

**OFFICE OF THE
STATE CORONER**

ANNUAL REPORT

2004 – 2005



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30th June, 2005

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

Dear Minister

***In accordance with Section 27 of the Coroners Act 1996
I hereby submit for your information and presentation to
each House of Parliament the report of the Office of the
State Coroner for the year ending 30 June, 2005.***

Yours sincerely

Alastair Hope
STATE CORONER

State Coroner's Overview



During the year 2004/2005 there were a considerable number of events of importance to state's coronial system.

It is pleasing to note that during the year the considerable efforts of the Chief Forensic Pathologist, Dr Clive Cooke, and Forensic Odonologist, Dr Stephen Knott, were recognized and both received Order of Australia Medals.

In Dr Cooke's case, the award acknowledged his major contribution in a number of overseas tragic events. Following the Bali bombings on 12 October 2002 Dr Cooke was a major contributor in the initial Australian Disaster Victim Identification (DVI) team. DVI is the term given to procedures used to positively identify deceased victims of a multiple fatality event.

Dr Cooke has also had considerable involvement, assisting with investigations, in relation to the Jakarta Marriott Hotel Bombing in 2003, the Jakarta Australian Embassy Bombing in 2004 and the South East Asian Tsunami Thailand Contingent of 2004/05.

The fact that Dr Cooke was invited to Indonesia to assist with investigations after the first Bali bombing case reflects the high regard in which his expertise is held overseas.

Dr Knott played a key role in identifying deceased persons following the Bali Bombings of 12 October 2002 and has had ongoing important input in relation to DVI following further tragedies including three visits to Thailand following the tsunami disaster.



The awards presented to Dr Cooke and Dr Knott were well deserved and the State has reason to be proud of their achievements.

*Dr Stephen Knott, Forensic Odontologist
and Dr Clive Cooke, Chief Forensic
Pathologist and Clinical Director of Forensic
Pathology*

On 26 December 2004 following an earthquake, a tsunami battered the coasts of Indonesia, Thailand, Malaysia, Sri Lanka, Maldives, Burma, Bangladesh, India and East Africa. The death toll from the tsunami, while



difficult to estimate with accuracy, was considerable and involved many thousands of people.

Following the tsunami urgent action was taken in Western Australia so that the state would be prepared in the event that a number of bodies would be repatriated to this state. On 29 December 2004 the Coronial Counsellor liaised with Managers of the Department of Justice and Court Counselling Branch including the Victim Support Service, Child Witness Service, Family Court and the Director of Court Counselling Services to ensure that counsellors would be available, if required, to assist in disaster victim identification anti-mortem information collection.

By 30 December 2004 a major incident room had been allocated at Police Headquarters, East Perth, and teams were in place ready in the event that anti-mortem data was to be collected. Fortunately the numbers of Australian deaths were relatively few and by 14 January 2005 the incident room was shut down.

On 21 January 2005 a briefing was provided to State Coroners and others by Mr Karl Kent and Dr James Robinson of the Australian Federal Police. Present were forensic pathologists, representatives of the Department of Foreign Affairs and Trade, State Police representatives, a representative of the Commonwealth Attorney General's Department and others with legitimate interests. It was clear from the briefing that Australia played a considerable role in the body identification process in Thailand because of strong ties between Thailand and Australia developed over many years.

Important lessons had been learnt following the Bali disaster, but the scale of the tsunami disaster was such that many problems were encountered which had not been previously identified.

In the Annual Report of 2003/2004 it was noted that Mr Glenn Spivey, the former Manager of the Coroner's Court, had retired from the public service on 12 August 2004. At the time of writing the Manager's position has not been filled and my thanks go to Mr Simon Walker who has acted in the position during the year, capably assisted by all staff, particularly Mr David Dent.

In previous annual reports a summary of a number of inquest findings, particularly findings in cases of deaths in custody, have been included. In this year's annual report inquest cases have not been summarised because access to the inquest findings is now readily available at the Coroner's Court website on the internet at www.coronerscourt.wa.gov.au Completion of this annual report has been delayed in the expectation that availability of access



to the reports on the website would avoid a necessity to refer to the findings in detail. My thanks go to the Attorney General, the Honourable Jim McGinty, for his support in relation to provision of the website address.

Involvement of Relatives

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

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

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

During the year 1 July 2004 - 30 June 2005 a total of 2,251 deaths were referred to the Coroners Court. In 626 cases a death certificate was issued at an early stage and the body was not taken to the mortuary. Of the remaining 1,625 cases, a total of 128 objections were made to the conducting of a post mortem examination.

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

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

Where objections are made, every effort is taken to attempt to ascertain the extent to which a cause of death can be determined without an internal post mortem examination. It is a rare case in which there are no external factors which would give some insight into a likely cause of death.

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



Deaths Referred to the Coroners Court from
1 July 2004 - 31 December, 2004

	Jul	Aug	Sept	Oct	Nov	Dec	Total
Death Certificate issued although the body was admitted to the Mortuary	19	19	19	14	17	11	99
Immediate post mortem ordered (usually these are homicide cases)	6	3	2	0	0	4	15
No post mortem because body missing etc.	1	1	0	3	0	1	6
No objection to post mortem	113	107	129	114	101	93	657
Objection received by the Coroners Court	11	16	11	14	14	11	77
TOTAL NUMBER OF DEATHS	150	146	161	145	132	120	854

Developments in Cases where an Objection was initially received

	Jul	Aug	Sept	Oct	Nov	Dec	Total
Objection withdrawn prior to a ruling being given by a Coroner	3	4	1	2	7	7	24
Objection accepted by a Coroner and no post mortem ordered	4	10	10	10	7	4	45
Objection over-ruled by a Coroner*	4	2	0	2	0	0	8
TOTAL	11	16	11	14	14	11	77



Deaths Referred to the Coroners Court from
1 January 2005 - 30 June 2005

	Jan	Feb	Mar	Apr	May	Jun	Total
Death Certificate issued although the body was admitted to the Mortuary	15	5	21	13	10	23	87
Immediate post mortem ordered (usually these are homicide cases)	4	2	1	1	0	3	11
No post mortem because body missing etc.	1	0	0	0	0	1	2
No objection to post mortem	95	93	105	109	117	101	620
Objection received by the Coroners Court	10	5	7	10	7	12	51
TOTAL NUMBER OF DEATHS	125	105	134	133	134	140	771

Developments in Cases where an Objection was initially received

	Jan	Feb	Mar	Apr	May	Jun	Total
Objection withdrawn prior to a ruling being given by a Coroner	5	0	3	6	1	5	20
Objection accepted by a Coroner and no post mortem ordered	2	5	4	4	4	6	25
Objection over-ruled by a Coroner	3	0	0	0	2	1	6
TOTAL	10	5	7	10	7	12	51



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 128 objections of which 44 were withdrawn prior to a ruling being given by a Coroner and 80 were accepted by a Coroner and no post mortem examinations were ordered. In only 14 cases did a Coroner order that a post mortem examination should be conducted.

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

Counselling Service

The past twelve months in the Coronial Counselling Service has seen two different counsellors working alongside Kristine Trevaskis while the original counsellor, Simon Walker has been Acting Manager, Coroner's Court.

Tracey Gillet from the Family Court Counselling Service worked in the Coroner's Office from October to December 2004 and upon her departure Philip Riseborough joined the Coroner's Court and continues in the position to the present date. Philip was previously with Carers WA and SIDS and KIDS.

Since the Bali bombing the Counselling Service has continued to develop its role in working alongside Western Australia Police in Disaster Victim Identification (DVI). DVI is the term given to procedures used to positively identify deceased victims of a multiple fatality event. The recruitment, selection and training of a pool of 21 counsellors (from within the Department of Justice) for secondment for DVI work has been completed. A Policy and Procedures Manual for the service is in the process of being finalised.

Finally, the end of 2004 saw the resignation of Trish Mazzola as a Volunteer Court Companion to the Coroner's Court. Trish has given several years and hundreds of hours of her own time to supporting grieving families through the inquest process. Her dedication, commitment and care to scores of families has been highly valued and appreciated by those families and by the Coroner's Court.



REFERRALS - CORONIAL COUNSELLING SERVICE

1 July, 2004 - 30 June, 2005

TOTAL NEW CONTACTS

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

3,048

Information			
Objection	Coronial Procedure	Retention	File Viewing
216	1,845	162	96

Counselling		
Phone	Office	Home
907	169	119

Support	
Scene Mortuary	Court
24	41



Coronial Ethics Committee

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

Guideline 16 of the Guidelines for the Ethics Committee, issued pursuant to section 58 of the *Coroners Act 1996*, requires the State Coroner to provide a specific report on any recommendation of the Committee which has been rejected by the State Coroner. On no occasion did the State Coroner reject a recommendation of the Committee.

The Committee strives to keep informed of innovations in medical research from an ethical viewpoint. To assist in this aim the Committee has been registered with the NHMRC and receives regular correspondence from the Association.

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

The members of the Committee are as follows:

Associate Professor Jennet Harvey - *Chairperson*
Department of Pathology, UWA

Mrs Felicity Zempilas - *Secretary*
Lawyer, Coroner's Office

Ms Evelyn Vicker S.M.
Deputy State Coroner

Dr Gerard Cadden
Forensic Pathologist, PathCentre

Ms Jan Battley
Executive Director, Holyoake

Ms Pam McKenna
Director, Palmerston



Ms Martine Pitt

Executive Director, Communicare

Mr Clive Deverall

Lay Member

Mr Jim Fitzgerald

Lay member

Ms Heather Leaney

Lay member

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

Number of Projects Considered	Number of projects approved	Number of projects not approved
22	19	3

Counsel to Assist Coroners

During the year Mrs Felicity Zempilas was counsel assisting attached to the Coroner’s Court and in addition to performing duties in respect to inquests generally, Mrs Zempilas monitored investigations into deaths in custody to ensure that Recommendations 26, 27 and 28 of the Royal Commission into Aboriginal Deaths in Custody continued to be implemented.

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

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

Mrs Zempilas and Mr Mulligan have provided the Court with a very high level of professional assistance which is necessary for the conducting of complex and important inquest hearings and their assistance is clearly necessary in cases where issues arise relating to police involvement.



Inquests

During the year inquests were heard by the State Coroner, Mr Alastair Hope, the Deputy State Coroner, Ms Evelyn Vicker.

A total of 43 Inquests were heard during the year with a total number of 135 sitting days.

The State Coroner and Deputy State Coroner conducted a total of 7 inquests in country regions.

A chart follows detailing the inquests conducted during the year.

It should be noted that in the case of the almost 1,500 cases each year which are not inquested, each of these cases is investigated and in every case Findings are made by a Coroner and a Record of Investigation into Death document is completed detailing the results of the investigations which have been conducted.

In Perth the majority of these cases were finalised by the Deputy State Coroner while in the country regions they were finalised by the Regional Coroner.



INQUESTS FOR THE YEAR 1 JULY, 2004 - 30 JUNE, 2005

NAME	REGISTRY NUMBER	DATE OF DEATH	DATE OF INQUEST	NUMBER OF SITTING DAYS	CORONER	COURT SITTING	FINDING COMMENTS OR RECOMMEND	DATE OF FINDING
FURNISS	27/04	12/8/02	6-7/7/04 26/7/04	3	Deputy	Perth	Natural Causes	16/8/04
HERRICK	28/04	17/5/03	13-14/7/04	2	Deputy	Perth	Natural Causes	19/7/04
COMRIE	29/04	13/9/04	20-21/7/04	2	Carnarvon	Perth	Accident	15/10/04
PARSONS	30/04	2/11/03	20-22/7/04	3	Deputy	Busselton	Accident	23/7/04
JOHNSON	31/04	20/8/01	3-5/8/04	3	Deputy	Fremantle	Suicide	28/10/04
MAHONEY	32/04	13/6/03	17/8/04	1	Deputy	Perth	Suicide	9/04
MARTIN	33/04	On or about 24/12/1994	24-26/8/04 31/8-2/9/04 & 10/11/04	7	State	Carnarvon Perth	Unlawful Homicide	11/1/05
MORGAN	34/04	21/12/01	7/9/04	1	Deputy	Perth	Natural Causes	8/10/04
GAMBLE	35/04	5/5/03	10-16/9/04	5	State	Perth	Suicide	14/10/04
MORRISON	36/04	18/8/03	13-15/9/ & 5/10/04	4	Deputy	Perth	Accident	28/10/04
JENKINS	37/04	12/11/02	19/10/04	1	State	South Hedland	Accident	7/12/04
KELLY	38/04	3/4/00	20- 21/10/04	2	State	South Hedland	Accident	29/10/04
MORTENSEN	39/04	15/12/01	26- 28/10/04	3	Deputy	Perth	Accident	12/11/04
GARCES	40/04	4/8/73	4/11/04	1	State	Perth	Accident	4/11/04
STEEL	41/04	28/8/77	4/11/04	1	State	Perth	Open Finding	4/11/04
WARE	42/04	24/11/02	9/11/04	1	Deputy	Perth	Natural Causes	26/11/04



INQUESTS FOR THE YEAR 1 JULY, 2004 - 30 JUNE, 2005

NAME	REGISTRY NUMBER	DATE OF DEATH	DATE OF INQUEST	NUMBER OF SITTING DAYS	CORONER	COURT SITTING	FINDING COMMENTS OR RECOMMEND	DATE OF FINDING
ANSTEY & MUNGAR	43/04	3/10/03	15-19/11/04	5	State	Busselton	Open Finding	3/12/04
RAY	44/04	17/12/04	17/11/04	1	Deputy	Perth	Natural Causes	26/11/04
GROOTHEDE	45/04	31/1/03	30/11/04 62/12/04	3	Deputy	Fremantle	Suicide	14/1/05
DREW	46/04	14/9/03	6/12/04	1	State	Albany	Accident	10/12/04
WARD & MELIA	47/04	26/12/04	7-17/12/04 24/1/05-4/2/05	16	State	Albany	Accident	3/05
GARLETT	48/04	4/4/03	14-16/12/04	3	Deputy	Perth	Suicide	14/1/05
QUARTERMAINE	1/05	17/5/02	18-21/1/05	4	Deputy	Perth	Natural Causes	13/4/05
STEINBRENNER	2/05	27/2/04	21/1/05	1	Deputy	Perth	Suicide	4/2/05
CHAPMAN	3/05	4/4/04	11/2/05	1	Deputy	Perth	Natural Causes	1/3/05
SHARPE	4/05	19/4/04	11/2/2005	1	Deputy	Perth	Natural Causes	1/3/05
ANDERSON	5/05	1/3/01	15-17/2/05 9/3/05 12/4/05	5	State	Perth & Fremantle	Homicide	4/5/05
BERTONCINI	6/05	27/12/02	21-23/2/05	3	State	Perth	Natural Causes	3/3/05
TAYLOR	7/05	23/8/02	15-17/3/05	3	Deputy	Perth	Suicide	5/7/05
SPINKS	8/05	3/12/02	5-6/4/05	2	Deputy	Perth	Natural Causes	5/05



INQUESTS FOR THE YEAR 1 JULY, 2004 - 30 JUNE, 2005

NAME	REGISTRY NUMBER	DATE OF DEATH	DATE OF INQUEST	NUMBER OF SITTING DAYS	CORONER	COURT SITTING	FINDING COMMENTS OR RECOMMEND	DATE OF FINDING
PROTOOLIS & WARRINER	9/05	11/8/03 4/11/03	18-29/4/05 9-13/5/05 23-25/5/05 7-24/6/05 27/7/05	37	State	Perth	Accident	12/05
SWEET	10/05	30/5/02	16/4/05	1	Deputy	CLC	Accident	23/5/05
McKAY	11/05	23/1/03	2-5/5/05	4	Deputy	Perth	Natural Causes	5/05
KOCOVSKI	12/05	24/10/03	17-18/5/05	2	Deputy	Perth	Natural Causes	6/05
SPRY	13/05	19/2/99	23-27/5/05	5	Deputy	Perth	Adj sine die	
DEWHURST	14/05	27/5/03	3/6/05	1	Deputy	Perth	Suicide	30/6/05
SULLIVAN	15/05	20/6/04	3/6/05	1	Deputy	Perth	Natural Causes	30/6/05
HOBSON	16/05	26/1/02	3/6/05	1	Deputy	Perth	Suicide	30/6/05
TAUWHARE	17/05	10/2/02	9/6/05	1	Deputy	Perth	Accident	30/6/05
WEBSTER	18/05	23/11/02	9/6/05	1	Deputy	Perth	Accident	30/6/05
O'NEILL	19/05	6/12/02	9/6/05	1	Deputy	Perth	Natural Causes	30/6/05
DE WAAL	20/05	26/12/02	9/6/05	1	Deputy	Northam	Misadventure	25/8/05
BELLCHAMBERS	21/05	1/3/03	9/6/05	1	Deputy	Perth	Suicide	7/05
WARD	22/05	20/2/00	28/6/05		Deputy	Perth	Suicide	8/05

Mr Hope 12 Inquests 80 sitting days
Ms Vicker heard 31 Inquests 55 sitting days

Total Inquests heard 43
Number of Sitting Days 135
8 Prison Deaths In Custody Heard
7 Country deaths heard by Metropolitan Coroners



Inquests – Deaths in Custody

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

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

It is not proposed to summarise the findings in relation to each of these inquests in this report as the Record of Investigation into Death documents are publicly available and can be readily accessed on the Coroner’s Court website www.coronerscourt.wa.gov.au under the heading “Coroner’s Inquest Findings”.

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

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

In this context there were two relevant inquests held during the year where there was a concern that section 22(1)(b) might apply –

- Richard Stanley TAUWHARE
- Louis Bernard TAYLOR

Inquests – Deaths In Care – Department of Justice

During the year 8 inquests were conducted into the deaths of persons who died while in the custody of the Department of Justice.

It is not proposed to detail the findings in relation to each of these inquests in this report as in each case the Record of Investigation into the Death is publicly available on the website www.coronerscourt.wa.gov.au

These inquests were in relation to the following deaths –



1. Michael John HERRICK
2. Parata Peter JOHNSON
3. Charles Raymond GAMBLE
4. Marileen WARE
5. Jan Hendrik GROOTHEDE
6. Damien George GARLETT
7. Kevin Gregory QUARTERMAINE
8. Reginald Brian O'NEILL

The following chart details the position in respect of all deaths in care since January 1991 where the deceased was either in prison custody or there was police involvement (note : Only the more recent inquest findings are available at www.coronerscourt.wa.gov.au).



The following chart details the position in respect of all cases of deaths in care since January 1991 where the deceased was either in prison custody or there was police involvement.

Date of Death	Date of Inquest	Name of Deceased	Police/ Prison Custody	Place of Death	Medical Cause of Death	Finding
1/1/91	25/6/91 & 2/7/91	WALSH Justin Anthony	Prison	Fremantle Hospital	Hypoxic Encephalopathy following Hanging	Open Finding
25/1/91	1-3/7/91, 7/8/91, 5 & 12/9/91, 22/10/91	ISAACS Edward (a)	Prison	Fremantle Hospital	Coronary Atherosclerosis with recent Myocardial Infarction	Natural Causes
4/5/91	2/4/92	MODRIJAN Bogomir (a)	Prison	Fremantle Hospital	Cirrhosis of the Liver associated with Alcoholic Liver	Natural Causes
20/4/91	1/4/92	LORD Francis Robert James	Prison	Sir Charles Gairdner Hospital	Head Injury in association with Myocardial Infarction	Accident
27/6/91	7-8/4/92, 16/9/92	REYNOLDS James William	Prison	CW Campbell Remand Centre, Canning Vale	Plastic Bag Asphyxia	Suicide
9/1/91	21/6/94, 22/5- 3/7/95, 1/8/95, 4- 5/9/98	IRVIN Colin	Police	31 Royal Street	Gunshot Wound to the Head	Lawful Homicide
19/11/91	6/4/92	FOSTER Kerrin Jules	Prison	Fremantle Hospital	Chronic Obstructive Airways Disease	Natural Causes
27/12/91	29/9/92, 20/10/92, 23/11/92, 1/12/92	METCALF David Ernest	Prison	Casuarina Prison	Hanging	Accident
8/6/92	14-15/1/93	VINCENT Paul Maitland	Prison	Fremantle Hospital	Hypoxic Encephalopathy due to Neck Compression	Suicide
26/10/92	9-10/3/93	GIBSON Russell Dean	Prison	CW Campbell Remand Centre, Canning Vale	Hanging	Suicide
19/4/93	9/9/93	SUMMERS Kenneth Wesley	Prison	Casuarina Prison	Ligature Compression of Neck	Suicide
15/6/93	12/4/94, 25/5/94	HITCHCOCK Shane	Prison	Canning Vale Prison	Mechanical Asphyxia due to Hanging	Suicide
23/1/94	14-15/6/95 26-28/7/95	YORKSHIRE Douglas Shanyne	Prison	Canning Vale Prison	Acute Opiate Toxicity	Unlawful Homicide
25/1/94	18-19/9/95	RICHARDS Graham	Prison	Geraldton Regional Hospital	Acute Myocardial Infarction	Natural Causes



Date of Death	Date of Inquest	Name of Deceased	Police/ Prison Custody	Place of Death	Medical Cause of Death	Finding
21/7/94	28/10/97	OSMOND Kenneth	Prison	Casuarina Prison	Penetrating Injuries to the Neck	Unlawful Homicide (Riders)
5/9/94	21-23/6/95 29/8/95	BOYLE Darren	Prison	CW Campbell Remand Centre	Ligature Compression of Neck	Suicide
13/9/94	4-8/12/95, 11-15/12/95	NIXON Kim Peter (a)	Police	East Perth Lockup	Hypertensive Arteriosclerotic Heart Disease	Natural Causes
14/9/94	21-23/6/95 29/8/95	HILL Ronald	Prison	CW Campbell Remand Centre	Ligature Compression of Neck	Suicide
14/9/94	9/7/96	KENNEDY Ryan	Prison	Canning Vale Remand	Ligature Compression of Neck	Suicide
5/10/94	4-5/12/95 11-15/12/95	NICHOL William	Police	26 Cape Street Osborne Park	Asphyxia in Association with Amphetamine Effect	Misadventure
26/10/94	5-8/3/96, 11-15/3/96, 25-29/3/96, 17-28/6/98	GOULD Raymond	Police	Hay Street, East Perth	Gunshot Wounds to Chest	Justifiable Homicide
10/3/95	30/1/96	BEACH Ian	Prison	Fremantle Hospital	Bowel Instruction due to Intra Abdominal Spread of Carcinoma of Colon	Natural Causes
13/6/95	3/9/96	HAYES Martin	Prison	Casuarina Prison	Ligature Compression of the Neck	Suicide
5/7/95	29/11/95	EVANS Brian	Prison	Fremantle Hospital	Coronary Arteriosclerosis	Natural Causes
29/10/95	18-21/6/96 29-30/10/96	REYNOLDS Keith	Prison	Broome Prison	Acute Myocardial Infarction Coronary Arteriosclerosis	Natural Causes
4/11/95		JONES Colin	Police Chase			
7/12/95	22-24/6/98	YOUNG Pita	Prison		Natural Causes	Natural Causes
9/12/95	15-17/7/97	YAMBA Steven (a)	Police Chase	Regional Hospital Halls Creek	Multiple Injuries	Accident
12/1/96	6-9/8/96	JACKSON Carl	Prison	Casuarina Prison	Ligature Compression of the Neck	Suicide



Date of Death	Date of Inquest	Name of Deceased	Police/ Prison Custody	Place of Death	Medical Cause of Death	Finding
12/2/96		PUHARECH Matthew (a)	Police Chase			
7/4/96	5-12/5/97	McMAHON David	Prison	Casuarina Prison	Ligature Compression of the Neck	Suicide
24/4/96	28-29/5/97 5, 25, 27/6/97	INMAN Malcolm Arthur	Prison	CW Campbell Remand Centre	Ligature Compression of the Neck	Suicide
7/96	25-29/5/98	VIVAS Victorio	Prison	Wooroloo Prison	Ligature Compression of the Neck	Suicide
30/7/96	17-20/6/97	BANGMORO Alan Lawrence (a)	Prison	Broome Regional Prison	Ligature Compression of the Neck	Suicide
20/8/96	16-19/2/98	UGLE & INDICH (a)	Police Chase	Forrest Road Thornlie	Head & Spinal Injuries & Laceration of the Aorta	Open Finding (Riders)
27/9/96	8-9/7/97	WILLIAMS John Neil	Police	Carnarvon Police Lock Up	Ligature Compression of the Neck	Suicide
20/10/96	25-27/8/97	RAWLINGS Shaun	Prison	Casuarina Prison	Ligature Compression of the Neck	Suicide (Riders)
6/1/97	27-31/7/98	GOOCH Richard	Police TRG	RPH	Gunshot Wound to the head	Suicide
11/1/97	3-6/3/98	WOOD Anthony	Prison	Canning Vale	Eelectrocution	Suicide
11/1/97	20-21/4/98	CAMERON Peter (a)	Prison	Day-release - Balga	Coronary Arteriosclerosis	Natural Causes (Riders)
23/1/97	8-12/9/97 & 11/12/97	DOOREY Wesley	Prison	Casuarina Prison	Ligature Compression of the Neck	Suicide (Riders)
9/2/97	4-8/5/98	WINMAR Michael (a)	Police Chase	RPH	Head Injury	Accident
17/2/97	18-22/5/98	MASLIN John	Prison	Casuarina Prison	Acute Opiate (Heroin) Toxicity	Accident
8/3/97	3-7/5/99	SPENCER Craig	Prison	Casuarina Prison	Acute Opiate (Heroin) Toxicity	Accident (Comment)
6/4/97	8/6/98, 10-18/9/98, 5-6/10/98	CLARKE Noel	Prison	Casuarina Prison	Ligature Compression of the Neck (Hanging)	Suicide (Recommend)



Date of Death	Date of Inquest	Name of Deceased	Police/ Prison Custody	Place of Death	Medical Cause of Death	Finding
6/5/97	26-27/10/98	O'LEARY Michael Anthony	Police	Whilst being arrested	Spinal Injuries	Accident
4/6/97	13-16/9/99 (Carnarvon)	ROE Garath Jackson (a)	Prison	Carnarvon - Home detention	Ligature Compression of the Neck	Open Finding
6/8/97	1-5/2/99	OSBORNE Darren	Prison	Casuarina Prison	Ligature Compression of the Neck	Suicide
19/8/97	24-25/8/98 (Derby)	MOWALJARLI Benjamin (a)	Derby LockUp	Derby LockUp	Acute Alcohol Intoxication	Accident (Comment)
21/8/97	7-11/12/98 22/2/99	HAYES Shaun	Prison	Canning Vale	Plastic Bag Asphyxiation	Suicide (Recommendations)
1/10/97	6-10/9/99	SHAW Colin (a)	Prison	RPH	Pneumonia & Diabetes mellitus	Natural Causes (Comments)
14/11/97	8-9/3/99 & 19/3/99 (Geraldton)	LINDSAY Geoffrey	Prison	Greenough	Acute Myocardial Infarction & Coronary Arteriosclerosis with Thrombosis	Natural Causes (Recommendations)
24/11/97	12-16/7/99	DEGOIS Christopher	Prison	Casuarina	Ligature Compression of the Neck	Suicide (Recommendations)
15/12/97	12-16/4/99	PHILLIPS Raymond	Prison	Canning Vale Remand	Asthma in Association with Chronic Obstructive Airways Disease	Natural Causes
7/1/98	10-12/3/99 (Geraldton)	CAMERON Bevan (a)	Prison	Greenough Prison	Ligature Compression of the Neck	Open Finding (Recommendations)
9/1/98	20-24/9/99	MICHAELS Winnie (a)	ex Prison	Fremantle Hospital	Pneumonia & Hypoxic Encephalopathy following Cardiorespiratory Arrest due to Gangrenous Appendicitis	Natural Causes (Comments)
25/1/98	6-17/12/99	HOLT Neil	Prison	Canning Vale	Ligature Compression of the Neck (Hanging)	Open Finding (Recommendations)
3/2/98	15-18/11/99	JACKAMARRA John(a)	Prison	Greenough Prison	Ligature Compression of the Neck	Suicide
15/2/98	22-23/11/99 & 26/11/99	LE Huy	Prison	Canning Vale Remand	Ligature Compression of the Neck	Suicide
16/2/98	26-30/7/99	DAWSON Steven	Prison	Canning Vale Remand	Cyanide Toxicity	Suicide



Date of Death	Date of Inquest	Name of Deceased	Police/ Prison Custody	Place of Death	Medical Cause of Death	Finding
13/3/98	12-13/3/99	GREEN Tammy Lee (a)	Prison	Bandyup Womens Prison	Bronchial Asthma	Natural Causes
8/4/98	17-19/8/00	LEONE Alessandro	Prison	Casuarina Prison	Ligature Compression of the Neck	Suicide (Comments)
9/4/98	4-5/4/00	GROTH Kenneth John	Prison	Casuarina Prison	Ligature Compression of the Neck	Suicide
18/4/98	31/5,1-2/6/99 (Kalgoorlie)	SHEPHERD Frank William (a)	Police	Kalgoorlie Hospital	Undetermined	Natural Causes (Comments)
9/5/98	22-26/3/99	CHARMLEY John Andrew	Police	Verge Welshpool	Electrocution	Accident (Recommendations)
17/5/98	9-13/10/00	RYAN David John	Prison	Casuarina Prison	Ligature Compression of the Neck	Suicide
31/5/98	17-20/4/00	LAUDER Dean Kiernan	Prison	CanningVale	Ligature Compression of the Neck	Suicide Comments
15/7/98	11-14/4/00	McINTOSH Gregory Thomas	Prison	Albany Regional Prison	Ligature Compression of the Neck	Suicide Recommendations
8/10/98	14-18/8/00	HALLIGAN Phillip Edward	Prison	Casuarina Prison	Ligature Compression of the Neck	Suicide Comments
2/11/98	2-5/11/99	EADIE Wendy Anne (Remand Prisoner Bandyup)	Prison	Graylands Hospital	Ligature Compression of the Neck	Suicide Recommendations
8/11/98	5/9/00	McGINNIGLE Philip Mark	Police	Reid Highway BALGA	Head and Chest Injuries	Accident
5/12/98	15-19/11/99	MacARTHUR Bruce (Remand Prisoner)	Prison	Graylands Hospital	Ligature Compression of the Neck	Suicide
13/12/98	Finding Upon Enquiry	BES Maxine (Police arrest)	Police	RPH	Multiple Injuries	Suicide
3/3/99	4-8/10/99	ACKERMAN Norman Frank	Prison	Cottage Hospice via Wooroloo	Suffocal Carcanomia with widespread medistatic disease	Natural Causes
11/3/99	6/10/00	ROWLAND Dwayne	Prison	ShentonPark Hospice via Canning Vale	AIDS	Natural Causes
12/3/99	6-8/2/01	MALONE James Gerard	Prison	Canning Vale	Ligature Compression of the Neck	Suicide



Date of Death	Date of Inquest	Name of Deceased	Police/ Prison Custody	Place of Death	Medical Cause of Death	Finding
30/6/99	28-30/6/00	BRUMBY Stanley (a)	Police	Derby Lockup	Ligature Compression of the Neck	Suicide (Recommendations)
19/7/99	27-30/11/00	LAYFIELD Kenneth Ronald	Prison	Casuarina Prison	Suffocation – plastic bag	Suicide Comments
23/8/99	10-12/9/01	COYNE Wayne John (a)	Prison	Casuarina Prison	Ligature Compression of the Neck	Suicide (Recommendations)
2/9/99	24-26/6/02	RAPLEY Bradley William	Casuarin Prison	Fremantle Hospital	Suffocation – plastic bag	Suicide
14/9/99	11-15/12/00	GIBSON Willy	Police	Warburton Lockup	Ligature Compression of the Neck (Hanging)	Suicide (Recommendations)
2/11/99	3-4/7/01	FRY Reginal Cyril	CanningV ale Prison	Fremantle Hospital	Liver Failure consequent upon Hepatitis "C"	Natural Causes Comments
	23-27/10/00	WEBER Janek	Police	Port Hedland	Police Shooting	Self-defence Comments
27/11/99	19-20/6/01	WOODS Gerald Trevor	Prison	CW Campbell Remand Centre	Coronary Arterthrombosis superimposed on severe coronary arteriosclerosis	Natural Causes Recommendations
6/1/00	5-6/11/01	GARNER Adam Timothy	Prison	Canning Vale	Ligature Compression of the Neck (Hanging)	Suicide Recommendations
6/1/00	16-207/01 23-24/8/01 23/11/02	JOSEPH Phillip (a)	Prison	Roebourne Prison	Ligature Compression of the Neck (Hanging)	Suicide (Recommendations)
1/00	26-30/11/01	BROOKS Peter Anthony	Police	Como	Gun Shot Wound to Chest	Lawful Homicide
19/2/00	11-14/2/03	LOOHUYS Mark	Police Officer		Head Injury - Police pursuit	Accident
7/5/00	26-28/11/01	WESLEY Leslie	Prison	Casuarina	Ligature Compression of the Neck (Hanging)	Suicide
22/5/00	15-16/1/02	MATTHEWS Jason Paul	Prison	Casuarina	Coronary Artery Thrombosis in Association with Coronary Arteriosclerosis	Natural Causes
23/5/00	5-7/2/02	SAVORY Bradley	Prison	Albany Prison	Ligature Compression of the Neck (Hanging)	Suicide (Comments)



Date of Death	Date of Inquest	Name of Deceased	Police/ Prison Custody	Place of Death	Medical Cause of Death	Finding
26/5/00	3-4/4/02	LAWSON Kirk	Prison	Kalgoorlie Prison	Epilepsy in Association with Cerebral Cortical Dysplasia	Natural Causes (Comments)
4/6/00	11-13/3/02	DAVIDSON Scott	Prison	Casuarina	Ligature Compression of the Neck (Hanging)	Suicide (Recommendations)
7/6/00	22/1/02	RILEY Frederick Ronald Aka Frederick Steven Wilson	Prison	Casuarina	Ruptured Berry Aneurysm	Natural Causes (Comments)
16/6/00	8-10/4/02	OTERO Simon	Prison	Canning Vale	Ligature Compression of the Neck (Hanging)	Open Finding (Comments)
25/6/00	16/4/02	THERON Gerhardus	Prison	Canning Vale	Ligature Compression of the Neck (Hanging)	Suicide
1/7/00	6/11/01	FRAGOMENI Francesco	Prison	Casuarina/Murdoch Hospice	Prostrate Cancer	Natural Causes
5/12/00	29/4-2/5/02	CRAIG Alan McKenzie	Prison	Casuarina	Ligature Compression of the Neck (Hanging)	Suicide
8/12/00	16-18/4/02	MOORE Derek	Police	Pursuit	Multiple Injuries	Accident
8/12/00	DPP	MOORE Christopher Peter	Prison	Wooroloo Prison	Heroin	Subject to prosecution
9/12/00	1-3/4/03	UGLE Mark Amelo (a)	Police	East Perth Lock-up	Heart Attack	Natural Causes
28/12/00	6-7/8/02	AUSTIN Alan Edward	Prison	Casuarina	Natural Causes	Natural Causes
11/2/01	30/4/02-2/5/02	PRIDHAM Steven Anthony	Prison	Pardalup Prison Farm	Immersion	Accident (Comments)
13/3/01	18-20/2/03	SLATER Evan Charles	Prison	Hakea Prison	Ligature Compression of the Neck (Hanging)	Suicide
4/4/01	10/9/02	YAPPO Mervyn	Prison	Hakea Prison	Liver and Kidney Failure	Natural Causes
22/5/01	4/9/02	BECKETT Richard John	Prison	Karnet Prison	Ligature Compression of the Neck (Hanging)	Suicide
18/6/01	28-31/10/03	RILEY Tyron (a)	Prison	Bunbury Regional	Ligature Compression of the Neck (Hanging)	Suicide



Date of Death	Date of Inquest	Name of Deceased	Police/ Prison Custody	Place of Death	Medical Cause of Death	Finding
20/8/01	3-5/8/04	JOHNSON Parata Peter	Prison	Casuarina Prison	Ligature Compression of the Neck (Hanging)	Suicide
27/8/01	24-26/2/04	QUARTERMAIN Natasha Leanne (a)	Prison	Bandyup Women's Prison	Ligature Compression of the Neck (Hanging)	Suicide
19/9/01	10-11/6/03	HOLCROFT Gary John Williams	Prison	Casuarina	Ligature Compression of the Neck (Hanging)	Natural Causes
9/10/01	5-6/2/03	TANADI Pangky	Prison	Albany Prison	Ischaemic Heart Disease	Natural Causes
22/12/01	28/2/03	BOYLE James Hughes	Prison	Casuarina	Aspiration Pneumonia & Meningitis	Natural Causes
29/12/01	25-26/11/02	PALMER Yola	Police	Stabbing (self inflicted) in police presence		Suicide
10/2/02	9/6/2005	TAUWHARE Richard Stanley	Police	Arrested in police presence after being handcuffed Girrawheen	Gastro-intestinal Haemorrhage due to erosive gastritis in association with acute on chronic amphetamine toxicity	Accident
17/2/02	22-23/7/03	VAUGHAN Michael Roy	Prison	Hakea Prison,	Ischaemic Heart Disease & Coronary Arteriosclerosis with Thrombosis	Natural Causes
5/3/02	22/7/03	CAUST Ross Andrew	Police	Bushland	Ligature Compression of the Neck (Hanging)	Suicide
8/3/02	2-4/12/03	HATCHER Marie	Prison	Bandyup Women's Prison	Ligature Compression of the Neck (Hanging)	Open Finding (Recommendations)
18/3/02	28/2/03	CASSIDY Michael Patrick	Prison	Fremantle Hospital	Emphysema/Cancer	Natural Causes
9/5/02	6-7/8/03	WAYMAN Donald James	Prison	Casuarina Prison	Asphyxiation – Plastic Bag	Suicide
17/5/02	18-21/1/05	QUARTERMAINE Kevin Gregory (a)	Prison	Fremantle Hospital	Ischaemic Heart Disease and Severe Multifocal Coronary Atherosclerosis in a man with Diabetes Mellitus	Natural Causes
11/7/02	3-4/2/04	GREEN Dylan Robert (a)	Prison	Hakea Prison	Ligature Compression of the Neck (Hanging)	Suicide



Date of Death	Date of Inquest	Name of Deceased	Police/ Prison Custody	Place of Death	Medical Cause of Death	Finding
23/8/02	15-17/3/05	TAYLOR Louis Bernard (a)	Police		Stabbed himself in police presence	Suicide
3/9/02		WILLIAMS Thane Anthony	Police	Kalgoorlie	Conveyed home by police after scuffle in pub	
12/9/02	4/4/04	JUMBURRA Lionel Paul (a)	Police	Broome	Ligature Compression of the Neck (Hanging) after police conveyed him for loitering	Suicide
24/11/02	9/11/04	WARE Marileen	Home Detention	Perth	Consistent with cardiac failure secondary to atherosclerotic heart disease, systemic hypertension & diabetes mellitus	Natural Causes
12/12/02	4-5/5/04	FLOWERS Larence Brian	RPH	Hakea Prison	Pneumonia in association with lung abscess in a man with documented chronic alcohol misuse	Natural Causes
21/12/02	16-18/3/04	DODD Austin Edward	Prison	Casuarina Prison Infirmary	Natural Causes	Natural Causes
22/12/02	10-14/11/03	YAMERA Wesley Russell (a)	Police	Fitzroy Crossing	Head Injury	Accident (Recommendations)
31/1/03	30/11/04-2/12/04	GROOTHEDE Jan Hendrik	Prison	Hakea Prison	Ligature Compression of the Neck (Hanging)	Suicide
1/2/03	9/6/04	NEUMANN Raymond Murray	Karnet Prison Farm (Parole)	Bushland Glenn Forrest	Ligature Compression of the Neck (Hanging)	Suicide (Recommendations)
5/4/03	14-16/12/04	GARLETT Damien George (a)	Prison	Hakea Prison	Ligature Compression of the Neck (Hanging)	Suicide
6/4/03	26-28/6/06	WINGO Veronica (a)	Police Lockup	Geraldton Police Station		
6/5/03	13-16/9/04	GAMBLE Charles Raymond (a)	AIMS	Prison Van	Ligature Compression of the Neck (Hanging)	Suicide
17/5/03	13-14/7/04	HERRICK Michael John	Prison	Acacia Prison Sir Charles Gairdner Hospital	Severe Liver Failure	Natural Causes



Date of Death	Date of Inquest	Name of Deceased	Police/ Prison Custody	Place of Death	Medical Cause of Death	Finding
23/9/03	25-29/7/05 AND 20-21/9/05	SAMSON Peter Darryl (a) (aka) Leyley	Police Lockup	Derby Police Station	Pelvic Injury	Accident
26/11/03		POWER Edward Charles	Prison	Casuarina Prison	Heart problems	
28/11/03	8-12/5/06	HAMBRIDGE David Lee (a)	Prison	Eastern Goldfields Regional Prison	Ligature Compression of the Neck (Hanging)	
6/12/03	9/6/05	O'NEILL Reginald Brian	Prison	Karnet Prison Farm	Intra-abdominal haemorrhage associated with metastatic carcinoma of the oesophagus	Natural Causes
19/1/04		BURNS Cheryl Dale	Police	Pursuit by police in Geraldton		
26/2/04	5/7/05	BARICEVIC Steve	Police	Motor cycle pursuit Gnangara Road, Gnangara	Consistent with a head injury	Accident
6/3/04		CARROLL Rhett Daniel	Police	Motor cycle pursuit Hamilton Drive Eaton		
24/7/04		BARNARD Peter	Acacia Prison	RPH		
9/8/04		CRONIN Shaun Ryan	Police Pursuit	Boulonnais Drive Brigadoon		
2/9/04		DONALDSON Leon John	Prison	Casuarina Prison	Ligature Compression of the Neck (Hanging)	
10/9/04		BROWN Gerald Ian	Police	Safety Bay Overpass Bridge	Multiple Injuries	
14/9/04		MOURISH Jack (a)	Prison	Hakea Prison	Overdose Heroin	
17/10/04		WONGAWOL Phillip	Prison	RPH Acacia Prison	Natural Causes	
25/10/04		HIGGINS Rodney Scott	Prison	RPH Casuarina Prison	Natural Causes	
1/11/04		MARTIN Noel	Prison	Albany Regional Prison	Ligature Compression of the Neck (Hanging)	



Date of Death	Date of Inquest	Name of Deceased	Police/ Prison Custody	Place of Death	Medical Cause of Death	Finding
26/12/04		AXFORD Michael John	Prison	RPH	Aneurism	
22/2/05		MERRITT Joel Anthony James	Police	Kwinana Freeway SOUTH PERTH	Multiples Injuries (Police Chase)	
22/2/05		UNDABI Robert (a)	Police	Fitzroy Crossing	Natural Causes (Rear of police van)	
9/3/05		BOLTON Wayne	Police	Passenger in stolen vehicle	Police chase	
21/5/05		HICKS Lawrence	Prison	Nickol Bay Hospital Karratha	Cancer	
16/6/05		HOLLY Ian Henry	Police	Sir Charles Gairdiner Hospital	Shot gun to head in police presence	
10/7/05		WHEELLOCK Laurence Noel	Prison Parole	Carnarvon	Ligature Compression of the Neck (Hanging)	
3/9/05		HENDERSON Gordon James	Prison	Casuarina Prison	Natural causes	
8/9/05		GARTSIDE Andrew	Police Chase	Berrigan Drive Jandakot	Multiple Injuries (Police Chase)	
7/10/05		BIRNIE David John	Prison	Casuarina Prison	Ligature Compression of the Neck (Hanging)	
19/10/05		TRIMMER Billy	Prison	Wyndham Work Camp	Natural Causes	



Deaths Referred to the Coroners Court 1 July 2004 – 30 June 2005

A total of 2,251 deaths were referred to the coronial system during the year.

Of these deaths, in 809 cases death certificates were ultimately issued by doctors. In many cases there were initial problems experienced in locating a treating doctor or a treating doctor had initial reservations about signing a certificate which were ultimately resolved.

In the Perth area there were 1,049 Coroner's cases and in the country regions there were 393 Coroner's cases.

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

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



**Deaths referred to a Coroner for investigation for the
Metropolitan area**

1 July, 2004 - 30 June, 2005

Natural	548
Suicides	185
Accidents	158
Traffic	100
Homicide	11
Open	6
Misadventure	0
Inconclusive	41
No Jurisdiction	0
TOTAL	1,049

**Deaths referred to a Coroner for investigation for the
Country area**

1 July, 2004 - 30 June, 2005

Natural	173
Suicides	65
Accidents	37
Traffic	79
Homicide	13
Open	4
Inconclusive	19
TOTAL	393

