Mack of the WA Water Police, who assisted with the search and rescue response after the tragedy, and Lieutenant Commander Livingstone, who was in command of HMAS Pirie at the time of the emergency response.

Those comments and recommendations are directed largely towards the possibility of enhancing surveillance to the north of Christmas Island, improving the capability for an emergency at sea response from Christmas Island and reducing risks for naval personnel involved in rescue operations.

The following recommendations were made –

Surveillance Capability Around Christmas Island

Recommendation No. 1

I recommend that Border Protection Command continues to examine ways of improving its surveillance capability around Christmas Island so that the risk of SIEVs arriving undetected is reduced.

Recommendation No. 2

I recommend that Border Protection Command implement a surveillance strategy, possibly with the assistance of other Commonwealth authorities and organisations on the island such as the AFP, which heightens its coverage at times when the weather and sea conditions are rough.

Search and Rescue Model and Response System (SARMAP)

Recommendation No. 3

I recommend that the AFP take steps to determine whether access can be obtained to the National Search and Rescue Council endorsed SARMAP program covering the Australian Search and Rescue Region as well as adjoining tiles for Indonesia. Steps should be taken to ensure that if possible coverage would include high traffic areas where SIEVs enter the Australian Search and Rescue region allowing timely search and rescue plans to be drawn up for any potential incidents.

Training in Search and Rescue Management

Recommendation No. 4

I recommend that the AFP takes steps to ensure that there are on Christmas Island at all times appropriately trained AFP officers who have completed the National Police Search and Rescue Manager’s Course and that upskilling should be ongoing to establish a cadre of trained search and rescue personnel.



The Provision of a Suitable Search and Rescue Vessel for the AFP on Christmas Island

Recommendation No. 5

I recommend that the AFP be provided with a search and rescue vessel which is suitable to the specific conditions of Christmas Island.

I further Recommend that steps be taken to ensure that if for any reason the search and rescue vessel is not available, there is a replacement vessel on Christmas Island capable of providing an emergency response in difficult sea conditions.

The Possible Acquisition of Personal Water Craft (PWC) or Jet Skis

Recommendation No. 6

I recommend that consideration should be given to acquiring two personal water craft for deployment by appropriately trained and equipped staff of the AFP or the VMRS or both on Christmas Island

The Ethel Beach Boat Ramp

Recommendation No. 7

I recommend that the Commonwealth and the Shire of Christmas Island take steps to ensure that the Ethel Beach boat ramp is significantly upgraded, that it should be provided with shelter in the form of a rock groyne or similar buffer and that provision should be made so that a person can walk beside the ramp on a stable footing; or

If this is not considered likely to be effective in providing an appropriate means of deploying a rescue vessel in adverse conditions, such other action be taken as is necessary to ensure that there is a means of deploying a rescue vessel in adverse conditions.

The Suitability of the Vessel provided to the VMRS

Recommendation No. 8

I recommendation that the Commonwealth liaise closely with representatives of the Christmas Island VMRS prior to purchasing or replacing any vessels for the VMRS in the future.

Repair and Maintenance of VMRS Vessels on Christmas Island

Recommendation No. 9

I recommend that the Christmas Island VMRS be given autonomy to maintain operational readiness for the VMRS rescue vessel(s) and an appropriate budget be provided to allow this to take place.

The Need for the Christmas Island VMRS Vessel to be Commercially Surveyed

Recommendation No. 10

I recommend that arrangements be put in place which would remove the requirements for Masters of Volunteer Marine Rescue vessels to hold a commercial certificate of competency. Operators could then be qualified through the FESA Volunteer Marine Rescue Training pathway as skippers and crew. This would increase the number of available skippers in the event of a search and rescue incident and would make appropriate training easier to arrange.

Reinstating the Military Liaison Officer Position at Christmas Island and Providing Facilities for a Shore Party

Recommendation No. 11

I recommend that BPC establish an onshore presence as recommended by Lieutenant Commander Livingstone.



Establishing a Mooring Buoy in the vicinity of Ethel Beach

Recommendation No. 12

I recommend that the Commonwealth ensure that there is a mooring buoy which will enable the mooring of SIEVs to take place and free up the Christmas Island response vessel for ongoing surveillance duties.

Complete the Hydrographic Survey of Christmas Island

Recommendation No. 13

I recommend that the Commonwealth prioritise completion of a hydrographic survey of Christmas Island and ensure that such a survey is completed in the near future.

Jet Intake Blockage

Recommendation No. 14

I recommend that the issue of RHIB jet intake protection be allocated a high priority and that there be ongoing investigation of possible solutions to reduce the problem.

Mark Anthony FRYER

The Deputy State Coroner, conducted an inquest hearing into the death of Mark Anthony Fryer (the deceased), which was held at the Perth Coroner's Court, on 3-5 May and 10 October 2011. The Deputy State Coroner found death occurred on 19 October 2008 at Royal Perth Hospital as a result of Bronchopneumonia Complicating Injury to the Head/Neck (Subarachnoid Haemorrhage).

In the early hours of 18 October 2008 the deceased was in Lindfield Crescent, Albany, when he received a blow to the head, as the result of which he collapsed onto the ground. He was unconscious and unresponsive, and remained so through transfer to Albany Regional Hospital (ARH) and then Royal Perth Hospital (RPH). He was declared brain dead on 29 October 2008, but life support was not removed until 20 October 2008 to facilitate the donation of body organs.

At the conclusion of the medical evidence the Deputy State Coroner was satisfied the brain injury resulting in the deceased's death was traumatic in origin.

The Deputy State Coroner was also satisfied as to three things:-

1. The deceased was punched
2. As a result of the punch he collapsed immediately and never recovered, despite medical treatment.
3. The injury which resulted in the deceased's death was traumatic in origin.

On 5 May 2011, the Deputy State Coroner referred the death of the deceased to the DPP, without finalising a manner of death.

On 3 August 2011 the Office of the DPP returned the matter to the Coroner's Court with the exhibits and transcript which had been provided.



At the conclusion of the evidence on 10 October 2011 the Deputy State Coroner was still satisfied:-

- (i) the deceased was punched,
- (ii) As a result of the punch he collapsed immediately and never recovered, despite medical treatment,
- (iii) The injury which resulted in the deceased's death was traumatic in origin, and was further satisfied
- (iv) The deceased had been walking and talking appropriately prior to the punch and his collapse in Lindfield Crescent.

The Deputy State Coroner observed the DPP had failed to keep the parents of the deceased informed of events despite a request from this office they advise the parents of the deceased as to progress of the matter.

The Deputy State Coroner found the deceased died as the result of a traumatic brain injury when he was punched and, following which, fell to the ground in the early hours of 18 October 2008. He never recovered and was pronounced brain dead on 19 October 2008.

On 7 June 2012 DPP advised the Deputy State Coroner of his intention to resume conduct of a prosecution with respect to the death of the deceased.

Shaun Michael Ian PRICE

Coroner Packington conducted an inquest hearing into the death of Shaun Michael Ian Price (the deceased), with an Inquest held at Albany Coroners Court on 3-6 May 2011. Coroner Packington found that death occurred on 7 June 2008 at 11 Aylmore Street, Gnowangerup as a result of complication of facial injury.

The Coroner found that the deceased died by way of Homicide. That finding was provisional.

The Coroner noted that the DPP had discontinued a prosecution relating to this death in the District Court on 15 April 2009, but, based on additional evidence which the inquest had received, determined to report the case to the DPP. In making that report the Coroner then went on to respectfully recommend to the DPP that, if it is still the view of the State that a prosecution of this matter does not have reasonable prospects of success, as the District Court was advised on 15 April 2009, then a comprehensive explanation of how that view has been formed should be given to the deceased's family who, in his view, have thus far been ill-served by the criminal justice system of Western Australia.

At the time of the publication of the annual report the DPP had not advised the Office of the State Coroner whether a prosecution would be re-commenced.



Ashton Michael SUNFLY; Mitchell NANALA, Lewis John KALIONS; Jason MILNER and Liam TCHOOGA (Balgo Community Deaths)

The State Coroner conducted an Inquest into the above deaths which was held at Balgo on 2 August 2011 and Kununurra Court House on 3-4 August 2011 and Perth Coroner's Court on 8-10 August 2011. The State Coroner found that the identities of the deceased persons were –

Ashton Michael SUNFLY, and that his death occurred on 17 June 2008 at Balgo Community via Halls Creek as a result of Ligature Compression of the Neck (Hanging)

Mitchell NANALA, and that death occurred on 27 February 2009 at Balgo Community via Halls Creek as a result of Ligature Compression Injury to the Neck (Hanging)

Lewis John KALIONS, and that death occurred on 27 June 2009 at Balgo Community via Halls Creek as a result of Ligature Compression Injury to the Neck (Hanging)

Jason MILNER and that death occurred on 23 April 2009 at Balgo Community via Halls Creek as a result of Ligature Compression of the Neck (Hanging)

Liam TCHOOGA and that death occurred between 29 June 2010 and 24 July 2010 in an area known as "Kangaroo Valley" approximately 1 km from the town centre of Halls Creeks of Unascertainable causes in the following circumstances -

The inquest was held to explore the circumstances of the deaths of four young Aboriginal male persons who died by way of suicide in Balgo Aboriginal Community in a period of approximately 12 months and the death of another young Aboriginal male person whose death occurred shortly afterwards and resulted from self-destructive behaviour, solvent sniffing.

Since the *Coroners Act 1996* was proclaimed in every year the largest single cause of non-natural deaths in Western Australia has been suicide. In every year the deaths clearly identified as having resulted from suicide have exceeded the number of deaths which have resulted from motor vehicle collisions, work and domestic accidents and all other causes of non-natural death. In each year the number of deaths by suicide has exceeded 200 and in one year at least has exceeded 300 (1 July 2007 – 30 June 2008).

The average rate of suicide within Western Australia equates to approximately one suicide per ten thousand of population; suicide rates of Aboriginal persons in the Kimberley are far higher. The current rate is approximately 6.25 times higher than the rate for the state population as a whole.

Balgo has a population of less than 500 persons and at times the population is said to be as low as 100 persons. Four suicides in a twelve month period in a population of this size was vastly in excess of the rate to be expected of the state population as whole. While the total numbers for Balgo are relatively small, it is obvious that the suicide rate in Balgo in the relevant period, which was between 16 June 2008 and 27 June 2009, was more than 100 times the suicide rate of the general population.

The State Coroner found that this concentration of suicides in one small community over a 12 month period clearly constituted a cluster.

The State Coroner determined that it was appropriate that a public inquest be held in order to explore the circumstances surrounding this exceptionally high suicide rate.



The State Coroner observed that it is often difficult to determine with any precision why a deceased person has suicided. In the absence of suicide notes (there were none in the present cases) it was necessary to explore surrounding circumstances in order to infer intent and also to have an appreciation of the circumstances of the death.

Even when there are suicide notes, these very rarely provide a complete explanation for the decision to suicide.

It is sometimes said that suicide stems from the interaction of personal vulnerability factors and situational factors.

The State Coroner observed that a striking feature of the present case was the fact that the immediate situational factors were relatively minor in all but perhaps one case.

In respect of two of the suicide deaths there was no identified obvious precipitating stressful event at all. In the two other cases the young men concerned appeared to have experienced relationship difficulties.

A question in this case is why the resilience of the young men concerned was so low.

The State Coroner found that during the period of the deaths the subject of the inquest petrol sniffing was a major problem in Balgo. The evidence revealed that most, if not all, of the five young men in question sniffed petrol at one time or another. While petrol sniffing undoubtedly had some degree of negative impact on the lives of all of the deceased persons, it was clearly a major factor in the circumstances of the death of Liam Tchooga.

The State Coroner found that in his case his death resulted directly or indirectly from petrol sniffing and his life was already significantly damaged by solvent abuse.

The State Coroner noted that Tristan Ray of CAYLUS gave evidence that after some initial teething problems the *Volatile Substance Abuse Prevention Act 2005* (NT) has been an effective tool in the Northern Territory for ensuring that chronic solvent users who are at risk of severe harm undergo suitable treatment at appropriate facilities.

In this context the State Coroner made the following recommendation –

Recommendation

I recommend that the State Government consider implementing legislation similar to the Volatile Substance Prevention Act 2005 (NT) which would enable the making of treatment orders specifying treatment programs and the facility or place where the treatment programs are to be provided for volatile substance abusers at risk of severe harm.

This case also highlighted the fact that there are no suitable residential rehabilitation centres in Western Australia which are available throughout the year for young Aboriginal people who sniff volatile substances or who suffer from other forms of drug addiction. In particular there is no culturally appropriate centre which can provide the service in “country”.

Clearly without facilities a legislative provision such as suggested in the above Recommendation would have less practical benefit.

The State Coroner made a further recommendation as follows –



Recommendation

I recommend that the State Government consider funding, or at least working with Aboriginal organisations such as KALACC, to provide culturally based solutions that address the issues of substance abuse and youth justice diversionary schemes.

I further recommend that consideration be given to relaxing the tendering procurement process in appropriate cases in recognition of the fact that the organisations which are capable of providing such services are very limited in number.

The State Coroner found that a feature of the background of each of the five young men the subject of the inquest was that the level of education achieved was extremely low. It was also obvious from the files relating to four of them that truancy was a major factor in the low level of education achieved.

The extent of the truancy by these four deceased persons was very important in this context for at least the following reasons –

- ✚ increasing truancy was an early indicator that their lives were taking a negative turn;
- ✚ poor results clearly impacted adversely on self worth and confidence and increased personal vulnerability;
- ✚ low education levels dramatically reduced any prospect of worthwhile long term employment, again increasing personal vulnerability; and
- ✚ non-attendance at school contributed to an environment where life skills necessary for most gainful employment would not be achieved.

Unfortunately there are still many students who are not attending school and, like the deceased persons, are being left behind the greater community.

With respect to truancy the State Coroner made the following recommendations –

Recommendations

I recommend that the Department of Child Protection consider including as a factor in determining whether the Child Protection Income Management Program should be implemented for parents or guardians of children of school age the question whether those children are attending school as part of the overall assessment of the child care being provided.

I recommend that in cases of repeated non-attendance at school by children of compulsory school age resort should be had to the powers contained in the School Education Act 1999 and the Parental Support and Responsibility Act 2008.

The State Coroner heard evidence during the inquest hearing in relation to mental health issues and found that it was clear that two of the young deceased men had significant mental health issues.

State Coroner found that it had long been recognised that mental health issues are a risk factor for suicide and self-destructive behaviour and in these cases the mental health issues were of significance.



The State Coroner also concluded that it is clear that the Kimberley Mental Health and Drug Service faces very considerable practical difficulties in attempting to provide a comprehensive mental health service to Aboriginal communities throughout the Kimberley, including the Balgo Aboriginal Community.

The State Coroner observed that it is unfortunate that there are not better facilities available for Aboriginal children or adolescents living in the Kimberley who suffer from mental health problems. The State Coroner observed that for cases where patients must be transferred to the Bentley Unit or Princess Margaret Hospital in Perth, that involves lengthy and distressing air flights, particularly for patients who have to be restrained during travel, and considerable allocation of resources on the part of both the Royal Flying Doctor Service and WA Police.

The State Coroner found that while it may be difficult and expensive to provide a secure location for young acutely ill mental health patients in the Kimberley this is an important issue which should be addressed.

In this context the State Coroner made the following recommendation –

Recommendation

I recommend that the Health Department give consideration to reviewing facilities available for adolescents and children suffering from mental health problems in the Kimberley with a view to provision of facilities for secure admission so that these persons can be treated as involuntary patients in the Kimberley.

Responses to the State Coroner’s recommendations are as follows –





Minister for Transport; Housing

Our Ref: 30-16757

Mr Dominic Mulligan

Dear Mr Mulligan

I refer to your letter to the Hon Peter Collier MLC, Minister for Indigenous Affairs, requesting input and advice relating to the Balgo Aboriginal Community. Minister Collier referred your letter to me for response regarding the level of support provided by the Department of Housing to the Balgo Community. I was sorry to learn of the loss of three young men at the Community.

The National Partnership Agreement for Remote Indigenous Housing (NPA) seeks to address poor housing outcomes in remote Indigenous communities. The Department is charged with delivery of the NPA and since 2008 has built eight new dwellings and refurbished 27 existing dwellings in Balgo. An additional 28 houses in Balgo will be refurbished by 30 December 2011 and completion of this program will ensure all houses are in good repair.

Houses constructed in Balgo since 2008 incorporate recommendations of the National Indigenous Housing Guide and Code of Practice for the Provision of Housing and Essential Services and include design features such as:

- additional veranda space;
- stainless steel security/insect screens;
- security doors;
- use of more durable materials and stronger fixtures;
- larger bedrooms and living areas;
- 6-star rated energy efficiency;
- outdoor cooking areas; and
- additional toilets and showers with external access to reduce the impact of visitors on the core household.

I am advised that the Department has also provided the Coroner with a statement by Mr James Butterworth, Director Remote Indigenous Housing, to further inform the Inquest.

Should you have any further queries regarding this matter please contact Ms Mel Croke, Regional Manager, at the Department's Halls Creek office on 9168 9300.

Yours sincerely

HON TROY BUSWELL MLA
MINISTER FOR HOUSING

10 OCT 2011

Level 12, Dumas House, 2 Havelock Street, West Perth Western Australia 6005
Telephone: +61 8 9213 6900 Facsimile: +61 8 9213 6901 Email: Minister.Buswell@dpc.wa.gov.au



**MANAGEMENT REVIEW REPORT
REGARDING THE CIRCUMSTANCES OF THE FIVE DEATHS
WITHIN THE BALGO ABORIGINAL COMMUNITY**

Introduction

The current suicide rate for Aboriginal persons in the Kimberley region is approximately 6.25 times higher than that for the general population in Western Australia. Four young Aboriginal males were found to have died by way of suicide (ligature compression) in the Balgo Aboriginal Community (Balgo) over approximately 12 months, from 17 June 2008 – 27 June 2009. For a community which has a population of less than 500 persons and at times as low as 100 persons, these deaths represent an alarmingly high rate of suicide for that period, equating to more than 100 times that of the general population in Western Australia.

A fifth young Aboriginal male person died in Balgo, of unascertainable causes, between 29 June 2010 – 24 July 2010. This death, which occurred shortly after the aforementioned four suicides, "resulted from self-destructive behaviour, [namely] solvent sniffing" (refer page 3, Coroner's Findings)¹.

It was thus "appropriate that a public inquest be held in order to explore the circumstances surrounding this exceptionally high suicide rate with a view to determining whether common features could be identified and recommendations made with a view to preventing repetition of the events" (page 4).

Pursuant to section 40 of the *Coroners Act 1996*, these five deaths were explored collectively in the one inquest. The State Solicitors Office appeared at the inquest on behalf of the entire State Government. The Coroner made five recommendations, however only one recommendation is viewed as being applicable to the Department of Corrective Services (DCS) as follows:

Recommendation Two

"The case of the deceased highlighted the fact that there are no suitable residential rehabilitation centres in Western Australia which are available throughout the year for young Aboriginal people who sniff volatile substances or suffer from other forms of drug addiction. In particular there is no culturally appropriate centre which can provide the service in country" (page 37).

"One organisation which has been particularly active in maximising diversions from the justice system and addressing problems such as petrol sniffing and alcohol abuse is the Kimberley Aboriginal Law and Cultural Centre (KALACC) located in Fitzroy Crossing. KALACC has been involved in a successful diversionary program for Indigenous youth known as the Yiriman Project" (page 38). This program involves Indigenous elders working with youth to promote a cultural framework and build community relationships and capacity.

¹ All references throughout this report will refer to the Coroner's Findings



While KALACC is in the process of applying for surplus Government funding in order to extend this program, the organisation "faces problems associated with compliance with strict Treasury Department guidelines, which require a tendering procurement process involving presentation of a business case and a competitive tender process in order to obtain funding" (page 39).

The Coroner's Recommendation (page 40) has been separated into two distinct sections, as follows:

- a) *I recommend that the State Government consider funding, or at least working with Aboriginal organisations such as KALACC, to provide culturally based solutions that address the issues of substance abuse and youth justice diversionary schemes.*

DCS Response – This recommendation is supported in principle. In 2011, DCS expanded the Regional Youth Justice Services (RYJS) to the West and East Kimberley and Pilbara regions. RYJS provides prevention and diversion services for young people, including drug and alcohol rehabilitation, educational and cultural programs, counselling services and short term accommodation support services for young people eligible for bail. These services are provided by non-profit organisations to provide culturally based solutions. Although none of these programs currently service Balgo, DCS currently funds a Youth Diversion Service in Halls Creek, provided by the Local Shire. This service, which has been in place since 2006, is designed to offer positive alternatives to young people at risk of offending, including recreational activities, mentoring, counselling and culturally-specific programs. Suicide intervention also forms a key component of this service. While service providers in Halls Creek are able to offer services in Balgo, they are located several hours away (by car) and hence service provision is only ad hoc or periodic.

KALACC and other Aboriginal organisations are represented on the West Kimberley Regional Youth Justice Services Community Reference Group. This group informs the gaps in services for at risk young people and the identification of local non-Government organisation service providers. DCS has previously attempted to engage KALACC on an as needs basis to provide services to young people who are likely to offend, or who have offended.

- b) *I further recommend that consideration be given to relaxing the tendering procurement process in appropriate cases in recognition of the fact that the organisations which are capable of providing such services are very limited in number.*

DCS Response - The new State Government 'Delivering Community Services in Partnership Policy' has significantly reduced the bureaucratic processes which have previously made it difficult for non-Government organisations to meet Government contractual requirements.



DCS recognises that the funding of youth diversion services in regional areas must be sustainable and cover the full cost of service delivery to elicit a positive response. In early 2012, DCS is re-tendering a Youth Diversion Service to Young People in Roebourne and Kununurra through a two stage procurement process that will allow for greater community sector involvement in the planning and development of the required services. This approach will encourage innovation in the design of the service model and the sustainability in the delivery of the service.

Preparation of this Report

This report was prepared by Mr Joe Apai, Professional Standards Division, with input from the Community and Youth Justice and Corporate Support Divisions.



Joe Apai
Coordinator Coronial Inquests
CRITICAL REVIEWS UNIT

17 January 2012

Endorsed: _____
Deputy Commissioner
Community and Youth Justice

Endorsed: 
Assistant Commissioner
Corporate Support

Endorsed: 
Assistant Commissioner
Professional Standards



A report from the Department of Health (Mental Health) received February 2012 is as follows –

“:Status : Ongoing.

February 2012 : The Coroners Recommendations Advisory Group has tabled this report and is reviewing the recommendations made by the Coroner’s Office. A number of possible options for implementation are being considered relative to this recommendation. The outcomes of the chosen action will be reported on in August 2012.

The State Coroner received a response from the Hon Helen Morton, Minister for Mental Health as follows -





Minister for Mental Health; Disability Services

Our Ref: 43-04468

Ms Dawn Wright
Administrator
Office of the State Coroner
Level 10 Central Law Courts
30 St Georges Terrace
PERTH WA 6000

PERTH DISTRICT COURT
10 AUGUST
F112

Dear Ms Wright

INQUEST INTO THE CIRCUMSTANCES SURROUNDING THE DEATHS OF ASHTON MICHAEL SUNFLY, MITCHELL NANALA, ALWYN KALIONS, JASON MILNER AND LIAM TCHOOGA

Thank you for your letter of 9 February 2012 addressed to the then Attorney General Christian Porter MLA, seeking advice on any proposed actions resulting from the Coroner's Findings into the above Inquest for inclusion in the State Coroner's Annual Report to the Attorney General. Your letter was forwarded to me for response as the Minister responsible for alcohol and other drug issues, which includes volatile substance use. I apologise sincerely for the delay in responding.

Recommendation No 1 of the Coroner's Findings, relates to the consideration of legislation, similar to the *Volatile Substance Abuse Prevention Act 2005 (NT)*, which would enable the making of treatment orders specifying treatment programs for volatile substance users at risk of severe harm.

Volatile substance use is a complex problem that requires a coordinated and multifaceted response. This includes a balance of supply, harm and demand reduction strategies, of which appropriate legislation may be one. Wherever possible, it is important that any initiatives implemented are informed by evidence, including appropriate research and evaluation, and practitioner and community expertise. I also recognise the need to engage Aboriginal communities in the planning, development and implementation of appropriate responses for both the individual and their community.

There are compulsory treatment options available in some circumstances regarding alcohol and other drug treatment in Western Australia. However, services are not configured to detain people and 'force' treatment. A range of diversion programs are offered that vary in their level of coercion. The *Children and Community Services Act 2004* and the *Mental Health Act 1996* can provide some protection for at-risk people by providing options for placement in care.

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In some circumstances it may be possible to admit a juvenile using volatile substances to the Department for Child Protection's secure care facility under the *Children and Community Services Act 2004*. Additionally the *Aboriginal Communities Act 1979* and the *Local Government Act 1985* enable communities to regulate deleterious substances.

The practical issues associated with detaining someone for alcohol and/or drug treatment are complex and difficult. In the Northern Territory, the *Volatile Substance Abuse Prevention Act 2005 (NT)* has provision for mandatory treatment for persons deemed to be at risk of severe harm from inhalant use. It includes court-ordered mandated treatment for people who are sniffing volatile substances, including petrol.

The *Volatile Substance Abuse Prevention Act 2005 (NT)* encounters some of the same constraints as the Western Australian environment in that authorities cannot mandate a person to be detained or cooperate with treatment.

In late 2011, the Drug and Alcohol Office reviewed the current evidence relating to compulsory treatment programs across Australia. To date, there is little evidence to demonstrate the efficacy of the Northern Territory legislation in comparison to what is already available in Western Australia. Even so, the Drug and Alcohol Office is further reviewing this matter and seeking additional advice from those with the relevant expertise in this area. If future evidence demonstrates the efficacy of the Northern Territory legislation in comparison with existing Western Australian legislation, then I would be prepared to consider the appropriateness of such an approach in this State.

Addressing volatile substance use is a priority for the Government and the Drug and Alcohol Office has developed a *Volatile Substance Use Plan 2012-2015* with the aim to prevent harmful volatile substance use, and protect the health and welfare of volatile substance users and their families.

Recommendation 2 related to providing culturally based solutions that address the issues of substance abuse and youth justice diversionary schemes.

With respect to youth justice diversionary schemes:

- The MHC is a member of the Youth Justice Steering Committee auspice by the Department of Corrective Services. The committee has broad representation from government departments; the community sector and NGO service providers who meet quarterly providing a mechanism for stakeholders to share information on developments within the youth sector.
- The purpose of the Youth Justice Steering Committee is to contribute to the prevention of offending through strategies that address the social exclusion and specific factors that lead to young people offending. A memorandum of understanding (MOU) has recently been signed with the committee members by the MHC with the stated intention to implement the Western Australian Strategic Framework for Youth



Justice 2009-2014 which is part of the 'Juvenile Justice in Western Australia: New Ways Forward' report 2009.

- A key purpose of the MOU is to provide a framework to establish how the signatory agencies and additional members can work together to address the social issues and cost related to children and young people who offend or who are at risk of offending in Western Australia. In particular this inter-agency group aims to reduce the overrepresentation of Aboriginal children and young people in the Western Australian justice system.
- As part of this year's budget, the Government announced that a mental health diversion and support program will be piloted. This is a joint project between the Department of the Attorney General and the Mental Health Commission, and will be based in the Perth Magistrates Court and the Perth Children's Court. It will place mental health clinicians in the courts and assist people to access mental health services. Research from other jurisdictions shows that such programs are able to make a positive difference to people's engagement with services, general wellbeing and offending behaviour. While the program is being piloted in Perth metropolitan courts, it is hoped that a successful pilot would lead to expansion into regional areas.

Recommendation 5 related to the provision of facilities for secure admission for children and adolescents suffering from mental health problems in the Kimberley so that they can be treated as involuntary patients.

The MHC recognises the need to increase the availability of specialist mental health services for children and young people living in rural and remote areas. While there are no immediate plans to develop a secure facility for children in the Kimberley region, the MHC will explore with the Department of Health the possibility of considering, on a case by case basis, the admission, including involuntary admission, of young people under the age of 18 years to the acute inpatient unit which opened in Broome in May 2012.

The MHC has increased the community based mental health resources in the Kimberley region since 2010 with 12 additional FTE employed in the Kimberley region as part of the expansion of the Statewide Specialist Aboriginal Mental Health Service (SSAMHS) program with the particular aim of improving the availability of mental health services for children and young people living in remote communities including Balgo.

During 2011 an urgent inter-agency response was developed to respond to the increased suicides in the Kimberley. The Minister for Mental Health visited Broome in March 2011 to announce additional funding for suicide prevention in the Kimberley, including funds to enhance Standby postvention support

Other suicide prevention measures supported by the MHC in 2011 include additional staff support and 'personal safety plans' for identified vulnerable youths and



temporary 'foot patrol' for communities in Derby; community forums and bush meetings with community groups to develop suicide prevention plans and community action plans; and support for twenty community members to attend the Blank Page Summit Hard Yarn Youth Mob in Billard in July 2011.

Thank you for forwarding me a copy of the Coroner's Findings. I have noted the Coroner's recommendations as they relate to mental health and alcohol and other drug problems and will ensure that they are considered within future deliberations.

Yours sincerely



**HON HELEN MORTON MLC
MINISTER FOR MENTAL HEALTH**

cc Hon Michael Mischin MLC; Attorney General

09 AUG 2012



David Peter ELLERY

Coroner Mulligan conducted an inquest into the death of David Peter Ellery at Perth Coroner's Court on 1-4 November 2011 and 12-16 December 2011. Coroner Mulligan found death had occurred on 31 July 2007 at 5 Kookaburra Place, Seville Grove as a result of Ligature Compression of the Neck (Hanging).

The deceased was a 25 year old man who lived alone at 5 Kookaburra Place, Seville Grove.

The deceased was an amphetamine user. The deceased had been using illicit drugs for about eight years prior to his death. The amount of the drug consumed by the deceased varied, however, he was using amphetamines heavily during the first half of 2007.

The deceased began to suffer from depression and he was initially prescribed with antidepressant medication on 29 March 2007.

The deceased's sister became aware of her brother's drug use. She spoke to the deceased who agreed that his addiction problem was "out of control" and that he wanted to stop taking amphetamines.

The deceased was referred to the Holyoake Centre for drug rehabilitation by his GP. He went for an initial assessment at the Holyoake Centre on 25 July 2007. During the course of the assessment the deceased told the counsellor that he had recently started to experience paranoid and psychotic thoughts which were causing him to feel suicidal.

On 30 July 2007 the deceased attempted to suffocate himself by placing a plastic bag over his head. When this proved unsuccessful he tried to kill himself again by first placing a rag in his mouth and then putting a plastic bag over his head. These attempts at suicide were unsuccessful.

On 31 July 2007 the deceased was visited by his uncle. The deceased appeared very unwell and to be suffering from a high degree of paranoia. The deceased's uncle was sufficiently concerned about his nephew's well-being to take him to the Mill Street Centre at Bentley Hospital so that he could be assessed by mental health experts.

Whilst stopped at traffic lights on Albany highway, the deceased jumped from his uncle's car and hid in nearby bush. The deceased's uncle called for police assistance. About an hour later the deceased came out of hiding and agreed to go to the Bentley Hospital.

The deceased arrived at the hospital at about 3:30 PM. He went into the facility and spoke to a triage nurse. The only doctor on duty was unavailable as she was dealing with a very pressing case.

The deceased told the triage nurse about his amphetamine use. He also told her that he felt suicidal and that on the previous day he had tried to kill himself. He told the nurse about his attempts to suffocate himself with the rag and the plastic bag.

The deceased also told the triage nurse that before going to the hospital he had tried, on three occasions, to strangle himself with his belt. The deceased told the nurse that he was hearing voices and on occasion he was getting messages from the television.



The triage nurse spoke with the duty doctor who instructed the nurse to give the deceased a small quantity of diazepam. The triage nurse did this, however the deceased only pretended to take the medication.

At about 4 PM the deceased left the hospital and was taken home by his father, who had been called to his son's assistance.

The deceased's departure was against the wishes and advice of the triage nurse. The triage nurse was unable to prevent the deceased leaving the hospital because she was not an authorised mental health practitioner who could place the deceased "on forms". Moreover, the triage nurse lacked the physical means of stopping him from leaving the hospital. The hospital did not have any security staff on duty at the Mills Street Centre, who may otherwise have been able to restrain the deceased.

The triage nurse was very concerned about the deceased's decision to leave the hospital because of his recent suicidal behaviour, suicidal comments and demonstrated psychotic symptoms.

After the deceased left the hospital the triage nurse spoke to the duty doctor. The doctor gave the triage nurse an instruction to contact the relevant Community Emergency Response Team (CERT) and ask that they go to the deceased's home. She was also instructed to telephone the police.

The role of CERT is to complement normal mental health services by providing after hours emergency response services to the community, which would otherwise not be available.

CERT is made up of senior mental health professionals who are authorised mental health practitioners under the Mental Health Act 1996 (WA). These health professionals are able to place a person "on forms" and compel that person to be assessed by a psychiatrist.

During the afternoon shift of 31 July 2007 the Armadale CERT was made up of a two-person team; Anna Fagence, a registered psychologist, and Wayne Jones, a level 3 nurse.

The Armadale CERT operates on the same basis as those working in a firehouse. They await and respond to emergency situations. If there are no emergencies to be dealt with, then there is nothing for its team members to do.

In July 2007 the Armadale CERT team dealt with a total of 14 referrals. This means that on average, in July 2007, there was very nearly 1 referral to the Armadale CERT every two days.

Each referral was dealt with by a two-person team. Each referral was meant to take CERT about two hours to complete, allowing for travelling time.

Armadale CERT was extremely well resourced to meet the actual demand it experienced. This was the case on 31 July 2007 when the deceased was referred to the Armadale CERT. During the course of the entire afternoon shift (3 PM – 11:30 PM) the Armadale CERT received no other tasking. Their only referral related to the deceased. They were accordingly in an extremely strong position to be able to assist the deceased and give careful attention to his predicament.

The triage nurse at Bentley hospital telephoned the Armadale CERT at about 4:25 PM on 31 July 2007 and provided Nurse Jones with very clear information and instruction. The triage



nurse also faxed CERT a copy of the relevant triage form. The form included the deceased's correct name, address and mobile phone number.

CERT operates under its own triage system, which has 5 levels of response.

The acuity of the deceased's crisis should have seen the deceased classified as a Response Level 1 patient. This should have seen the Armadale CERT initiate an immediate response.

During the course of their shift Nurse Jones and Ms Fagence entered information into CERT's computerised information system.

One matter they had to consider was the clinical prioritisation of the deceased. The CERT officers entered the deceased into their computer system as a person requiring a Level 2 Response. Under the CERT triage system a rapid response was required, that is a response within two hours.

As noted above the Armadale Cert had no other taskings during their shift.

Notwithstanding the manner in which the CERT officers completed the computerised details relating to the deceased, they both gave evidence that they had in fact felt that the acuity of the deceased's position required a Level 1 Response.

Both CERT officers believed that the Armadale CERT did not in fact respond to cases where a Level 1 Response was called for. They believed such cases should be dealt with by the police. Neither Nurse Jones nor Ms Fagence told the triage nurse at Bentley Hospital that they were declining the case or gave her any reasonable basis to believe that the Armadale CERT would not respond appropriately.

There followed a number of phone calls between Bentley Hospital and the police, Bentley Hospital and the Armadale CERT, and the Armadale CERT and the police. The result of these communications was that at about 7:33 PM two police officers, who were on patrol in a police car, were asked to conduct a welfare check on the deceased. The police code for the job was "448". This job code means "welfare check (non-urgent)".

The police communications centre, which despatched the officers to the deceased's property, gave the officers a significant amount of information in relation to the deceased's recent past. This included his drug use, paranoia and suicide attempts which they were told took place "last night and again today".

The officers were also told "*Armadale CERT team will meet police if possible at the address. I've got a phone number for Wayne, who's from Armadale CERT.*"

The officers telephoned Nurse Jones via one of their mobile phones. The police officer advised Nurse Jones that the police officers were at that the deceased's address. The police officer requested Nurse Jones' presence at the doctor's property, so that he could be involved in the assessment of the deceased. According to the police officers Nurse Jones declined to go to the deceased's property as he considered that "at this time it was just a welfare check and there was no need for them to attend".

The two CERT employees did not go to the deceased's home and carry out an assessment the deceased. It should be noted that the Armadale CERT was based no more than a 5 – 10 minute drive from the deceased's home.



Neither police officer had any experience in the area of mental illness or of assessing a person's mental health. Neither officer had an awareness of section 195 of the *Mental Health Act 1996 (WA)* which relates to the police's power to take a mentally ill person into protective custody.

The senior police officer was not happy that he had been asked to carry out a welfare check in the absence of the CERT. He telephoned the Police Incident Management Unit to alert them to the situation. The police officers nevertheless were instructed to carry out the tasking.

The two officers spoke with the deceased for about ten minutes. The senior police officer told the deceased why they were at his home and about their concerns for his mental health.

The deceased appeared calm and polite and did not show signs of anxiety or abnormal behaviour.

The police made a number of offers to help the deceased by taking him back to the hospital. The deceased declined these offers.

Because of the way the deceased behaved during the interview the senior officer did not believe that he had any lawful authority to compel the deceased to accompany him to Bentley Hospital.

During the course of evidence the senior officer told the court:

He stated that he was going back the next morning to receive further treatment and I was – I continually tried to get Mr Ellery to come with us voluntarily, knowing – or believing and knowing that I didn't have the power to take him involuntarily, but he had all the right answers and he was very calm about it. It was almost like a mind game. He knew that I knew that I couldn't take him and the answers that he gave me were not supportive of me taking him from his home.

At about 7:52 PM the two officers left the deceased's property and returned to their vehicle. Once there the police called and spoke to Nurse Jones. The senior officer told Nurse Jones that *"their own concerns and knowledge of the current risk level associated with Mr Ellery, should give cause to them to consider providing assistance to Ellery in a timely manner"*.

Nurse Jones told the police that CERT would monitor the deceased themselves.

At sometime between 7:52 PM and 10:30 PM the deceased committed suicide by hanging himself. He died of ligature compression of the neck.

In my opinion the Armadale CERT response was sub-optimal and did not adequately address the mental health crisis the deceased was going through prior to his death.

Notwithstanding the fact that the Armadale CERT were under no pressure of work and had become seized of the matter at about 4:35 PM they did not contact the deceased before his death.

It is my opinion that an assessment by two senior mental health professionals may have been beneficial to the deceased. Moreover Mr Jones and Ms Fagence would have brought greater expertise to the assessment process than that available from the two police officers.



It would be wrong to conclude that the outcome for the deceased would necessarily have been different had he been assessed by the Armadale CERT

Issues 1 & 2

The deceased was able to leave Bentley hospital, notwithstanding the triage nurse's view that he should be detained so that he could be properly evaluated. The triage nurse was unable to:

1. Place the deceased "on forms" under the Mental Health Act 1996 (WA), requiring him to stay at the hospital until evaluated.
2. Physically prevent the deceased from leaving hospital, as there were no security guards able to prevent the deceased from leaving against his will.

Recommendations

1. **That the Department of Health should, as a matter of priority, consider offering appropriately qualified nurses undertaking triage duties in mental health facilities the opportunity to become Authorised Mental Health Practitioners under the Mental Health Act 1996, so that they can place appropriate patients "on forms".**
2. **That Bentley hospital and in particular the Mills Street Centre be provided with sufficient security staff so that staff security is enhanced and those "on forms" can be prevented from leaving the hospital.**

Issue 3

There were a number of phone calls between Bentley hospital, the Armadale CERT and the police. Those phone calls resulted in the two police officers going to the deceased's property under a job code "448", being a "welfare check (non urgent)". This is plainly not what was required or intended in the circumstances.

The police do have a higher priority code that could have been assigned in this case. Incident code 168 C relates to "Mental Health Incident – Excluding Escort (Suspected Mental Condition; Threats of Suicide)"

In order to achieve a higher incident code and a quicker response by the police, the Department of Health can:

- a. Reinststate the memorandum of understanding with the police, which expressly dealt with how those in the mental health field could access a speedy police response.
- b. Co-locate a health Department official at the police communications headquarters so that official can liaise and negotiate with the police about the appropriate priority to be given to any individual case that comes from a mental health facility or CERT team. This would assist the police and the management of their resources and ensure that urgent mental health crises receive priority.

Recommendation 3

That the Department of Health and the West Australian Police Service work together in order to create an environment that will enable those suffering a mental health crisis to receive speedy and efficient welfare checks. The parties should consider co-locating a



Department of Health official at the police communications headquarters to assist in determining the priority of cases coming from mental health facilities or services.

Issue 4

This case highlights the dangers of substituting the informed expert opinion of CERT with well-intentioned but uninformed views of the police. It is the function of CERT to respond to mental health crisis and to take appropriate action.

Recommendation 4

The Department of Health should, as a matter of priority, communicate to its employees engaged in triage and in CERT teams that a welfare check undertaken by the West Australian Police Service does not replace a thorough mental state examination conducted by senior mental health professionals.

Issue 5

This case highlights a lack of ownership by either CERT or the Bentley hospital (MSC) in relation to which party would ensure the deceased's mental health crisis was quickly and appropriately dealt with. Bentley hospital triaged the deceased's case to the Armadale CERT. The Armadale CERT did not believe that they should be dealing with the case because in their mind it warranted a Response Level 1. They did not adequately convey that view to Bentley hospital and there was accordingly a lack of "ownership" of the deceased's case.

Subsequent to the death of the deceased program manager, Ms Ruth Lawrence published a memo to CERT staff, which helps to instruct CERT staff in relation to the "ownership" relating to Response Level 1 matters. The memorandum is a useful document which in my view should be formalised into a policy document.

Recommendation 5

The Department of Health should, as a matter of priority, create and communicate to its staff working in triage and in CERT teams, who has ownership of Response Level 1 matters and who will either intervene or ensure that a request of the police to locate the consumer is made in a timely manner and in such a way as to ensure a priority response.

Recommendation 6

CERT officers should, in all circumstances assess a consumer, who has been placed at Response Levels 1, 2 and 3, unless by doing so CERT staff place themselves at risk by attending to a consumer who is armed, threatening or poses a threat to others. In those situations of danger CERT staff should not attempt to assess the consumer in the absence of the police.

Issue 6

The two police officers were largely ignorant of the powers granted to them under section 195 of the Mental Health Act 1996. In the senior officer's case he received no training in this regard. The junior colleague may have received some training however she knew very little about the operation of the particular section.



In 2008 new police recruits are receiving substantial training in relation to mental health. A total of 13.5 hours of training related to the subject is now being delivered over a four-day period. The content of the course as explained by Inspector Kim Travers seems to be comprehensive and to adequately address issues arising under section 195 of the Mental Health Act 1996.

Since 2008 in-service training relating to mental health has also been provided to all fourth-year Constables during the officer enhancement course. It is also now a pre-requisite for those obtaining the first promotion rank of first-class constable.

There is a gap in mental health training for police who attained the rank of first-class constable, or higher, before 2008.

Recommendation 7

The Commissioner of police should draw to the attention of all officers who have not had mental health training, their powers under section 195 of the Mental Health Act 1996. As resources allow the Commissioner should ensure that all officers receive appropriate training relating to mental health and their responsibilities and powers under the Mental Health Act 1996

Josephine Wilma TROY

The Deputy State Coroner conducted an inquest hearing into the death of Josephine Wilma Troy (the deceased) at Perth Coroner's Court on 5-8 December 2012 and 16-19 January 2012. She found death had occurred on 14 February 2006 at Bunbury Regional Hospital as a result of Intra-Cerebral Bleed Secondary to Thrombocytopenia in a person with Polymorphocytic Leukaemia previously treated with Chemotherapy.

The deceased had been diagnosed with leukaemia in 2004. She was initially treated with chemotherapy for an acute form of leukaemia, but the diagnosis was later refined to polymorphocytic leukaemia (PLL), the most aggressive of the chronic leukaemias (CLL). Following chemotherapy the disease was still present in her bone marrow which, with the chemotherapy, compromised her blood production capacity. She experienced a low white cell count, a low platelet count and low haemoglobin, making her pancytopenic and very susceptible to infection and febrile neutropenia.

On Sunday 12 February 2006 the deceased recorded a temperature in excess of 38°C and attended Bunbury Regional Hospital (BRH). As an immunocompromised patient, susceptible to febrile neutropenia, she was properly started on antibiotics and a full blood screen ordered. She recorded a very low platelet count (3) which required platelet transfusion.

She was admitted to St John of God Hospital, Bunbury (SJOGHB), where her treatment for neutropenic sepsis continued.

The following day another blood count indicated an even lower platelet count (1) and an order was placed for platelets from Australian Red Cross Blood Service (ARCBS) in Perth. Her blood was also crossed matched and she was transfused with two units of blood.



There was apparent improvement in her condition following the blood transfusion but in the early hours of 14 February 2006 the deceased suffered a marked deterioration in her presentation.

The platelets became available during the morning of 14 February 2006 and were transfused, however, it became apparent the deceased had suffered a catastrophic intracranial bleed from which she did not recover. She was 63 years of age.

The family of the deceased were very unhappy with the course of events. They understood their mother was suffering from leukaemia, however, believed that with appropriate monitoring and treatment compliance she would live for many years. They really did not comprehend quite how vulnerable she was to a catastrophe as a result of her pancytopenia.

The Deputy State Coroner found there had been some mis-communication during the course of the deceased's last period of life which had made events difficult for the deceased's family to understand. The first miscommunication related to where the deceased would be staying during active treatment. Nevertheless the deceased's neutropenic sepsis was appropriately treated when doctors in Bunbury found themselves unexpectedly dealing with the deceased's illness.

The second miscommunication related to the provision of platelets outside the metropolitan area. The pressing requirement for platelets was not so urgently accommodated, nor does it seem to be an issue about which a blanket protocol for the ordering of platelets for any count below 10 should be implemented, or it would by now already appear on Hospital Alert Febrile Neutropenia Cards.

The Deputy State Coroner considered the decision not to transfer the deceased to Fremantle Hospital on the afternoon of 12 February 2006 may have contributed to the final outcome, however, on the evidence that was not an unreasonable decision at the time. In view of the evidence as to the vulnerability of the deceased, both as to her cancer and chemotherapy, it is impossible to say she would have survived, even with optimal treatment at an optimal time.

The Deputy State Coroner accepted the deceased died of an intracranial bleed as a result of her thrombocytopenia, an expected complication of her prolymphocytic leukemia and its treatment. While the delay in the provision of platelets following appropriate treatment by way of antibiotics for her neutropenic sepsis may have contributed to her death, it was impossible to say so with any certainty. Her pancytopenia was as a result of treatment for a terminal, naturally occurring disease.

Deputy State Coroner concluded death arose by way of Natural Causes and made the following:-

- 1. I recommend the Febrile Neutropenia Cards used by most emergency departments for their own chemotherapy patients provide a current diagnosis to enable unexpectedly treating practitioners more ready access to the history and prognosis of the individual patient.**



- 2a I recommend the introduction of *“Medical Smart Cards”*. I understand the ethical considerations which have been raised but note a significant number of deaths would be avoided if doctors needing to treat patients unexpectedly, did not have to rely solely on a patient’s memory or understanding of their diagnosis and prognosis, for input.

Failing the introduction of “Medical Smart Cards”

- 2b I recommend the introduction of hard copy patient diaries for cancer/chemotherapy patients such as those now used by SJOGHB. In conjunction with a Febrile Neutropenia Card this would ensure patients fully understood their diagnosis and treatment regime and would be informative for unexpectedly treating medical practitioners.
3. I recommend Fremantle Hospital Haematology Day Clinics require progress notes be completed by medical practitioners immediately following a review to ensure staff completing the review are aware of the patient’s current status.
4. I recommend patients provided with Febrile Neutropenia Cards are specifically advised in writing it is preferable they remain accessible to their treating clinic at times of vulnerability in treatment.
5. I recommend Regional Hospitals establish appropriate protocols and procedures for the treatment of cancer/chemotherapy patients who may need urgent blood products, taking into account their individual location.
6. I recommend Medical Scientists located in remote areas inform treating doctors for their area of the relevant time-lines for the provision of specified blood products to their location when discussing blood pathology and product ordering.
7. I recommend the introduction of a tool for remote areas similar to that now produced by ARCBS for Bunbury for the processing of requests for urgent blood products.”

Shar Rose BENFIELD

Coroner Mulligan conducted the inquest into the death of Shar Rose Benfield with an inquest held at Perth Coroners Court on 23 – 24 January 2012 & 25 – 27 January 2012. Coroner Mulligan found that the death occurred on 24 June 2008 and that the cause of death was unascertainable.

The deceased was the firstborn of twin girls delivered by Caesarean section on 7 December 2007 at King Edward Memorial Hospital.

The deceased was born into a very disadvantaged Aboriginal family who normally lived in Kalgoorlie. The deceased's mother suffered severe mental illness. The deceased's father, although well-intentioned, had negligible expertise in raising a child.



The deceased, her twin and her mother returned to Kalgoorlie on 23 December 2011. The mother's mental health was very poor and she was admitted as an involuntary patient into Ward A, the mental health unit, At Kalgoorlie Regional Hospital. The deceased's mother remained in the hospital until 24 January 2008.

On 8 January 2008 the deceased and her twin were discharged from hospital into their father's care. This arrangement was facilitated by the Department for Child Protection (the DCP).

On 15 January 2008 the deceased's father left his twins (including the deceased) and his one-year-old daughter in the care of three children, the oldest of who was aged 11. Whilst deceased's father was away from his home he was arrested by the police on unrelated matters. The deceased was subsequently incarcerated.

The DCP did not take the children into care. At a meeting convened the following day the DCP field officer assigned to the case told family members that the DCP "did not have a statutory role or legal obligation to the children".

It was subsequently determined that the deceased and her two siblings would live with a relative for the next six months. This arrangement would allow the deceased's mother to regain her mental composure and the deceased's father to regain his liberty.

This agreement had the support of the DCP and the relevant family members.

The deceased's father regained his liberty in early February 2008. By this time the deceased's mother had been released from hospital although she remained under a Community Treatment Order.

The deceased's parents immediately wanted the return of their children, notwithstanding the recent agreement that would allow another family member to have custody of the children for a period of six months.

The DCP on learning of the situation decided that it would take no action, other than to write to Legal Aid WA. An officer of the DCP wrote to Legal Aid WA on 15 February 2008, in the following terms:

There have been grave concerns for the well-being of the three children of the couple and of the capacity of the parents to adequately care for them.

And:

The Department would have serious concerns should the parents take the children back into their care at this time.

During the morning of 24 June 2008 the deceased was sleeping with her father on his bed. The room was very warm (about 30°) and the deceased went to sleep on her stomach.



At about midday the deceased's father awoke and realised that his daughter was dead. She was 6 ½ months old.

A post mortem examination was not able to determine the cause of death, which remains unascertainable.

In this case the deceased was subject to six risk factors that are thought to be associated with sudden unexpected death in infancy. Those factors were:

1. The fact that the deceased was born prematurely, at 33 weeks gestation.
2. The fact that the deceased was co-sleeping with her father at the time of her death.
3. A parental history of smoking, especially in pregnancy.
4. A history of maternal illicit drug and alcohol use.
5. Hypothermia; the deceased's bedroom was warmed to a temperature of about 30 degrees.
6. The deceased was found to be sleeping on her stomach rather than her back.

Neither the deceased's mother (through mental illness and being held as an involuntary patient) nor her father had received or retained any knowledge or information relating to sudden infant deaths.

The DCP did run programs that evaluated a child's surroundings, care and well-being. The programs also provided advice to parents about sudden infant deaths and ways to minimise risk factors, thought to be associated with sudden infant deaths.

One such program is called "Best Beginnings" which incorporates 24 home visits by a DCP officer to a child's home over a 24 month period. The program is voluntary and is aimed at the parents of children aged 0 – 2 years old.

The first objective of the program relates to SIDS prevention. Under the program it is expected that the DCP will provide parents with steps to follow in order to reduce the risk of SIDS. The goal of the program is for the parents of a child to be educated about this objective by the time the child is 10 weeks of age.

By the time a child is seven months old (the approximate age of the deceased at the time of her death) he or she should have benefited from 13 home visits.

Each visit is recorded by the DCP work on a preformatted check sheet. On each visit the first two items the DCP worker should note are:

- Discuss SIDS prevention and shaken baby syndrome.
- Record observations of SIDS risk factor behaviour on assessment tool.

In my view, the provision of this type of information and assessment are of great advantage to the community and would have been of particular benefit to those who cared for the deceased.

The DCP has also developed a more wide-ranging initiative called "Responsible Parenting". This program is designed to assist the parents of children who are at most risk. The program is tailored to suit the needs of individual parents and children and can include the Best beginnings program as part of the overall services designed to aid the family.



None of the deceased's caregivers was offered a place in the Best Beginnings program or in the Responsible Parenting program.

Recommendation

I recommend that the DCP, in the Goldfields, offer the Best Beginnings program (or any subsequent and similar program) to all new parents with whom the DCP has dealings so that the program that draws the widest participation from the broadest range of the population, particularly those parents whose circumstances are challenging.

During the course of the inquest I heard from Dr Scurlock and Dr Cadden. It is clear from their evidence that the science and understanding of sudden infant deaths is constantly evolving. A number of stakeholders in the community work to try and deliver an effective and clear message about the source of potential risks to the health and safety of newborn and infant children.

The Department of Health has a significant investment and interest in this area as do the DCP and organisations such as SIDS and Kids and many Aboriginal health providers. In my view it would be very helpful if those stakeholders develop and deliver as consistent a message as possible to the community.

Recommendation

I recommend that WA Health work with other stakeholders (Community Health Nurses, the Department of Child Protection, Aboriginal Medical Health Providers, SIDS and Kids and other interested groups) to work towards developing and transmitting a coherent message relating to the known risks that can cause unexpected infant mortality. In providing that information to Aboriginal parents it should be developed and delivered in a culturally appropriate and relevant way.

Ms Huxtable of the ALSWA acted for Mr Benfield during the course of the inquest. Ms Huxtable provided very helpful submissions including a proposed recommendation in the following terms:

A voluntary culturally appropriate educative programme be designed to encourage participation from Aboriginal families, particularly those Aboriginal families living in remote or regional Western Australia. Any such program to include specific reference to the dangers of co sleeping and be targeted towards vulnerable parents or guardians similar to the Strong Families Program already offered by the Department of Child Protection. The Department of Child Protection to work in conjunction with the Western Australian Health Department, Aboriginal Health Services, Aboriginal communities and other related agencies to ensure a holistic program has developed.

The Coroner endorsed Ms Huxtable's sentiment in relation to the development of a holistic program to aid vulnerable Aboriginal parents or guardians.

The Coroner did not know the details relating to the Strong Families Program that is currently being offered by the DCP. For that reason I do not propose to make the proposed recommendation, however the Coroner invited the parties named by Ms Huxtable to give



earnest consideration to her suggestion and work to continue to develop a holistic program that assists the most vulnerable young aboriginal children.

The Purple Book

The parents of each child born in Western Australia is given a "purple book" by the Department of Health, that assists parents plan for their child's healthy future, record important milestones and take prophylactic precautions such as immunisation.

There is a Tab in the purple book entitled "Immunisation" which has a concise two-page explanation as to why immunisation is important, where to get a child immunised, possible adverse reactions to immunisation and appropriate advice as to where parents can source further information about immunisation.

The purple book also includes a "childhood vaccination record card" which provides a timeline as to when each particular vaccination is required as well as a record of the fact of each immunisation.

The purple book is a very helpful, authoritative and concise document capable of providing information about the risk factors thought to be associated with sudden infant death.

Dr Scurlock highlighted the fact that in her view the purple book could be improved by adding a section that relates to safe sleeping. The Coroner shared Dr Scurlock's view, but believed the purple book could highlight more than just the issue of safe sleeping.

Recommendation

I recommend that the Department of Health develop a Tab in its purple book (or subsequent iteration), that gives parents advice about the fact of sudden infant deaths, the factors that are reasonably thought to be associated with those deaths and practical advice as to how to reduce risks to a child. For example parents should be provided with appropriate information about their child's safe sleeping arrangements, the risks associated with a child being exposed to second-hand smoke and a child being kept in an environment that is too warm.

Ricardo Maderia da SILVA

The State Coroner conducted the inquest into the death of Ricardo Madeira da Silva (the deceased), with an Inquest held at Perth Coroners Court on 30 January 2012 - 1 February 2012. The State Coroner found that death occurred on 24 April 2010 at sea about 4 nautical miles west-north-west of Two Rocks as a result of drowning.

The inquest was conducted in order to explore the circumstances surrounding the death and particularly to explore whether comments could be made on matters connected with the death relating to safety issues which could reduce the possibility of deaths occurring in similar circumstances in the future.

According to his fiancée, the deceased regularly fished off rocks, but had owned small boats.

The deceased held a Recreational Skippers Ticket issued by the Department of Transport on 13 May 2009.



The State Coroner found that the deceased died as a result of drowning on 24 April 2010.

He died when his four metre long runabout capsized about four nautical miles west-north-west of Two Rocks.

The deceased was in the water for several hours prior to his death and though he was wearing a life jacket it appears it was not worn correctly.

Two friends of the deceased, who were with him at the time the boat capsized, were located when the boat was coincidentally discovered by Two Rocks VMR personnel who initiated an extensive search. Those two persons were extremely lucky to have survived the incident.

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

The State Coroner noted that this case highlighted the importance of taking basic safety precautions when ocean fishing from small vessels.

Evidence at the inquest showed that the deceased breached a number of basic safety requirements and that these together contributed to the dangerous situation which resulted in his death.

The State Coroner made a comment in the following terms –

This case has highlighted the importance of persons taking small boats onto the ocean complying with basic safety procedures, such as those detailed in the Department of Transport Workbook for the Recreational Skipper's Ticket.

The State Coroner made two recommendations in respect to safety equipment for recreational skippers.

The State Coroner observed that in this case even if the flares which had been stored on the boat had been found and used, there were no parachute flares. Parachute flares have an extended sighting range.

There are three types of flares, designed for different purposes, and in the case of an emergency it would be beneficial to use parachute flares first and then use one or other or both of the other types of flares. In this context the State Coroner made the following recommendation -

I recommend that consideration should be given to requiring all three types of flares to be carried for both inshore and offshore waters.

It was the evidence of Senior Constable Trivett of the WA Police water police Branch that if there had been an EPIRB on the boat and it had been activated the deceased probably would have been saved.

There was no EPIRB on the boat.

It appeared likely that the fact that there was an extended EPIRB exempt area to the West of Perth was a major factor in the deceased's failure to carry an EPIRB.

In that context the State Coroner made the following recommendation –



I recommend that urgent consideration be given to the possibility of amending the Navigable Waters Regulations 1958, section 52BAB, to reduce or remove the extended EPIRB exempt area of the ocean to the west of Perth which currently extends from the area of Garden Island to Mindarie Keys.

Responses to the recommendations are as follows -





Minister for Transport; Housing; Emergency Services

PERTH CORONERS COURT

16 MAR 2012

REC

Our ref: 30-25538

Mr Alastair Hope
State Coroner Western Australia
Level 10, Central Law Courts
30 St George's Terrace
PERTH WA 6000

Dear Mr Hope

**INQUEST INTO THE CIRCUMSTANCES SURROUNDING THE DEATH OF
RICARDO MADERIA DA SILVA**

Thank you for the letter dated 9 February 2012 from your office regarding the inquest into the circumstances surrounding the death of Mr Ricardo Maderia da Silva.

The Department of Transport (DoT) supports in general the recommendations made in the Coroner's findings into the death of Mr Ricardo Madeira da Silva and is currently working with the WA State Search and Rescue Advisory Group (SAR) and others towards developing an implementation timeline for Recommendation 1.

As the implementation of Recommendation 2 requires changes to regulation, a preliminary impact statement and cost-benefit analysis must be developed. DoT will work with SAR in conducting the necessary analysis.

Yours sincerely

**TROY BUSWELL MLA
MINISTER FOR TRANSPORT**

15 MAR 2012

Level 10, Dumas House, 2 Havelock Street, West Perth Western Australia 6005
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WESTERN AUSTRALIA POLICE
OFFICE OF THE COMMISSIONER

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Your Ref:
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PERTH CORONERS COURT

29 FEB 2012

RECEIVED

Ms Dawn Wright
Administrator
Office of the State Coroner
Level 10, Central Law Courts
501 Hay Street
PERTH WA 6000

Dear Ms Wright

Thank you for your letter dated 6 February 2012 referring to a comment made by Mr Alastair Hope, State Coroner in respect to the excellent work provided by the Water Police and in particular the assistance given by Senior Constable Trivett, following the death of Ricardo Madeira Da Silva.

It is gratifying to receive correspondence where the positive actions of police personnel are recognised and brought to notice. The comments made by Mr Hope reflects favourably upon these officers and the Western Australia Police in general.

I will ensure your words of acknowledgement are conveyed to the officers at Water Police and that a copy of your correspondence is recorded within the personal file of Senior Constable Trivett.

Yours sincerely

KARL J O'CALLAGHAN APM
COMMISSIONER OF POLICE

29 February 2012

Our Mission: To enhance the quality of life and well-being of all people in Western Australia by contributing to making our State a safe and secure place



Simon James BRAZIER

Coroner Mulligan conducted an inquest into the death of Simon James Brazier on 10 February 2012 at the Perth Coroner's Court. Coroner Mulligan found that death occurred on or about 30 March 2005 and the cause and manner of death was unknown.

The inquest was held under section 32 (2) of the *Coroners Act 1996 (WA)* in order to determine whether Mr Brazier, who was a missing person, was in fact dead.

The deceased lived at a property he owned in Mandurah. Most of his family lived in Queensland. The deceased had only recently returned from living with his family in Queensland before he went missing in March 2005.

The deceased suffered severe mental illness and had been admitted to psychiatric units in Queensland on three occasions between 8 September 2003 and 2 September 2004. When the deceased was last released from a Queensland psychiatric unit he was provided with ongoing care under a Compulsory Treatment Order. The deceased was discharged from that order on 25 January 2005, in the expectation that he would move to his property in Mandurah and continue to receive care and treatment from the Rockingham Kwinana Mental Health Service.

The deceased was seen at his home by a community mental health nurse on 23 March 2005. At that time the deceased appeared to be suffering from the negative symptoms of his illness as well as social isolation and a lack of motivation. He presented as having blunted affect although it was considered that his judgment and insight were reasonable.

The community mental health nurse suggested that the deceased should make contact with a GP.

The deceased was last known to be alive when he used his Visa account to purchase a pizza on 30 March 2005.

Subsequently the deceased's family and the State Emergency Service extensive carried out extensive searches for the deceased.

The deceased's disappearance was also reported on television and in the newspaper. That publicity did not lead to any information suggesting the deceased was alive.

The WA Police and interstate police services carried out extensive enquiries to try and locate the deceased.

The police collected a large volume of information, contained in 5 1/2 lever arch folders. The searches and investigations undertaken failed to locate the deceased or any record that suggested he was still alive and living elsewhere.

On 17 January 2010 the deceased's wallet was found on an access strip leading to the beach at Secret Harbour. The wallet contained 14 important cards, without which the deceased would have found it almost impossible to survive on a daily basis. The wallet and its contents had an aged and weathered look that was consistent with having been buried under the sand for some time before it was located by two passers-by.



The totality of the evidence presented to the court persuaded me that Mr Brazier had died on or about 30 March 2005 at an unknown location, from unknown causes.

Recommendations: Nil

Andrew Ian ALLAN

The Deputy State Coroner conducted an inquest into the death of Andrew Ian Allan (Andrew) on 9-11 May 2012 at the Northam Coroner's Court and concluded death occurred on 17 September 2010 as a result of Pneumonia Complicating Influenza A (H1N1) Infection.

Andrew was a 16 year old student who, in the months preceding his death, had suffered from skin infections. He had been provided with, firstly IM, and then oral antibiotics which had settled the eruptions.

On 11 September 2010 he contracted influenza A which exhibited itself with him feeling unwell. He did not seek medical attention because he believed he was getting a cold. Andrew stayed home and was probably recovering from the influenza infection when a pre-existing *Staphylococcus* colonisation invaded his disrupted airways and caused bronchitis. Instead of recovering from the influenza A H1N1, Andrew began to suffer from *Staphylococcal* pneumonia.

On 16 September 2010 Andrew felt extremely unwell, to the extent he was accepting of the fact he needed medical intervention. Unable to obtain him a GP's appointment Mrs Allan took Andrew to Northam Regional Hospital Emergency Department (NRHED). This was the most appropriate place for his presentation in view of the fact he now needed IV antibiotics at the very least.

The extent of Andrew's illness was not recognised and his superficial symptoms dismissed as gastroenteritis by a junior nurse. The fact of the abnormally high temperature, sweats, blotched skin and clammy cold hands was not adequately assessed as indicating septic shock and as a consequence he was not referred for medical assessment, despite the fact a doctor was present in ED meters away. Andrew was septicemic.

Andrew was discharged home where he went to bed and died in the early hours of the 17 September 2010.

The Deputy State Coroner concluded it was impossible to say Andrew would have survived despite full and appropriate medical intervention at 5:00pm on 16 September 2010, however, she found he was deprived of the opportunity for proper medical care and succumbed to a naturally occurring medical condition which may have responded to treatment.

The Deputy State Coroner recommended:-

1. **WACHS develop a standardised on-line e-learning package for preceptors.**
2. **Nursing rosters make it plain who is a preceptor on any given shift.**



3. **Introduction of a requirement all new nursing staff sign to acknowledge receipt of orientation documentation and that the document they sign contains an index of the documents they receive.**
4. **Mandatory provision of verbal and written advice to all new nursing staff detailing the differences between working in a tertiary hospital in the metropolitan area and a regional hospital such as NRH.**
5. **Mandatory provision of verbal and written advice to all new nursing staff detailing the role of preceptors and the area/s in which it is believed the new nurse requires support over and above that of adapting to a new regime/facility.**
6. **Mandatory completion of the MR1 (or equivalent) patient name and basic observations at/for every presentation to triage unless impossible due to the patient's state of consciousness and/or required immediacy of treatment.**
7. **The Department of Health continue the roll-out of the new patient administration system to ensure improved access to clinical information to country hospitals and real time access to patient information.**
8. **Provision of on-site educational workshops to assist in competency compliance in key areas which must include triage. This will require roster support.**

David James LEE

Coroner Mulligan conducted an inquest into the death of David James Lee on 14 – 18, 21 May 2012 & 6 June 2012 at the Perth Coroners Court and South Hedland Coroners Court and concluded death occurred on 15 July 2007 death being consistent with respiratory arrest in Association with medication drug effect and alcohol intoxication.

The deceased was a 37 year old Aboriginal man who lived in port Hedland. He died on 15 July 2007. The cause of death was consistent with respiratory arrest in association with medication effect and alcohol intoxication. The deceased died, under sedation, at Port Hedland Regional Hospital whilst awaiting evacuation to Perth by the Royal Flying Doctor Service, for treatment at Graylands Hospital.

On 14 July 2007 the deceased was suffering from a severe mental illness. The deceased was suffering schizophrenia and he appeared to be extremely paranoid. The deceased's condition was exacerbated by his failure to take his medication. In addition the deceased had consumed a large quantity of alcohol.

At about 2 PM the deceased behaved extremely badly and entered the caravan of a friend and neighbour whom he threatened with an axe. The deceased very quickly left the caravan without doing his neighbour any physical harm.

The police were called to the property. The police dealt with the deceased in a manner sympathetic to his mental illness. They allowed him to finish his beer and lock-up his house before volunteering to take him to the hospital, where they hoped he would be able to receive appropriate medication.



The deceased travelled in the rear, caged portion, of the police vehicle. It is possible that during the ride to the hospital he struck his head and suffered a concussion.

By the time the deceased arrived at the hospital his demeanour had changed. From being calm and reasonable he became very agitated and hostile.

The deceased arrived at the hospital at about 3:30 PM. The deceased was subsequently allowed to calm down and settle. Between 4:30 – 5 PM he was given the medications that were intended to sedate him.

At about 5 PM the deceased was sufficiently calm, sedated and groggy to be able to get out of the police wagon and walk calmly into the Emergency Department.

On entry into the Emergency Department the deceased co-operated as he was given a further 5 mg of Midazolam, intended to further sedate him.

The deceased had an adverse reaction to this dose and he went into a state of collapse. The action of the midazolam was quickly reversed after the injection of another drug. However, from that point onwards the deceased was kept heavily sedated until his final collapse at about 1:50 AM the following morning.

The deceased was kept heavily sedated because there was a misunderstanding by the Emergency Department consultant as to the level of risk the deceased posed to her and her colleagues. The deceased was also heavily sedated because the hospital did not have any security staff who could be used to help contain a lightly sedated or un-sedated patient.

The deceased suffered another collapse at about 1:50 AM on 15 July 2007. Medical staff were unable to adequately oxygenate the deceased and he subsequently died whilst under sedation.

It is very likely that if the deceased had not been over-sedated throughout the period he was at the hospital, he would not have collapsed at 1:50 AM on 15 July 2007 and that his death could have been avoided.

The deceased was scheduled to be evacuated by the Royal Flying Doctor Service at about 11 AM on 15 July 2007.

It should be noted that the Royal Flying Doctor Service do not want to transport heavily sedated patients, as the degree of sedation increases the risk and complexity of safely transporting a patient by air.

The deceased did not give informed consent to any treatment at the hospital. It is uncertain as to whether he was being treated as an involuntary patient under the Mental Health Act 1996 (WA), under a medical duty of care or whether his treatment was involuntary and unauthorised by any legal or ethical tenet.

Recommendation

The WACHS Pilbara should take immediate steps to employ permanent and/or ad hoc security staff to help medical staff care for and treat agitated mental health patients, so as to minimise the need for prolonged and deep sedation.



Recommendation

The WACHS Pilbara should take immediate steps to ensure that when a patient is cared for or treated, without informed consent first having been obtained, then the treating doctor should contemporaneously, or as soon as practicable thereafter, record the fact that the treatment or care has been given without consent and explain the basis upon which the treatment or care was provided.

Recommendation

The WACHS Pilbara should take immediate steps to ensure that in the case of a patient who is unable to provide informed consent and who needs to be sedated or restrained; then,

- i. The most limited form of sedation/restraint should be applied
- ii. Any period where a person is sedated/restrained needs to be limited to the shortest possible period of time.

Recommendation

The WACHS Pilbara and the Department of Health should consider providing greater funding for the Royal Flying Doctor Service, so that transfer times for severely mentally ill patients can be minimised.



Deaths in Care

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

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

Involuntary patients within the meaning of the Mental Health Act 1996.

Warwick Andrew ASHDOWN

The State Coroner conducted an inquest into the death of Warwick Andrew Ashdown (the deceased) at Perth Coroner's Court on 3-14 October 2011. The State Coroner found that death occurred on 12 October 2007 at Montgomery Ward, Graylands Hospital, Mt Claremont, as a result of cardiac arrhythmia during restraint.

At the time of his death the deceased was an involuntary patient within the meaning of the *Mental Health Act 1996* and for that reason was a "person held in care" for the purposes of section 3 of the *Coroners Act 1996* (the Act). As the deceased was a person held in care, it was necessary for a public inquest to be held into the circumstances surrounding the death and pursuant to section 25 of the Act, there was a requirement to comment on the quality of the supervision, treatment and care of the deceased while in care.

In this case at the time of his collapse and death the deceased was being physically restrained at Graylands Hospital and it appeared likely that this restraint was a factor in his death. In that context there was a particular need to closely explore the circumstances in which the deceased came to be physically restrained, the appropriateness of the restraint used and the extent of any injuries caused to the deceased while he was restrained.

The deceased had a long history of mental illness. He suffered from chronic paranoid schizophrenia complicated by its treatment resistant nature, his propensity to be non-compliant with prescribed medication and a long standing, fluctuant use of illicit substances and alcohol.

The deceased had been admitted to Graylands Hospital as a result of his mental illness on many occasions prior to his death. His first admission to that hospital was during the last two months of 2000 for twelve days. At that time he was a 20 year old single male living in rented accommodation in Subiaco.

His last admission was on 17 April 2007 until his death on 12 October 2007 and that was his eleventh admission.

On 5 May 2006 he was moved to a secure unit because of concern about his response to unseen stimuli, his perception of "astral rape" and his delusions concerning alternative dimensions and persecution by paedophiles. During this admission the deceased assaulted another patient and there was an incident in September 2006 when he assaulted a staff



member and required restraint by five nursing staff. It appears that two staff members sustained injuries during that incident of restraint.

The Mental Health Review Board had a third hearing during this admission in early November 2006 and it was noted at the time that there were no suitable community accommodation options.

The deceased was subsequently commenced on unescorted ground access as part of a process of transfer to an open ward, to which he was transferred on 21 August 2007.

A week after transfer to the open ward the deceased was involved in a verbal altercation with another patient. Two days later he went missing from the ward and was recorded as absent without leave. The deceased returned later by taxi admitting that he had used "a little cannabis".

On 2 September 2007 the deceased again left Graylands Hospital without authorisation. The deceased returned the next day anxious, restless and delusional. He was transferred to a secure ward for two days while his mental health again settled sufficiently for his placement on an open ward. The day after returning to the open ward, however, the deceased was involved in a physical altercation with a patient from another ward and sustained superficial scratches.

On 22 September 2007 he became verbally abusive in the afternoon and this happened again one week later when he admitted to, "having a couple of bourbons". He attended the Royal Perth Show on 3 October 2007 in the afternoon but returned increasingly paranoid and hit a patient in the chest because he believed that the other patient had raped him. On that occasion he denied any illicit substance abuse.

On 9 October 2007 the Integrated Progress Notes reveal that the deceased presented with "...delusional ideas regarding paedophiles".

On 11 October 2007 another patient complained to nursing staff that the deceased had called him a paedophile.

On 12 October 2007 it is alleged that the deceased struck the patient who had complained about him the day before in the region of his eye causing injury. It was this event which resulted in the deceased being restrained and his ultimate death.

It was the view of the deceased's treating psychiatrist at the time of his death, Dr Serich, that there was a recurring pattern for the deceased. He would spend time on a secure ward, then would have a graded return to an open ward following periods when he was allowed escorted and unescorted ground access. After a period on an open ward, however, the deceased's mental condition would deteriorate in a context of illicit substance use and the fragility of his illness, he would then be returned to a secure ward and the cycle would begin again. It only took consumption of a small amount of alcohol or drugs for the deceased to suffer a serious deterioration in his mental health.

Dr Serich also gave evidence that the deceased was in the cohort of the most severely unwell mental health patients in the state.



It is significant to note that after his death an empty bottle of whisky was found in the room the deceased had been occupying. While toxicology analysis of his urine sample taken at autopsy only gave an alcohol reading of 0.011%, it is likely that his earlier consumption of alcohol was a significant factor in the deterioration of the deceased's condition which took place shortly before his death.

On the evening of 12 October 2007 the deceased was housed in Hutchinson Ward, an open ward.

At approximately 8:15pm a patient approached the nurses' station and informed Registered Mental Health Nurse that another patient had been punched in the head by the deceased and was bleeding.

On investigating the complaint it was found that the patient had a cut and swelling over his left eyebrow. The cut was approximately 2cm in size.

The deceased was asked him if he had hit the other patient. The deceased stated, "He is a paedophile and a predator".

At that time the deceased appeared highly agitated and was clenching and unclenching his fists repeatedly and rocking back and forth on the chair he was sitting in on the verandah at the ward.

A nurse gave the deceased Haloperidol (oral) 10mg and Lorazepam (oral) 2mg, which was charted in the medication chart.

At Hutchinson Ward the nurses spoke with the deceased and advised him that he was to be moved. Initially he appeared agreeable with this suggestion, but indicated that he wanted to see a doctor first.

It was explained to the deceased that the doctor wanted him moved and that he could see the doctor when he got to the locked ward.

It appears clear that the deceased did not wish to be transferred to Montgomery Ward and that he was becoming increasingly agitated at this time. It was following this that the deceased was restrained and was forcibly transferred to Hutchinson Ward.

The State Coroner found that immediately prior to his death the deceased suffered neck injuries which resulted in bleeding and disruption of intervertebral disk C4/5 which resulted from there being a beyond normal movement between his head and body, a greater than normal flexion.

In addition the deceased suffered an injury to his neck which resulted in a bruise over the right sternocleidomastoid muscle. This injury appears to have been bought about by an entirely different mechanism to the injury to the neck described above and must have involved some application of pressure to the outside of the neck.

The State Coroner noted that at the time of his death the deceased was obese and it appears likely that this contributed to hypoxia, or lack of oxygen when he was lying face down on the floor. The State Coroner found that the deceased died of a sudden arrhythmia of the heart which occurred during the process of restraint and his struggling. The exact cause of the arrhythmia was uncertain but it was believed that the heart muscle, sensitised by the effects of



oxygen depletion and increased heart rate provoked an arrhythmia by increased circulating catecholamines which are produced during physical activity and psychological stress.

The State Coroner found that the death was an unexpected result and was unintended on the part of those involved in restraining the deceased.

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

The State Coroner made comments on the quality of the supervision, treatment and care of the deceased while in care and comments as to public health and safety issues.

In addition the State Coroner made a number of recommendations in the following terms–

I recommend that there be a review of the approach taken by Graylands Hospital to the searching of seriously ill patients, particularly involuntary patients, and consideration be given to there being regular searches conducted of their property with a view to identifying any alcohol or drugs retained by the patients or any items which could be used as a weapon and place other patients and staff at risk of harm.

I recommend that Graylands Hospital administration review arrangements in place at the hospital with a view to restricting the access of involuntary patients housed in open wards to alcohol and illicit drugs.

I recommend that WA Health conduct a review of appropriate restraint procedures, focusing on the extent to which the head is held during restraint and particularly during escort with a view to minimising the possibility of injury to patients and staff.

I recommend that WA Health review training provided to staff in respect to commencing manual restrain of patients with a view to minimising the likelihood that those initial restraint actions will provoke a violent response, particularly where the patient is not threatening immediate violence at the time when restraint is first applied.

I recommend that WA Health review the nature and extent of training being provided to staff in respect to restraining aggressive and potentially violent patients, particularly in the following respects –

- ✚ There needs to be in place a comprehensive and clear manual which describes in an unambiguous manner a number of alternative restraint procedures which can be used. That manual should be available to persons undergoing the training as a resource and reference.**
- ✚ There should be a comprehensive review of the restraint holds being taught with a view to ensuring that the restraint holds are appropriate to different circumstances and provide the least possible risk to patients and staff. While it needs to be recognised that all restraint procedures involve potential risk of injury, those risks should be kept to a minimum.**
- ✚ Consideration should be given to whether the extent of training is adequate and in particular consideration should be given to increasing the initial training course from two days to three days and ensuring that refresher courses are undertaken at no more than twelve month intervals and adequately cover de-escalation techniques as well as restraint holds. In the event of any significant changes in training being adopted or after every three years (or such other period considered more appropriate) persons trained should be again given the full training course.**



- ✚ The training should include a focus on when smaller or more frail staff members should be involved in a restraint and when it would be unsafe to embark on a restraint at all. There should be a focus on when evacuation is the safest option and when it is best to wait for more staff to become available to assist with a restraint or to call for police or other outside assistance.

Responses to the State Coroners recommendations are as follows –





Minister for Mental Health; Disability Services

Our Ref: 43-04104

PERTH CORONERS COURT

07 JUN 2012

RECEIVED

Ms Dawn Wright
Administrator
Office of the State Coroner
Level 10, Central Law Courts
30 St George's Terrace
PERTH WA 6000

Dear Ms Wright

RE: Inquest into death of Warwick Andrew ASHDOWN

Thank you for your letter of 9 February 2012 in relation to the inquest finding for Warwick Andrew ASHDOWN. My apologies for the delay in this response.

In response to the Deputy State Coroner's recommendations, the North Metropolitan Area Health Service – Mental Health Service has undertaken a review of its practices and implemented changes relating to recommendations one and two.

A review of the *Patients and Property Policy* has incorporated alterations to the processes and documentation for 'environmental checks' for the identification of hazards or concerning items (including the presence of drugs and alcohol). Furthermore, ward security checklists have been updated to reflect the need to conduct environmental checks for alcohol, drugs or items which could potentially be used as a weapon on each shift; and, ward orientation files have been updated to reflect the need to undertake environmental checks.

In regard to determining whether patients should be searched, while endeavouring to maintain their dignity and rights, it was decided this should be based on identified risk rather than a blanket rule to regularly search all involuntary patients. Staff will assess the likelihood of the patient harming self and/or others. A search is conducted if staff have reasonable cause to suspect that a person possesses item(s) that are capable of inflicting harm, based on set and defined criteria.

The *Alcohol/Illicit Substances – Use by Patients Policy* has also been reviewed incorporating changes in relation to the development of a clear management plan for any patient found in possession of, or under the influence of, alcohol/illicit substances; confiscation of offending substances; and, documentation of the incident in the patient's medical file.

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Additional activity in relation to recommendation two includes:

- the screening of a patient's urine/blood in cases of strong suspicion of alcohol/illicit substance abuse that compromises the patient's mental health and/or treatment plan;
- changes to the Psychiatric Assessment and Admission Management Plans that allow for the treating Medical Officer to assess alcohol and drug history with identified issue/s to be addressed within the Patients Management Plan;
- introduction of the Metabolic screening tool with a section to identify alcohol and drug use; and
- introduction of various health information and educational materials about the use of alcohol and illicit substance, including health facility policy in relation to their use.

In relation to recommendations three, four and five, the following activity has been initiated:

- The Coroner's Recommendations Advisory Group (CRAS) has written to the Mental Health Operations Review Committee (MHORC) requesting that MHORC consider the development of standardised policy principles in regard to restraining aggressive and potentially violent patients and to also consider the implementation of these principles through mental health services statewide.
- The State Seclusion and Restraint Working Group which is intended to commence in June will consider all of the areas of restraint practices including positioning of the patient, staff training and resources required to provide this, deciding whether to use restraint and what type of restraint and the importance of creating an environment which facilitates the use of non aggressive responses.
- Each area mental health service has a seclusion and restraint working party and is responsible for implementing these recommendations.

It is also worth noting that there has been extensive activity in relation to seclusion and restraint in WA over the last two years as part of the National Mental Health Seclusion and Restrain Project. The primary aim of this initiative is to reduce and, where possible, eliminate the use of seclusion and restraint in public mental health services. Western Australia, particularly the North Metropolitan Area Health Service, has been a strong contributor to this initiative.

The Department of Health's Coronial Liaison Unit, in conjunction with the Office of the Chief Psychiatrist, will monitor further improvements and provide additional comments via its routine six-monthly reporting to the Coroner.

I trust this information will assist the Coroner to fulfil the annual reporting requirements to the Attorney General.



Thank you for bringing this matter to my attention.

Yours sincerely



**Helen Morton MLC
MINISTER FOR MENTAL HEALTH; DISABILITY SERVICES**

01 JUN 2012



Deaths possibly caused or contributed to by actions of Members of the Police Service

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

The following inquests were conducted in whole or part to explore suggestions of possible police involvement in the deaths.

Shaun Ryan CRONIN

The Deputy State Coroner, conducted an inquest hearing into the death of Shaun Ryan Cronin (the deceased), at Perth Coroner’s Court, on 12 July 2011. The Deputy State Coroner found death occurred on August 2004 at Boulonnais Drive, 700 metres south of Caspian Way, Brigadoon as a result of Head Injury.

The Deputy State Coroner found that at approximately 2:30am on 9 August 2004 (the deceased) and Russel Lewis Collard (cousin) were the occupants of a stolen marked volunteer Toyota Landcruiser Utility Fire Truck (the fire truck) used to reverse into the Gun Mart store (Gun Mart) on Great Eastern Highway, Midland. The two men then went into the store, and removed firearms from the store before driving off in the direction of Roe Highway.

Two police officers, Constable Brian Williamson (Williamson) and Constable Lucy Davis (Davis), set off in pursuit of the fire truck knowing the occupants of the fire truck had used it to obtain firearms.

At a right hand bend on Boulonnais Road in Brigadoon the fire truck crashed and the two occupants were thrown onto the road surface. The deceased died at the scene. He was 20 years of age.

The Deputy State Coroner found death arose by way of Accident.

The Deputy State Coroner made comments and recommendations in respect to the actions of the members of the WA Police Service.

The death of the deceased during the course of a police chase automatically invoked the circumstances of the police actions being investigated by independent police. In this case the police investigation disclosed there had been a breach of the Urgent Duty Driving Policy, as it was at the time, by the two police officers.

The police officers involved in the pursuit were relaying speeds back to the Police Operation Centre (POC), both before and after being authorised a Priority 2 status, which exceeded the Urgent Duty Driving/Riding Policy. Not once were they reminded by POC of the requirement they only exceed the posted speed limit by 20kph. They were asked to drop back, and had themselves in any event, when they believed they were being threatened with a firearm. At other times their speed dropped in response to the road environment which also affected the fire truck.



The Deputy State Coroner found the deceased and his cousin appeared to have consumed a considerable amount of alcohol during the evening of 8 August 2004, which may have contributed to their later actions; however, the earlier sequence of events appears to have been relatively well planned, up to the theft of the firearms.

The Deputy State Coroner observed that this was a serious offence by any standard. The release of a number of firearms into the community for use in what would have to be illegal circumstances posed a considerable threat to the community at large.

The Deputy State Coroner referred to the findings made by His Honour, the State Coroner who handed down a finding from an inquest which had covered a number of police pursuit situations between October 2007 and December 2009.

The Deputy State Coroner considered the facts of the current case demonstrate why recommendations proposing clarity with respect to Urgent Duty Driving Policy and appropriate risk assessment were necessary. The incident which initiated the chase in this case was serious. The Deputy State Coroner considered it was not in the community interest for the deceased and his cousin to succeed in obtaining and releasing a quantity of firearms into the community illegally.

The Deputy State Coroner observed the events were a tragedy which ended in the death of the deceased, but it is likely the level of alcohol in whoever was driving contributed more significantly to the final outcome than the actions of the police officers in attempting to ensure an, at that time, unknown, number of illegal firearms were lost into the community at large.

The police involved had a duty to the community to take reasonable steps to prevent the successful completion of that course of action. The police involved, with the complicity of POC, attempted to discharge their duties in as safe a manner as was reasonable in all the circumstances with which they were confronted.

The Deputy State Coroner concluded the seriousness of the known risk to the community of allowing the fire truck to disappear undetected warranted the actions the police officers took in this case.

Matthew TJOE

The Deputy State Coroner, conducted an inquest hearing into the death of Matthew Tjoe, (the deceased) at Perth Coroner's Court, on 14 July 2011 and concluded death occurred on 2 November 2009 at Princess Margaret Hospital, Subiaco, as a result of multiple injuries in circumstances which significantly differed from that of Cronin with respect to the risk factors involved from the perspective of the community.

The deceased was an 11 year old boy who died as the result of injuries received when a motor vehicle which had been requested to stop by police over a possible traffic offence attempted to drive the wrong way around a roundabout in a busy precinct.

The police were not in active pursuit at the time of the crash, however, the driver of the motor vehicle had been driving appropriately before the request to stop and reacted excessively to the lights and sirens when an intercept was attempted.

Responses to the Deputy State Coroner's recommendations are as follows –





Minister for Police; Road Safety
Leader of the House in the Legislative Assembly

Our Ref: 31-16483

PERTH CORONERS COURT
15 MAR 2012
RECEIVED

Ms Dawn Wright
Administrator
Office of the State Coroner
10th Floor, Central Law Courts
501 Hay Street
PERTH WA 6000

Dear Ms Wright

Thank you for your letter of 6 February 2012 concerning the State Coroner's recommendations contained in the findings from the inquest into the circumstances surrounding the death of Matthew Tjoe.

As the Minister for Police, I can advise you that the Western Australia Police have reviewed and considered the recommendation.

In relation to the following specific recommendation, it should be noted that the WA Police Emergency Driving policy was implemented on 1 July 2010 and replaced the previous Urgent Duty Driving policy.

The risk to the general community of excessive speed of target vehicles, in precincts or areas exhibiting high density use, should generally not warrant the commencement of a chase or intercept, without a known greater risk, prior to appropriate authorisation.

The Emergency Driving policy has an improved risk assessment process for officers engaging in all forms of emergency driving. *TR-7.4.3 The Risk Assessment Process and its Importance in Decision Making* states:

"Risk levels may increase or decrease during the course of an 'Emergency Driving' incident and as such, the risk assessment must be continuous by all officers involved until the conclusion of the incident.

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Wherever the risk assessment indicates that the risk of the 'Emergency Driving' incident cannot be effectively managed, the incident is to be terminated forthwith by the person making the assessment."

WA Police advised that the Emergency Driving policy is detailed and prescriptive in regards to all levels of emergency driving and at what levels officers should be involved with consideration of their driver qualifications and vehicle classification.

I trust the above information is of assistance.

Yours sincerely



ROB JOHNSON MLA
MINISTER FOR POLICE; ROAD SAFETY

13 MAR 2012



Victoria Sumabat SHEPHERD

The Deputy State Coroner, conducted an inquest hearing into the death of Victoria Sumabat Shepherd (previously La-Madrid) (the deceased) at Perth Coroner's Court, on 19 July 2011. She concluded death occurred on 24 January 2009 at Royal Perth Hospital, as a result of complications of Chest Injuries.

The Deputy State Coroner was satisfied the deceased was a 55 year old married woman who had been out for the evening with her children, celebrating her daughter's birthday. On leaving the restaurant they were driven by her daughter in her daughter's vehicle, the Suzuki, and needed to travel from the restaurant, north on Albany Highway, towards Morley.

The deceased's daughter turned right out of the car park onto Hamilton Street and pulled up at the red traffic lights waiting to turn right across Hamilton Street into the northbound lanes of Albany Highway. It is a wide intersection and it was necessary the Suzuki travel straight ahead over a considerable distance before being able to turn right.

Although the driver believed she had her indicator activated, it would appear by the time she had pulled into the intersection it was not operating. Without a warning by way of indication, Police Officer Taylor believed the oncoming headlights would carry straight on, in the opposite direction, on the green through light.

The driver of the Suzuki did not notice the headlights of any oncoming vehicles on Hamilton Street when she left the right-hand turn lane and focused on her turn. She turned right directly into the path of the police vehicle leaving Taylor no time to take evasive action.

The Deputy State Coroner did not believe the speed of the police vehicle, which Police Officer Taylor had believed was the posted speed, was a relevant factor in contributing to the accident, other than the fact if it had been going more slowly it would not have reached the impact point at the time it did. That was purely a matter of chance in the circumstances of this case.

The Deputy State Coroner found death arose by way of Accident.

Elliott Peter WATT

The State Coroner conducted an inquest into the death of Elliott Peter Watt (the deceased) with an Inquest held at Perth Coroner's Court on 13-16 February 2012. The State Coroner found that death occurred on 22 December 2008 at Collie Police Station, Collie, as a result of gunshot wound to the head in the following circumstances -

The deceased was an acting Senior Sergeant of police with Western Australian Police (WA Police) at the time of his death on 22 December 2008. The deceased was born on 31 July 1972 and so was 36 years of age at the time of his death.

The deceased died at the Collie Police Station as a result of a self inflicted gunshot wound. At the time he was the relieving Officer in Charge of the Collie Police Station, the day of his death was his first day back at work after a period of three weeks long service leave.



On the day of his death the deceased worked from 8am and had been conducting his normal duties as the Officer in Charge of the Police Station throughout the day. It appears that he was last seen at about 3:45pm.

The deceased was discovered in the armoury at 4:25pm having died of a gunshot wound to the head.

The deceased used the Glock pistol which had been allocated for his own use to shoot himself while alone in the armoury of the Collie Police Station.

None of the police officers on duty at the Collie Police Station heard the shot being fired and none were alert to the possibility that the deceased might be about to take his own life prior to his doing so.

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

The State Coroner observed that it was important that families of serving members are alert to the available services as it is often family members who are most aware of changes in a person suffering from mental health problems.

In that context the State Coroner made the following recommendation –

I recommend that WA Police take action to better promote information in relation to available services to families of serving members.

The State Coroner observed that the deceased's colleagues were not alert to his deteriorating mental condition. This was in large part because the deceased concealed his condition from them, but it is also clear that they had received little training in the management or identification of persons suffering from depression.

Evidence at the inquest revealed that for officers taking on senior management roles, while training in respect of these issues is available, it is at present not a mandatory requirement.

The State Coroner made the following recommendation –

I recommend that training in respect of the identification and management of officers suffering from stress or depression should form part of the training for police officers entering management roles.

The State Coroner made the following recommendation in respect to improving the recording of conversation with the Health and Welfare Branch of WA Police in the context of evidence relating to contacts which had not been recorded or filed –

I recommend that WA Police ensure that there is in place appropriate computer software which will enable the recording of all contacts to the Health and Welfare Branch relating to individual officers where concerns have been expressed as to the welfare of those officers.

The State Coroner observed that the evidence in this case has highlighted the fact that policing can be a demanding and stressful occupation.



The deceased was described as a very good officer who was generally highly regarded and yet none of his work colleagues had any real appreciation of his deteriorating mental health.

In the State Coroner's view there needs to be some form of regular health review or wellness review of every police officer in WA Police.

In this context the State Coroner made the following recommendation –

I recommend that WA Police put in place a system which would ensure that in respect of every member there is some form of wellness review conducted or at least offered each year which will identify significant changes in physical and mental health.

A letter dated 20 March 2012 addressed to the Minister for Police invited the Minister to respond to the State Coroner's recommendations. At the time of publishing the annual report a response had not been received from the Minister's office.

Benjamin David DALY

The State Coroner conducted an inquest into the death of Benjamin David Daly (the deceased) with an Inquest held at Perth Coroner's Court on 28 November 2011. The State Coroner found that death occurred on 16 November 2008 at Rockingham, Kwinana District Hospital, Elanora Drive, Rockingham, as a result of gunshot injury to the head in the following circumstances -

The deceased was a 25 year old male who died on 16 November 2008 at 5 Haldane Link, Baldivis.

The deceased died as a result of a self inflicted gunshot injury to his head.

At the time when the deceased fired the shot, he was in the presence of police officers who had been called to the scene shortly beforehand. It was also a significant fact that earlier on the same weekend police officers had issued the deceased with a police order in accordance with section 30A of the *Restraining Orders Act 1997* and that was a 72 hour order pursuant to section 30F of the same Act.

The State Coroner found that prior to the incidents leading up to his death the deceased was a person of good character who had no recorded criminal record in Western Australia or in any other state in Australia.

At the time of his death the deceased was behaving in a manner which was out of character and inconsistent with his prior good record. In an effort to have a police order removed, which would have lapsed in 72 hours if he had taken no action, he had committed a number of serious offences including breaching that order itself. He was clearly not thinking logically.

While police officers were present at the time when the deceased shot himself, they had only recently arrived at the scene and prior to the shot the deceased had concealed the handgun which he used so that it was not visible. The deceased suddenly and unexpectedly produced the handgun, either from his shorts or from behind his back, and shot himself.

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



The State Coroner did not consider that the death was caused, or contributed to, by actions of members of the Police Force, rather it was the deceased's surprising overreaction to actions taken by members of the Police Force which appears to have played a part in his ultimate fatal decision making.

The State Coroner made comments in respect to safety issues in this matter in the following terms –

The entire case, however, has highlighted the fact that domestic disturbances and firearms are a potentially lethal mix. It is not only those involved in the disturbance who may be at risk, police officers and others may also be at risk of being shot.

While I accept that the decision making by police officers on 15 November 2008, which resulted in no action being taken to seize the firearms pursuant to the *Firearms Act 1973*, was reasonable in all the circumstances, there appears to be an anomaly in the legislation in that the *Restraining Orders Act 1997* contains a provision relating to firearms orders which applies in the case of every violence restraining order, but not in the case of police officers making police orders where there has been family or domestic violence.

In a case of a violence restraining order being made, section 14(1) of the *Restraining Orders Act 1997* provides that every such order includes a restraint prohibiting the person who is bound by the order from being in possession of a firearm or firearms licence.

Section 14(5) of the Act, however, provides that when making a violence restraining order a court may permit the respondent to have possession of a firearm in certain limited circumstances.

There is no similar provision applicable in the case where a police order has been made and the powers of police in that context are limited to the provisions of section 24(2) of the *Firearms Act* to cases where a firearm has been used to commit an act of family and domestic violence or it is believed a firearm might be used to commit an act of family and domestic violence.

In my view the dangers associated with possession of firearms in the context of domestic disputes is self-evident. I do not consider that limitation of access to firearms during the course of a police order would pose an excessive burden on persons concerned, particularly if the relevant legislation contained a provision in terms similar to section 14(5) of the *Restraining Order Act*.

The State Coroner made the following recommendation –

I recommend that consideration be made to amending the *Restraining Orders Act 1997* so that when a Police Order is made pursuant to section 30A of the Act, that order would normally include a restraint prohibiting the person who is bound by the order from being in possession of a firearm and enable police officers to seize any firearms in that person's possession or available to that person through a corporate firearms licence or otherwise.

A response was received from the Minister of Police dated 19 March 2012.



It is difficult to accept that whoever drafted the response for the Minister's signature read the inquest findings closely. The reference in the passage from the reasons set out above to the possible insertion of a provision in terms similar to section 14(5) of the Restraining Orders Act made it clear that what was proposed by the recommendation would not "... remove a police officer's discretion" as suggested in the Minister's letter, but rather would enable police to seize a firearm from a person involved in domestic violence in other than certain limited circumstances. The intent of the recommendation was to enable police to limit access to firearms by angry people in violent domestic relationships before firearms are used and in cases where there may be no direct evidence of intent to use firearms.





Minister for Police; Road Safety
Leader of the House in the Legislative Assembly

Our Ref: 31-16481

PERTH CORONERS COURT

20 MAR 2012

RECEIVED

Ms Dawn Wright
Administrator
Office of the State Coroner
10th Floor, Central Law Courts
501 Hay Street
PERTH WA 6000

Dear Ms Wright

Thank you for your letter of 9 February 2012 concerning the State Coroner's recommendations contained in the findings from the inquest into the circumstances surrounding the death of Benjamin David Daly.

As the Minister for Police, I can advise you that the Western Australia Police have reviewed and considered the recommendation.

In relation to the following specific recommendation, it should be noted that this will have significant impact on Western Australia Police.

Consideration be made to amending the *Restraining Orders Act 1997* so that when a Police Order is made pursuant to section 30A of the Act, that order would normally include a restraint prohibiting the person who is bound by the order from being in possession of a firearm and enable police officers to seize any firearms in that person's possession or available to that person through a corporate firearms licence or otherwise.

WA Police are afforded power under section 24(2) of the *Firearms Act 1973* to seize firearms and ammunition at a police officer's discretion. The recommended amendment to the *Restraining Orders Act 1997* will remove a police officer's discretion. Under this change to the *Restraining Orders Act 1997* every person issued a Police Order may be deemed not to be a 'Fit and Proper' person for the purposes of the *Firearms Act 1973*.

In addition the recommendation would create a significant impost on WA Police to seize, store and maintain firearms every time a Police Order is issued.

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This recommendation has been discussed by WA Police with the Department of the Attorney General (DotAG) in December 2011. DotAG have advised that this recommendation is being considered for inclusion in proposed amendments to the Act in 2012.

I trust the above information is of assistance.

Yours sincerely



**ROB JOHNSON MLA
MINISTER FOR POLICE; ROAD SAFETY**

19 MAR 2012



Andrew Richard COLLARD

Coroner Mulligan conducted an inquest into the death of Andrew Richard Collard on 27 – 28 February 2012 & 15 March 2012 at the Perth Coroners Court and concluded death occurred on 4 July 2010 as a result of Head and Chest Injuries.

The deceased was a 28 year old Aboriginal man who lived alone in a caravan at Carine.

He died on 4 July 2010 as the result of head and chest injuries suffered after he lost control of his motor vehicle and crashed on Coates Road, Wundowie. At the time of the crash the deceased was trying to evade police who were following him.

At about 5 PM on 4 July 2010 the deceased left Northam with the intention of driving back to his home in Perth. He was stopped at the outskirts of Bakers Hill by the police. He was informed of the fact that he was under fine's suspension and unable to drive further, because of that fact.

The deceased appeared to accept the position that he would be unable to drive his vehicle any further. However some time later the deceased got back in to his vehicle and began to drive back to his home.

The deceased drove his vehicle along Great Eastern Highway until he saw the police vehicle occupied by the two officers who had recently stopped him. The police vehicle was parked on the side of the road.

The deceased decided to evade the police and he accelerated markedly so that he could get away from them.

The deceased's driving was of a very poor nature and put other road users at significant risk.

A short time later the deceased reached the intersection of the Great Eastern Highway with Coates Road. The deceased left the highway and turned on to Coates Road. He continued to drive very quickly and after cresting a gentle hill he lost control of his car and crashed.

The police and other witnesses were quickly on hand to try and assist the deceased. Despite strenuous efforts to rescue and resuscitate the deceased, his condition was such that he could not survive. He died before he was able to be transported by helicopter to Perth for treatment.

The deceased died of head and chest injuries. The death arose by way of accident.

During the course of the hearing it became evident that the police officers dealing with the deceased were unfamiliar with the terms of section 49A of the *Road Traffic Act 1974 (WA)* (the Act). The officers were unfamiliar with the granting of a necessity permit under the provisions of that section. A necessity permit is a discretionary permit the police may grant in order to allow a driver who is unaware of the suspension of his licence to conclude his journey, or to drive to a place of safety, in a lawful manner.

Not only were the police are ignorant of the power granted to them pursuant to section 49A of the Act, but they had never seen the appropriate necessity permit form (a P314). The officers did not carry the document in their vehicle and did not know any of their colleagues who did.



Police officers routinely involved in traffic related matters should be aware of the law relating to those who are driving whilst under suspension. They should carry in their vehicle the relevant forms they require to carry out their duties.

Recommendation

I recommend that the Commissioner of Police reconsider the content of the P314 (Penalty Enforcement Suspension Form) and ensure that it is drafted so as to correctly advise the recipient of the form how he or she can contact the Fines Enforcement Registry or otherwise pay the outstanding fines in issue.

Recommendation

I recommend that the Commissioner of Police cause to be published to all officers the content of section 49A Road traffic Act 1974 together with a practical commentary as to its application.

Recommendation

I recommend that the Commissioner of Police direct that P314 forms be carried in all police vehicles likely to be used in traffic control duties.



Inquests – Deaths In Care – Department for Corrective Services

During the year 8 Inquests were conducted into the deaths of persons who died while in the custody of the Department for Corrective Services.

Four inquests were conducted by Magistrate J Packington but have not been completed at the time of the preparation of this annual report.

The following chart details the position in respect of deaths in custody of the Department of Corrective Services since January 2007.



Date of Death	Date of Inquest	Name of Deceased	Custody	Place of Death	Finding
26/7/2007		McDONALD Charles Edward	Prison	Hakea Prison	
18/8/2007	14-16/7/2009	LOVELESS Simon John	Prison	Roebourne Regional Prison	Suicide
16/11/2007	6-7/12/2010	GREEN Hector Cedric	Prison	Kalgoorlie Prison	Natural Causes
27/1/2008	10-20/3/2009 11-14/5/2009	WARD Ian	Prison	Transported in Prison van	Open Finding
28/4/2008	17-19/10/2011 & 31/10/2011	BRENNAN Declan John Paul	Prison	Acacia Prison	Suicide
15/6/2008	19/2/2010	GARDINER Terrence Sydney Graham	Prison	RPH	Natural Causes
1/6/2008	24-25 & 30/8/2010 & 2/9/2010	NJAMME Dennis	Prison	Greenough Regional Prison	Natural Causes
22/8/2008	27-30/4/2010	WINMAR Ian Frank	Prison	Albany Regional Prison	Misadventure
18/9/2008	23-26/3/2010	REX Justin	Prison	RPH	Natural Causes
19or 20/9/2008	28-29/6/2011	TUCKER Alan Murray	Prison	Casuarina Prison	Natural Causes
9/10/2008	7-8/6/2011	MORATO Henrique Gregory	Prison	Hakea Prison	Not completed
14/8/2008	30/6/2011	SHEEHY Andrew Michael Brian	Prison	Casuarina Prison	Accident
3/7/2009	2/6/2011	NEBRO Daniel Rowley	Prison	Bunbury Prison	
14/8/2009	30/6/2011	SHEEHY Andrew Michael Brian	Prison	Casuarina Prison	Suicide
24/9/2009	11/6/2011	NEUMANN Karl	Prison	Hakea Prison	
25/11/2009	23-27/8/2010 14-16/10/2010	DOYLE Blake Michael	Prison	Hakea Prison	Accident
19/1/2010	21-23/5/2012	JAMIESON Sandy	Prison	Albany Regional Prison	
14/2/2010		WILLIAMS Brian William	Prison	Albany Regional Prison	
21/3/2010		KIMOTO Ayumi	Prison	Hakea Prison	
22/3/2010	24-27/7/2012 adj.	WINMAR Grantley Ross	Prison	Acacia Prison	
15/9/2010		TINKER Amy	Prison	Greenough Regional	
2/10/2010	3/4/2012	GARRETT Jason Bruce	Prison	Casuarina Prison	Natural Causes
24/11/2010		HUMES Peter Phillips	Prison	Hakea Prison	
27/11/2010		NGUYEN Tien Chung	Prison	Wooroloo	
10/6/2011		ROBINSON Shane John	Prison	Casuarina Prison	
20/7/2011		HALE David Maxwell	Prison	Hospice Murdoch in Casuarina Prison	
8/8/2011		VAN VEGTEN Philip	Prison	Casuarina Prison	
14/8/2011		WILLIAMS Ronald Graham (a)	Prison	Swan Districts Hospital via Acacia Prison	
24/10/11		BROPHO Robert Charles (a)	Prison	RPH via Casuarina	
11/12/2011		PAPAKOSTAS Con	Prison	RPH via Casuarina	
9/1/2012		KLAVINS Valfrids	Prison	Sir Charles Gairdner Hospital via Acacia Prison	



A brief summary of deaths which have occurred in the care of the Department of Corrective Services and which were inquested during the year is as follows –

Brian William EDWARDS

The Coroner Mulligan conducted an inquest into the death of Brian William Edwards, having investigated the death with an Inquest held at Perth Coroner's Court on 23 September 2011. Coroner Mulligan found that death occurred on 14 February 2010 at Albany Regional Prison, Albany, as a result of acute exacerbation of chronic obstructive pulmonary disease (emphysema/asthma) in the following circumstances -

The deceased was a convicted prisoner being housed in Cell N8, Unit 3, at Albany Regional Prison at the time of his death. The deceased had been incarcerated, except for two short periods when he was an escapee from lawful custody, for the 33 years prior to his death.

The deceased was convicted in relation to two counts of wilful murder which occurred during a period when he was an escapee (18 November 1979). The deceased was sentenced to death in relation to these offences. On 18 December 1980 the deceased's death sentence was commuted to a strict security life sentence.

Between 5:15am and 8am on 14 February 2010, the deceased died, whilst lying on his bed in Cell N8, Unit 3, Albany Regional Prison.

The deceased died as the result of acute exacerbation of chronic obstructive pulmonary disease (emphysema/asthma).

During the time the deceased was a prisoner, particularly at Albany Regional Prison, I believe that the quality of the supervision, treatment and care the deceased received was good. I believe the deceased was reasonably housed, provided with good medical care, at least equal to that he could have hoped to receive in the community and that he was adequately supervised so the threat he posed to others and the threat others posed to him were acceptable.

Coroner Mulligan found that death arose by way of Natural Causes

Recommendations: Nil

Declan John BRENNAN

The Deputy State Coroner, conducted an inquest hearing into the death of Declan John Brennan (the deceased) at Perth Coroner's Court, on 17-19 October and 31 October 2011 and found death occurred on 27 April 2008 at Acacia Prison, by way of Suicide as a result of Exsanguination due to Penetration of Arm Veins

The deceased was a paranoid schizophrenic who suffered fixed delusions which were controlled by medication to the extent the deceased could control his response to the delusions. Had he been at large in the community one of his treating psychiatrists indicated he



would have been subject to enforced medication by way of a Community Treatment Order (CTO). The pressure for beds in the Frankland Centre was considerable and prisoner/patients were released back to prison at a time before they would have been considered for release into the community. Psychiatrists will not sanction CTOs in a custodial setting with the result prisoner/patients will not be forced to comply with medication regimes.

Pending his release from prison the deceased became non-compliant with his medication and, although appropriately monitored by the Mental Health Nurse and visiting psychiatrists, did not appear to be unwell to the extent he fell within the provisions for involuntary status warranting transfer back to the Frankland Centre solely to enforce his medication.

He committed Suicide.

In those circumstance the Deputy State Coroner was satisfied the deceased received appropriate supervision, treatment and care while in custody in Acacia as far as Acacia was able to care for a prisoner as severely unwell as the deceased. He was reviewed and monitored and treated, as far as was possible, in that environment.

The issue for the deceased was not the prison, but the system. The system by which Acacia had to abide did not allow for enforced medication by way of treatment as a prisoner, as opposed to a patient. It is impossible to say enforced medication would have prevented the death of the deceased, but the Deputy State Coroner believed it noteworthy the deceased always seemed better able to cope with his mental illness when successfully medicated. Both his family and his treating medical practitioners believed this to be the case.

“In the case of the deceased his family, mistakenly believed the prison would enforce his medication. They, not unexpectedly, were relieved when the deceased was in custody because they believed he would be made to take his medication. They knew from experience he benefited from compliance with his medication and abstinence from excessive abuse of illicit substances.

To a lay-person this view is entirely logical. In fact it is so obviously in the patient/prisoner’s best interest I have some concern as to why I do not fully understand the reasons the majority of psychiatrists are so opposed to the concept of a CTO in prison.”

“Current trends generally appear to confirm many patients are released back into the community without adequate safe guards. It is a known high risk time with respect to the potential for suicide for many patients. The option of a custodial CTO would seem to be a good use of time in custody to attempt long term stabilisation by way of medication for those patients for whom medication is effective.”

“Dr Petch was reasonably firm in his view CTO’s should not be used in prison due to his concern their use may be abused and prisoner/patients may not have adequate recourse to review by the Mental Health Review Board or equivalent. I can understand this concern but would hope that if prisoner/patients were still dealt with by psychiatrists attached to the Frankland Centre, with whom they had been involved while in that facility, and those psychiatrists were involved in the issuing of the CTO, this would be a useful safe guard to ethical use.”



“During the course of the inquest all the psychiatrists called indicated part of the problem with the ability to maintain patient/prisoners in the Franklyn Centre was the number of people requiring assessment under hospital orders from the various courts. All the psychiatrists who gave evidence either, were at the Franklyn Centre, or had been employed there at some stage or another, apart from Dr Davidson. The implication was an inability to refuse admission to those requiring assessment under a hospital order prevented the adequate treatment of those already in custody.

Sadly, and it indeed emphasises how under resourced the Franklyn Centre is in current needs terms, Magistrates Courts (courts of first contact for criminal matters) are no longer able to send prisoners about whom there are concerns to be assessed at the Franklyn Centre without their first being assessed, via video link, to determine whether or not they require admission. This, in addition to the waiting lists for main stream prisoners, where prisoner/patients have already been assessed by MHNs or visiting psychiatrists, ensures no prisoner/patient can be adequately stabilised before return to a custodial/detention type setting. Obviously this means they have to be assessed in a “*risk based*” system rather than a “*needs based*” system. Unfortunately it is generally recognised this can result in flawed decision making.

In the foreseeable future, until there are enough beds in the Frankland Centre, or a like facility, to ensure proper care of prisoner/patients, it must be preferable to care for prisoner/patients in the place to which they are returned prematurely, ie; prisons.

Specifically, in the case of the deceased, both Dr Morton and Dr Schineanu believed he benefited from compliance with medication and abstinence from substance abuse. Dr Morton had sent the deceased to Frankland Centre in January 2008 because he was so unwell he warranted involuntary status. Dr Schineanu, who treated him in Frankland Centre and had known him for at least eight years, was quite clear his view was the deceased was very unwell and required long-term treatment. He only released him from the Frankland Centre in January 2008 because he was returning the deceased to a structured, monitored environment, prison.

Had the option been the community, Dr Schineanu was quite clear he would not have released the deceased, even on a CTO, because he would not have succeeded.

Prior to his death no one considered the deceased was a real suicide risk; recurrence of his extreme paranoia, yes; suicide, generally not. It is only in hindsight, with knowledge of the content of his family phone calls, suicide notes and conversations with other prisoners, the risk is clearly apparent. There is no doubt his suicide is grounded, one way or another, in his severe mental ill health.

It was his mental illness which need treating, and had been since at least 2001, when Dr Schineanu outlined a treatment plan for the deceased. This did not succeed because the deceased could not be forced into treatment while left to his own devices in the community, or was un-medicated while in custody. This resulted in continued resource costly interventions by way of the Criminal Justice system.

In view of the fact it is generally recognised prison has become a catchment for those marginalised in the community by their mental ill health, it would seem to be appropriate both prison and psychiatric facilities worked together to provide improved long-term care where it would benefit all concerned, including ultimately the community at large.”



The Deputy State Coroner recommend:

- (i) **A dedicated, appropriately resourced, facility for the treatment of prisoner/patients with mental health issues.**
- (ii) **Meanwhile, there be provision of CTOs in nominated prison/s (Acacia Prison seems to be willing if appropriately approved) in circumstances where forensic psychiatrists will be prepared to monitor treatment in the best interest of the patient/prisoner.**
- (iii) **The continued provision of programs such as Gate Keeper/Lifeline to appropriate prisoners, as well as the continuation of training in those areas for prison officers/custodial officers.**
- (iv) **Prisoner/patient medical files be updated when there is a failure to attend a nominated medical review to outline reason given, if any, and action taken to provide follow up.**

The Department of Corrective Services' response to the Deputy State Coroner's findings are as follows -



**DEPARTMENT OF CORRECTIVE SERVICES' RESPONSE
TO THE FINDINGS OF THE CORONER
INTO THE MANNER AND CAUSE OF DEATH OF
MR DECLAN JOHN PAUL BRENNAN**

Background

At approximately 2345 hours on 27 April 2008, Mr Declan John Paul Brennan, a 38 year old prisoner at Acacia Prison, was found lying on his bed with what appeared to be extensive injuries to his arms. Staff commenced Cardio Pulmonary Resuscitation, however, attempts to resuscitate him were unsuccessful.

At 0040 hours on 28 April 2008, life was pronounced extinct.

During a subsequent search of Mr Brennan's cell, Police found disposable razors with the blades removed and blades on his bed and on the floor of his cell. At that point in time, it was believed that Mr Brennan used these razors to inflict the wounds on his arms.

At the time of his death, Mr Brennan had two days remaining on his sentence. Mr Brennan did not have an active alert recorded on the At Risk Management System (ARMS) at the time of his death.

Mr Brennan had a known history of illicit substance abuse and had been diagnosed with paranoid schizophrenia. Throughout his final period of incarceration, Mr Brennan had experienced a number of fixed delusions and complained that his medication was ineffective.

In January 2008, Mr Brennan was admitted as an involuntary patient to Graylands Hospital by his treating psychiatrist. At this time Mr Brennan was refusing treatment and his psychiatrist considered him a potential risk to himself. When Mr Brennan returned to Acacia on 18 January 2008, his medical notes indicate that he was "very well".

In the twelve days prior to his death Mr Brennan was non-compliant with medication. His discharge summary, which was prepared for his expected release from prison, makes reference to fleeting suicidal ideations and an unwillingness to provide a fixed address where he would be residing upon release.



Finding

The Deputy State Coroner found that Mr Brennan's death arose by way of suicide, as a result of exsanguination due to penetration of arm veins (refer pages 1 and 37, *Coroner's Findings*)¹.

The Coroner stated that Mr Brennan "quite deliberately obtained naked razor blades, went to bed and cut his forearms" (page 37).

Comments on the Supervision, Treatment and Care of the Deceased

The Coroner stated that "the deceased received appropriate supervision, treatment and care while in custody in Acacia as far as Acacia was able to care for a prisoner as severely unwell as the deceased. He was reviewed and monitored and treated, as far as was possible, in that environment" (page 38).

The Coroner made four recommendations in relation to this inquest:

Recommendation 1

"A dedicated, appropriately resourced, facility for the treatment of prisoner/patients with mental health issues".

The Coroner stated that "prisons do not force medication on prisoners unless they have been declared involuntary patients and transferred to an appropriate authorised facility where they can be forced to take medication. Difficulties with bed space and resources in the only authorised facility in Western Australia realistically able to take forensic patients (Frankland Centre/Graylands Hospital) is under great pressure. Prisoners are therefore released, prematurely, back to prison" (page 38).

The Coroner further stated that "long-term, a dedicated forensic facility with appropriate capacity to deal with the problem is the ultimate goal. Meanwhile, the provision of a dedicated prison unit or wing where treating psychiatrists and appropriately resourced [Mental Health Nurses] MHNs can monitor treatment and enforce medication compliance, with appropriate recourse to supervising bodies, whether that be by the Frankland Centre or a form of Prisoner Mental Health Review Board needs to be considered with serious good will" (page 46).

DCS Response: The Department supports this recommendation subject to funding. The Department supports the concept of a mental health facility and is willing to collaborate with the Department of Health, Mental Health Commission of Western Australia and other relevant agencies, to explore the potential establishment of such a facility in accordance with the National Mental Health Strategy.

¹All references throughout this report will refer to the Coroner's Findings



In respect to a dedicated psychiatric prison facility, the Department's Health Services Directorate has had internal discussions regarding this recommendation, with both Hakea and Casuarina Prisons suggested as potential venues. Further research is being conducted and future meetings have been arranged to formulate a business plan for presentation to the Commissioner.

Recommendation 2

"Meanwhile, there be provision of [Community Treatment Orders] CTOs in nominated prison/s (Acacia Prison seems to be willing if appropriately approved) in circumstances where forensic psychiatrists will be prepared to monitor treatment in the best interest of the patient/prisoner".

The Coroner stated that "a CTO effectively makes a mental health patient involuntary under the [Mental Health Act 1996] Act for the purposes of enforcing medication, while allowing them into the community to be monitored in the community...It is in their best interests and therefore a 'needs based' option, preferable to continual enforced hospitalisation" (page 40).

The Coroner also commented that "the reality is prisoners are forcefully detained regardless of their mental illness. The concern would appear to be the unethical enforced medication of prisoners to keep them docile or compliant without good cause" (page 40).

DCS Response: The Department does not support this recommendation. While there appears to be no legal impediment, under the WA Mental Health Act 1996, to the implementation of CTOs on prisoners in custody, there are ethical concerns, as identified in the Coroner's findings. Without a governing body in place (such as a 'Prison Mental Health Review Board') to review and monitor each case of non-compliance, the Department could not be certain that the practice of ongoing enforced medication would be in the best interests of the prisoner and thus could be perceived as a control device.

When applicable, clinicians have the power to transfer any prisoner with a mental health disorder in need of treatment to the Frankland Centre at Graylands Hospital in order to ensure compliance with medication and treatment.

Recommendation 3

"The continued provision of programs such as Gate Keeper/Lifeline to appropriate prisoners, as well as the continuation of training in those areas for prison officers/custodial officers".

The Coroner stated that "I am satisfied Acacia complied with its contractual obligations with respect to the welfare of the deceased, even to the extent of substituting Lifeline Training for its [Custodial Officers] COs when Gate Keeper Training was not forthcoming, for whatever reason, from conventional prison authorities" (page 38).



DCS Response: The Department supports this recommendation subject to funding. The Acacia Prison Services Agreement details that all relevant contracted staff at Acacia Prison undergo training in approved programs (such as Gatekeeper and Lifeline) and utilise these skills accordingly in their regular duties.

Between 2009 - 2011, DCS provided Acacia Prison with four Gatekeeper workshops. Whilst it is supported that all peer support prisoners and staff receive Gatekeeper training, additional funding and resources will be required for DCS to continue training delivery at Acacia Prison moving forward.

To overcome this, Acacia Prison was offered a place on the 'Gatekeeper Train the Trainer' course for facilitators in January 2012. As a result, one staff member received the training and is currently undergoing the accreditation process. In addition to the staff member who achieved accreditation in 2011 (facilitated by the Department), Acacia will soon have two staff members trained in Gatekeeper facilitation. This enables Acacia to run Gatekeeper at its site independently of the Department, with governance to be retained by the Department's Clinical Governance Unit.

Recommendation 4

"Prisoner/patient medical files be updated when there is a failure to attend a nominated medical review to outline reason given, if any, and action taken to provide follow up".

Mr Brennan did not attend a scheduled psychiatric appointment at the Medical Centre on 7 March 2008. Mr Brennan also failed to attend an appointment on 14 March 2008, opting to see a drug counsellor at the Methadone Clinic instead. Mr Brennan's next psychiatric appointment was scheduled for 28 April 2008, one day after his death.

The Coroner stated that "if the deceased chose not to see a psychiatrist his attendance could not be enforced, however, there are no notations in his progress notes as to any reasons explaining why the deceased may not have seen a specified practitioner" (*page 18*).

The Coroner further commented that "the deceased was listed to see a new psychiatrist he had not seen before on the day after his death (28 April 2008). It would be expected that psychiatrist would have been involved in discharge planning for the deceased's release on 30 April 2008. MHNS Pariagh had written a 'discharge plan' in the deceased's notes which would have informed that psychiatrist the deceased had been non-compliant with his medication for the preceding 12 days...the deceased's history of non-compliance and any deterioration would have been available to the psychiatrist when considering a final discharge plan for the deceased's release" (*page 18*).



DCS Response: The Department supports this recommendation. The majority of prisoners self-refer to Health Centres and then often do not attend. When a prisoner cancels a self-initiated appointment, Health Services staff do not have the requisite information to follow up with the prisoner, as they are not required to provide any information when making an appointment. However, in circumstances where Health Services staff made the appointment and the prisoner does not attend, it is expected and professional practice, for staff to document the prisoner's absence manually and schedule another appointment if staff identify that the prisoner requires follow up of a specific clinical indication.

Furthermore, the Department's Health Services Directorate is seeking funding and exploring options for an improved medical record system which will address this issue. The current medical records system used by the Department does not have a mechanism to automatically alert Health Services staff to missed appointments. A key feature of the desired medical records system would be automatic alerts for staff indicating a missed appointment, ensuring that follow up can occur and the risk to the prisoner's health minimised.

Preparation of this Report

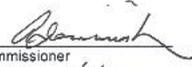
This report was prepared by Mr Joe Apai, Professional Standards Division, with input from the Divisions of Corporate Support, and Offender Management and Professional Development.



Joe Apai
Coordinator Coronial Inquests

6 March 2012

Endorsed: 
Deputy Commissioner
Offender Management and Professional Development
7.3.12

Endorsed: 
Assistant Commissioner
Corporate Support
7/3/12.

Endorsed: 
Assistant Commissioner
Professional Standards
6.3.2012

5



Christopher Peter Barnes (aka Moore)

The Coroner Mulligan conducted an inquest into the death of Christopher Peter Barnes, having investigated the death with an Inquest held at Perth Coroner's Court on 20-21 December 2011. Coroner Mulligan found that death occurred on 18 December 2000 at Wooroloo Prison Farm, Wooroloo, as a result of acute opiate toxicity with vomit aspiration.-

The deceased was a sentenced prisoner housed in a single cell, 1B 58, at Wooroloo prison farm.

On Sunday, 17 December 2000 the deceased was allowed to leave the prison with 13 other prisoners in order to go to a cricket match. The deceased was to be the team scorer. The prisoners left the prison at about 9:15 AM under the supervision of one prison officer. They travelled to Tompkins Park, Melville for the match. The prisoners arrived at the ground at about 11:05am. They set off to return to the prison at about 6:30pm, where they arrived at about 8 PM.

Whilst at the match the deceased was unobserved on at least 3 occasions when he went to the toilet. At some point during the day the deceased acquired a quantity of heroin.

The acquisition of the heroin may have been made easier when a number of people, including three people of ill-repute, attended the cricket match and consorted with a prisoner without having pre-booked a visit. The officer in charge of the prisoners had to spend some time determining who they were and recording their details in a log.

After the deceased returned to the prison he shared and used some of the heroin he had brought back into the prison.

At about 3am the deceased vomited in a communal toilet.

A muster took place at the prison at about 5:20am on Monday 18 December 2000. The officers conducting the muster, Officers Stenton and Olsen, looked into the deceased's cell at about 5:30am. The officers opened the cell and could see the deceased in a state of collapse. The deceased was upright on his bed and there was a bucket on the floor between the prisoner's feet. There was also a quantity of vomit on the floor of the cell. The whole cell smelt strongly of vomit.

Three other officers were called to the deceased's cell.

The officers in question undertook no resuscitative efforts and did not move the deceased from the position in which he was initially located.

The absence of resuscitative efforts was the result of a direction from Acting Senior Officer Charles Pieterston. He arrived at the deceased's cell shortly after the deceased had been discovered at 5:30am. He "checked" the deceased and ordered that nothing in the cell be touched. He ordered his fellow officers out of the cell and directed that the cell be locked.



When Officer Olsen told Acting Senior Officer Pietersen that the officers should be attempting resuscitation, Acting Senior Officer Pietersen told Officer Olsen and his colleague that he should obey his orders.

At about 6am Assistant Superintendent Bond arrived at the cell and he thereafter ensured that the relevant officers made good faith efforts to resuscitate the deceased. These efforts, while well intentioned, were simply too late.

Acting Senior Officer Pietersen called for an ambulance at about 6 AM. It arrived at about 6:21 am. The ambulance officers were told that resuscitative efforts had been underway since the deceased was discovered at approximately 5:30am.

The ambulance officers examined the deceased and determined that he was dead.

A post mortem examination was later performed on the deceased by a forensic pathologist. The forensic pathologist determined that the cause of death was acute opiate toxicity with vomit aspiration.

Forensic examination determined that the syringe located in the deceased's cell had contained heroin. An examination of a small item, wrapped in Glad wrap type plastic, and secreted in the opening of the deceased's anus was found to be a heroin.

The five officers who were initially in the deceased cell went to a conference room, where they asked to be left alone to do their reports.

The five officers: Officer Helen Stenton, Officer John Olsen, Officer Maxwell Tilbrook, Officer Pamela Coombs and Acting Senior Officer Charles Pietersen then wrote reports for both the police and for their employer.

The statements were a series of dovetailed lies told by the officers to show that the deceased had been properly treated after his discovery at 5:30am. Each of the officers developed four themes in the statements that they made to the police and the Incident Description Report provided to their employer. Those themes were:

1. Resuscitative attempts began shortly after the deceased was discovered by Officer Olsen.
2. The deceased was moved, shortly after his discovery by Officer Olsen, with some difficulty, by the officers into a prone position on his bed.
3. CPR was given to the deceased, by the officers, shortly after his discovery by Officer Olsen and continued unabated until the arrival of ambulance officers at about 6:21 am.
4. The Air-Viva unit was taken to the deceased's cell and was used, in an attempt to revive the deceased. It was used unabated from shortly after this deceased was discovered by Officer Olsen until shortly after the arrival of ambulance officers at about 6:21am

It should be noted that each of the statements provided to the police was concluded with a declaration to the effect that the contents of the statement were true and correct.



Each of the four themes developed by the five officers were false. The five officers in question deliberately misled the police and the Department of Justice about what had happened after the discovery of the deceased.

As noted above the deceased vomited in the communal toilet at about 3am.

The deceased was discovered collapsed in his cell at about 5:30am. The deceased had vomited copiously whilst in his cell.

It seems certain that at some point between about 3am and approximately 5:30am the deceased injected himself with a fatal dose of heroin that caused him to suffer a rapid death, meaning that death likely occurred within about 20 minutes of the injection of heroin.

I am not able to say whether both bouts of vomiting (in the toilet bowl and in the cell) occurred in a similar time frame and related to a single cause, or whether they related to 2 or more separate injections of heroin, the last of which occurred in his cell at some time before his discovery by Officer Olsen.

Given the subsequent lies told by the five officers who initially dealt with the deceased, it is impossible to say with any confidence whether the deceased was dead when he was discovered by prison officials or whether it would have been possible to have resuscitated him from an unresponsive state of collapse.

A person who is not overtly showing signs of life may nevertheless still be alive and functioning at a very low level, which can be detected with the benefit of appropriate medical equipment. In a situation like that a person may appear to be dead but nevertheless be able to be resuscitated by appropriately skilled and equipped practitioners.

In order to give those who have collapsed and are functioning at a very low level, the best chance of resuscitation, first responders need to immediately provide first aid, including CPR and the use of an Air-Viva.

It is important that resuscitation efforts be continued until appropriately qualified medical practitioners are able to make a determination as to whether the deceased is beyond resuscitation and is in fact dead.

These efforts are particularly important in the case of an overdose of heroin because of the way it acts as a powerful respiratory suppressant. When somebody suffers a heroin overdose, it suppresses that person's breathing. Their heart may beat, but not enough oxygen will be circulated through their body.

Early and continued CPR and the use of an Air-Viva may assist a person in a collapsed state remain stable until medical assistance arrives. Ambulance paramedics and hospital emergency departments are likely to have antidotes to heroin, such as Naloxone, which can be used to revive a person who has suffered an overdose.

In early January 2001 the five officers I have referred to provided their employer with Amended Incident Description Reports, in which they admitted that resuscitative efforts had not been commenced between 5:30am and 6am.



Because of the manner in which the five officers conducted themselves I made comment pursuant to section 25 (2) of the *Coroners Act 1996 (WA)* (the Act), that is to say a comment relating to the administration of justice. In my view the behaviour of the five officers tends to erode public confidence in the administration of justice. Their behaviour hampered the proper investigation and disposition of matters relating to the deceased.

I also made comment pursuant to section 25 (2) of the Act in relation to 2 senior officials employed at the prison; Assistant Superintendent Graham Bond and Superintendent Jim Dunstan.

On 18 December 2000 Assistant Superintendent Bond was responsible for ensuring that incident reports were completed by all relevant staff. Assistant Superintendent Bond did not complete an incident report in relation to the death of the deceased. On 4 May 2001 he signed a police statement. The statement addressed the fact that he knew that no resuscitative efforts had been made prior to his arrival at the deceased's cell and that the door of the cell was closed and that no officers were inside the cell.

It seems sub-optimal that Assistant Superintendent Bond did not file a report on the day of the deceased death, particularly as he was tasked with ensuring that all of the relevant officers filed reports on that day.

Had he provided a written incident report on a 18 December 2000, the discrepancy between his account of events and the initial accounts given by the five prison officers would have been manifest at the earliest stage.

I was also concerned in relation to Superintendent Dunstan's conduct on 18 December 2000 and made adverse comment in relation to him under section 25 (2) of the Act.

Superintendent Dunstan was aware during the morning of 18 December 2000 that his officers had not initially attempted to resuscitate the deceased.

Superintendent Dunstan directed a subordinate to prepare a briefing note which was to be sent to the General Manager of Prison Services. The briefing note stated that once the officers were able to position the deceased on his bed CPR was commenced and continued until ambulance staff arrived at 6:21am.

Superintendent Dunstan authorised the sending of the briefing note by fax even though he knew that the content to be factually incomplete and misleading.

In the course of my finding I noted other shortfalls I perceived in Superintendent Dunstan's conduct.

In my opinion superintendent Dunstan's conduct was sub-optimal and well below community or departmental expectations.

Recommendation

The Department for Corrective Services should consider introducing a policy directive aimed at informing prison officers charged with escort duty as to:



1. what contact prisoners should have with visitors who have not pre-booked a visit with The prisoner at an event outside the prison; and,
2. What to do in the event a prisoner has unauthorised contact with members of the general public, who are at an event.

The policy should inform prison officers as to the appropriate sanctions available to them, such as the early termination of an event.

Recommendation

The Department for Corrective Services should reconsider whether it introduces a policy that sets a staff/inmate ratio for events allowed pursuant to section 95 of the prisons act 1981, so as to ensure that prisoners are unable to receive contraband whilst outside prison.

Or it should take effective steps to search prisoners returning from section 95 events, so as to minimise the risk of contraband entering the prison.

Recommendation

The Department for corrective Services should take immediate steps to amend Policy Directive 30 relating to the death of a prisoner. Section 3 of the policy directive should be amended so that it directs the senior officer to immediately call for an ambulance when a prisoner is found in an unresponsive state of collapse, even if the prisoner is without apparent signs of life.

Recommendation

The Department for Corrective Services should consider the reintroduction of a trained canine unit, or appropriate technology, at Woorloo Prison Farm, with the intention of reducing the flow of illicit drugs into the prison, deterring prisoners from having drugs and detecting drugs in the prison environment before they can be used by prisoners.

Bruce Jason GARRETT

The Deputy State Coroner, conducted an inquest hearing into the death of Bruce Jason Garrett (the deceased) at Perth Coroner's Court, on 3 April 2012 and concluded death occurred on 2 October 2010 at Royal Perth Hospital, as a result of HIV infection complicated by Basal and Squamous Cell Carcinoma.

The deceased had been a medium security prisoner at Casuarina Prison detained pursuant to an Order under the Dangerous Sexual Offenders Act 2006 (DSO). He had been diagnosed in 2002 with HIV and in April 2009 with a basal cell carcinoma. He generally refused treatment other than symptomatic relief for pain.

On 16 September 2010 he was admitted to Royal Perth Hospital (RPH) where he remained until his death on 2 October 2010 at 52 years of age. His preference was to be transferred back to Casuarina Prison to die in familiar circumstances.



Overall the Deputy State Coroner was of the view the supervision, treatment and care of the deceased was perfectly reasonable.

She made the following recommendations to assist the DCS Health Services

- 1. Develop Not for Resuscitation protocols consistent with those used by Health Department for use in a custodial setting;**
- 2. Explore procedures to facilitate easy access to patients for observations and care while placed in the prison infirmary at the end stage of their illness;**
- 3. Obtain or facilitate the consent of prisoner/patients for appropriate placement at the end stage of their illness, including their expressed wish to die in a prison setting;**
- 4. Develop appropriate protocols to ensure the timely and relevant flow of medical information between agencies in relation to prisoner/patients;**
- 5. Develop appropriate protocols around removal of restraints consistent with relevant considerations;**
- 6. Develop relevant legislative change if necessary for early or urgent review in exceptional circumstances; and**
- 7. The Department of Health engage in this process to assist DCS in achieving an outcome consistent with current medical practices.”**



FREEDOM OF INFORMATION ACT DIRECTION TO POLICE ACTING AS CORONER'S INVESTIGATORS

In recent years there have been a number of applications made to WA Police for access to coronial evidence, some of these applications have been made pursuant to the *Freedom of Information Act 1992*.

There appears to have been some confusion in this context as to the application of relevant legislation, namely the *Coroners Act 1996* and the *Freedom of Information Act*.

The approach taken by this office has been that applications for access to information are governed by the *Coroners Act*. In respect of applications for access to information by next of kin, for example, section 26A of the *Coroners Act* should be relied upon.

In respect of access to information for research purposes, those applications should be referred to the Coronial Ethics Committee.

In accordance with section 58(2) of the *Coroners Act* the Coronial Ethics Committee was established in 1998 and that committee complies with National Health and Medical Research Council (NHMSC) guidelines and requirements.

It is a serious concern of the Coroner's Court that access to private and confidential information should be strictly controlled and that unless there is a public inquest, information and evidence received should be treated as private and confidential.

Information obtained in coronial investigations includes medical evidence, evidence as to the financial standing of individuals, evidence as to sexual practices and other evidence of a most private and confidential nature. Disclosure of such evidence in circumstances not adequately controlled by the Coroner's Court could cause great distress, constitute serious breaches of confidentiality and privacy and impact on the ability of the Coroner's Court to investigate cases in future. It is obvious that many persons would be reluctant to provide private and confidential information to investigators investigating sudden deaths on behalf of the coroner if there was a concern that the confidential evidence could be inappropriately published.

It was in the above context that on 27 May 2011 I made a direction that officers of WA Police acting as coroner's investigators not provide access to evidence obtained to other officers of WA Police or other organisations or individuals other than in accordance with normal investigative and criminal procedures and the supervision necessary to carry out the proper investigation of the circumstances of the deaths except with the approval of a coroner (this direction was made pursuant to section 14(3) of the *Coroners Act*).

While there appears to have been some confusion as to whether or not this was a reasonable direction, the legal situation appears to have been settled in a matter before the Information Commissioner, *Re Nine Network Australia Pty Ltd and Western Australia Police* [2011] WAICmr 27.



In that case the Information Commissioner was satisfied that the directions contained in my letter of 27 May 2011 prevented WA Police from giving access to the disputed documents and the Commissioner was of the view that as a result of the direction the documents were exempted under Schedule 1 clause 12(b) of the *Freedom of Information Act*.

So there can be no doubt in relation to the position, I repeat the direction made in my letter of 27 May 2011. I note that as a result of this direction all of information obtained as a result of coronial investigations is now exempt pursuant to Schedule 1 clause 12(b) of the *Freedom of Information Act*.

I hereby direct that officers of WA Police acting as coroner's investigators not provide access to evidence or any other information obtained to other officers of WA Police or other organisations or individuals other than in accordance with normal investigative and criminal procedures and the supervision necessary to carry out the proper investigation of the circumstances of the deaths except with the approval of a coroner.

Evidence or information obtained in these investigations includes photographs, medical evidence, evidence relating to the financial standing of individuals, police reports and statements, witness statements, mortuary admission forms, post mortem reports, toxicology reports, expert reports and suicide notes.

