JOINT SELECT COMMITTEE ON END OF LIFE CHOICES

INQUIRY INTO THE NEED FOR LAWS IN WESTERN AUSTRALIA TO ALLOW CITIZENS TO MAKE INFORMED DECISIONS REGARDING THEIR OWN END OF LIFE CHOICES

TRANSCRIPT OF EVIDENCE
TAKEN AT PERTH
TUESDAY, 27 FEBRUARY 2018

SESSION ONE

Members

Ms A. Sanderson, MLA (Chair)
Hon Colin Holt, MLC (Deputy Chair)
Hon Robin Chapple, MLC
Hon Nick Goiran, MLC
Mr J.E. McGrath, MLA
Mr S.A. Millman, MLA
Hon Dr Sally Talbot, MLC
Mr R.R. Whitby, MLA

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Hearing commenced at 8.59 am

Mr CHRIS DAWSON
Commissioner of Police, Western Australia Police Force, examined:

Miss AMANDA FORRESTER, SC
Director of Public Prosecutions, Office of the Director of Public Prosecutions, examined:

The CHAIR: Good morning. Welcome to the hearings for the end-of-life choices inquiry. This morning we have Ms Forrester, SC, Director of Public Prosecutions, and Commissioner Dawson. Thank you very much for joining us this morning. On behalf of the committee, I would like to thank you for agreeing to appear today to provide evidence in relation to the end-of-life choices inquiry. My name is Amber-Jade Sanderson. I am the chair of the joint select committee. I will introduce members of the committee. Joining us shortly will be Simon Millman—that is the empty chair there. We have Hon Dr Sally Talbot; John McGrath; Dr Jeannine Purdy, our principal research officer; Hon Col Holt; Hon Nick Goiran; Reece Whitby; and Hon Robin Chapple. The purpose of today's hearing is to discuss the current arrangements for end-of-life choices in Western Australia to highlight any gaps that may exist. It is important that you understand that any deliberate misleading of this committee may be regarded as a contempt of Parliament. Your evidence is protected by parliamentary privilege. However, this privilege does not apply to anything you might say outside of today's proceedings. I advise that the proceedings of this hearing will be broadcast live within Parliament House and via the internet.

Do you have any questions about your appearance here today?

The WITNESSES: No.

The CHAIR: Before we begin with our questions, do either of you wish to make a brief opening statement?

The WITNESSES: No.

The CHAIR: We will go straight to the questions. I understand that we have provided some of the questions for you. This is a question directed to the commissioner. I am going to ask you about some reportable deaths. For the purposes of the transcript, I will go through each one, and if you could just respond as to whether you would consider that any of these deaths would fall within the definition of "reportable death" under the Coroners Act, with a simple yes or no, or feel free to elaborate if you wish. The first would be a death potentially resulting from a refusal of life-sustaining medical treatment, including artificial nutrition or hydration, by a competent adult or alternatively their substitute decision-maker. Would you consider this a reportable death?"

Mr DAWSON: Yes, I would.

The CHAIR: You would. How would this come to the attention of police?

Mr DAWSON: Ordinarily, whenever a person's death is deemed to be either unnatural or suspicious or of the order that is outlined within section 3 of the Coroners Act, irrespective of the manner in which the person's life may have ended, if it falls within that broad definition—and I note that in the question that is put forward to me about, for instance, a refusal of life for a person who may voluntarily starve or something of that order, my view is that even though the refusal may be voluntary and the deceased may or may not have given consent, the way the law is constructed

under section 3 of the Coroners Act, my view is that, one, it is reportable and, two, the police would need to conduct suitable investigations to assist the State Coroner in any examination.

The CHAIR: Would you rely on a doctor necessarily to report that death, or family?

Mr DAWSON: Ordinarily it can come from either manner, from either a hospital and/or a medical practitioner if the person has been treated outside the hospital environment, and/or a family member.

The CHAIR: Thank you. The next is a death potentially resulting from voluntary palliated starvation when a competent individual chooses to stop eating and drinking and receives palliative care to address pain, suffering and symptoms that may be experienced by individuals as he or she approaches death.

Mr DAWSON: Once again, I think that police would have a duty to investigate such matters on behalf of the coroner and certainly any matters that might turn on elements of suspicion. Clearly, we have a duty. The Criminal Code obviously has a number of provisions in that sort of matter. Ordinarily, in very difficult matters, consistent with the DPP's guidelines, we at times do take time to consider that in conjunction with the Director of Public Prosecutions. These matters are often quite complicated and we do take professional advice from both medicos and indeed Public Prosecutions.

The CHAIR: Would a reportable death be a death associated with the doctrine of double effect where the administration of medication is intended to relieve pain but may hasten death?

Mr DAWSON: Yes, I guess it would.

The CHAIR: Would a reportable death potentially be associated with a medical practitioner's assessment that the administration of medical treatment would be futile and, therefore, not required in order to provide the necessities of life in accordance with section 262 of the Criminal Code?

Mr DAWSON: Once again, yes.

The CHAIR: Would a reportable death potentially be associated with terminal or palliated sedation—the use of pharmacological agents to reduce consciousness, reserved for treatment of intolerable and refractory symptoms—where artificial nutrition and hydration are withdrawn?

Mr DAWSON: Yes.

The CHAIR: Again, how would these be brought to the attention of the police? Do you depend on the family and the health professionals?

Mr DAWSON: Yes, either the next of kin, or associates, or in the case of a person in a hospital or another such facility, often the authorities will bring it to our attention. That is the ordinary way in which these matters are brought to our attention.

The CHAIR: If it is correct that deaths associated with the doctrine of double effect and/or terminal sedation are not routinely or if ever reported to the coroner or police, can you explain why such deaths would not be considered deaths occurring under anaesthetic?

Mr DAWSON: Under anaesthetic itself, again, we at times do get reports from hospitals where a person has died while under surgical procedure, but the difficulty in me providing you with a response is that each of these circumstances must be taken individually. The fact that anaesthetic might have been administered will not necessarily invoke a report. So, we have to assess each matter on the attendant circumstances.

The CHAIR: Just stepping back a bit, you have indicated that all of those deaths would be reportable deaths and would fall under the obligations associated with reportable death. Can you advise how many have been investigated over the last five years?

Mr DAWSON: I do not have those particulars with me today. I could attempt to ask my coronial and homicide divisions to provide that information, but I do not presently have that with me.

The CHAIR: Could we put that on notice?

Mr DAWSON: Yes, you could.

The CHAIR: We will write to you with details of that; thank you.

Mr DAWSON: Sure.

The CHAIR: One of the cases included in the NCIS report, which is the national coronial report, is classified as an "intentional non-administration of medical care". Can you elaborate on how this case came to be brought to the attention of the coroner and whether there was any role of the police?

Mr DAWSON: I am not familiar with that particular matter. Is this question 6, the supplementary?

The CHAIR: Yes.

Mr DAWSON: Look, that actual incident was incorrectly coded, as I am informed, by an employee at the State Coroner's office and was recorded in the National Coronial Information System. The death resulted, as has been reported to me, from the deceased purposely not taking his insulin with the intention of dying. Case 316/13 is referred to here. The State Coroner's office has advised that the death has now been accurately recorded.

The CHAIR: If a doctor deliberately injected a terminally-ill patient with medication intending to hasten their death but completed the death certificate indicating that the cause of death was the illness, how would this potentially unlawful killing come to the attention of the police?

Mr DAWSON: Once again, as I have answered previously, it could come in a number of ways—by being reported directly from family or next of kin and/or from the medical authorities or institution.

Hon Dr SALLY TALBOT: I wonder whether I could just ask you to tease out the phrase that the chair has used in all those questions, which is "the obligations associated with a reportable death". Can you help us understand what those obligations are and on whom they fall?

Mr DAWSON: The state Coroners Act provides expressly the principal head of power for the State Coroner to ensure that all such deaths are investigated. Police are described as officers who assist the court in its process, and it ordinarily falls to Western Australia police to assist the State Coroner in her or his deliberations. In that sense we act are not always entirely under the office of constable—the traditions of powers of police independently investigating. We do not lose that hat, but we have quite a specific duty to assist the coroner in the investigation of such matters and we ordinarily provide them a coronial file, as we call it, to the State Coroner, particularly when there is no charge under the Criminal Code. Those such matters are then put to the DPP and they will be considered for indictment or not and then go to trial. If in the police investigation we do not consider there is a matter substantive enough for a criminal charge, then we prepare a coronial report and it goes to the State Coroner for consideration. In regional Western Australia the magistrates carry out those duties on behalf of the State Coroner.

Hon Dr SALLY TALBOT: With the obligations as far as the police go, are there any obligations accruing to any other parties? So, if you are a medical practitioner, nursing staff, is there any obligation to report? Do they come under the obligation associated with a reportable death?

[9.10 am]

Mr DAWSON: Unless the Coroners Act expressly provides that for a medical practitioner—I think there are other duties that medical practitioners are under, but I am unaware of any express provision within the Coroners Act itself that requires a medical practitioner to do so under state law. There are certainly obligations under the Criminal Code for them to provide them with the necessities of life, as to a report of a person's death, as I understand, the main head of powers under the Coroners Act, but I am presently, as I am sitting before you, unaware of any express provision for doctors.

Hon Dr SALLY TALBOT: You cannot give us numbers associated with any of those five categories. Is there any case that you could give us, using the benefit of your experience, when a death has been reported in one of those criteria where the police have had to take action because it has been reported?

Mr DAWSON: Yes, numerous times.

Hon Dr SALLY TALBOT: Can you talk us through how the unfolds in practice?

Mr DAWSON: In practice, for instance, if a hospital reports a death, often it is generated because there is no medical certificate issued by a doctor, the medical certificate certifying life extinct. If that is not provided, the State Coroner will require the police to conduct an investigation. If that is undetermined, that invokes the actions of police in assisting the coroner, mostly as the coroner's investigators. That is the process when that occurs. That happens on a regular basis. At times when a person dies under medical care, it may take a medical practitioner of a number of days before they provide a medical certificate. In that case, while the matter still remains on foot as a reportable matter, the coroner will obviously take note of any medical certificates provided certifying the cause of death.

Hon Dr SALLY TALBOT: So, that would automatically trigger your interest if a death certificate is not issued within a certain number of hours after death?

Mr DAWSON: Not necessarily within hours. I mean, it is not uncommon for it to take several days. But, look, I guess, in the manner in which a person's life has ended we ordinarily will receive a number of reports. If a person is in a hospital, I would not necessarily see that police attendance and the commencement of an investigation is accelerated beyond that if they passed away outside of medical care. Although they are both reportable, it is fair for me to say that if a person was to die at home or outside of the dwelling, in an open area for instance, that would invoke a response by police investigating the matter somewhat differently than if they were under medical care.

Mr J.E. McGRATH: Further to that question, if a person died and as a result of that the family member complained or lodged a complaint that the doctor might have given an extra dose to speed up the death and they were not happy about that, where would that complaint go and how would that be handled?

Mr DAWSON: That would ordinarily go to the police, but they may also simultaneously complain to a coroner. Whenever a person dies suddenly, we provide not only attendance, but a brochure explaining to the next of kin or their friends and associates the processes that flow from a person's unnatural death. In that situation the next of kin or the immediate carers are provided with some additional information to assist them in understanding the role of both the State Coroner and the police officers.

Hon NICK GOIRAN: Commissioner, are there circumstances in which police are obligated to report to the coroner?

Mr DAWSON: Yes, there are.

Hon NICK GOIRAN: Can you describe the circumstances?

Mr DAWSON: When there are suspicious deaths that come to our attention, we will ordinarily report that to the State Coroner. We may, for instance, receive a complaint or police may, in fact, find that person deceased and then we have an obligation to report that to the coroner. That routinely occurs.

Hon NICK GOIRAN: Is that an obligation to police that is found under the Coroners Act or under a different piece of legislation?

Mr DAWSON: Under the Coroners Act.

Hon NICK GOIRAN: Is that obligations specific to WA police or to other agencies?

Mr DAWSON: Look, I would have to again take that on notice. I do not have the act in front of me, but certainly the obligation rests with police.

Hon NICK GOIRAN: Are you aware whether there are any circumstances in which the coroner is obligated to refer matters to the police?

Mr DAWSON: The coroner routinely does that. As to the express obligation of requiring it, the way the Coroners Act is constructed, as I outlined earlier, the police officers basically wear two hats. We do our independent investigation as to our office of constable and common law–type powers, but under the circumstances of a death described under section 3 as a reportable death, we also wear a separate hat as a coroner's investigator. We have just got to straddle both of those legal constructs.

Hon NICK GOIRAN: Sure, I understood you so earlier that in effect from time to time police act as investigators for the coroner.

Mr DAWSON: Yes.

Hon NICK GOIRAN: I am just interested to know whether the coroner has any mandatory requirement from time to time to report matters to you in the same way that you have a mandatory requirement to report matters?

Mr DAWSON: I am unaware of a direct provision. There may be one, but I am personally not familiar with that. But by convention and practice the State Coroner does routinely ask police to conduct further investigations on a matter that they might want further particulars on.

Mr R.R. WHITBY: Commissioner, in your response to those scenarios of deaths from (a) through to (e) you said that they have all been reportable deaths for police investigation. Is it fair to say that those types of deaths routinely happen quite often in Western Australia and are not reported and therefore not investigated?

Mr DAWSON: The situation for me is that it is probably going to be an anecdotal type of response as opposed to one with specificity, because certainly for geriatrics in care, suffering dementia, for instance, it is not uncommon. I saw that with my own parents before they died, with dementia taking hold and they are in the care of a hospital or an approved facility. But I still take the view that under section 3 they should be reportable deaths to ensure that, for instance, under those circumstances of refusal of sustaining of life, for example wanting to refuse food and starving in the later stages of life, we would have an obligation to ensure that any such refusal was voluntary and the person had the capacity to make a decision. They are two elements that in my view still fall within the category of a reportable death under section 3 of the Coroners Act.

Mr R.R. WHITBY: But do you concede that the obligation is on the next of kin or the doctor involved to report that, and if they do not, they are never investigated?

Mr DAWSON: We will not necessarily know the individual circumstances for each particular case, that is correct.

Mr R.R. WHITBY: Would you concede that if there was a change of law that allowed voluntary assisted dying and there was no report to police by the next of kin or the medical professional involved that again those deaths would occur without investigation?

Mr DAWSON: If it were the case that authorities in charge of people did not report that, then ordinarily it would not be the case that my officers would be scanning institutions for all such deaths.

Hon ROBIN CHAPPLE: You said on a regular basis you are looking at these issues. I think we are going to get a response from you through the Chair in relation to the number of cases you look at. We just heard from my colleague next to me that you do not necessarily know all the cases. Any idea what percentage you are looking at in this regard, in terms of matters that are referred to you? Obviously, there are a large number of deaths in Western Australia each year from a range of issues. Other than by somebody coming in and dobbing somebody in or raising questions, you do not get to see any of the overview of any of the other deaths?

[9.20 am]

Mr DAWSON: There is a national coronial information system. All Australian jurisdictions contribute to a national information system. It does express within those statistical gatherings the nature of some of the deaths that are statistically recorded, but I think that has some limitations. Again, because of my response to some of the earlier questions by the committee, as to whether a matter comes to our attention will be somewhat dependent on whether the hospitals, for instance, are reporting those.

Hon ROBIN CHAPPLE: Do you ever get deaths reported to you under the provision of what we call "do not resuscitate"?

Mr DAWSON: I do not have an express response to you in terms of that. My response earlier outlined that if a medical certificate is provided establishing the cause of death, that will drive whether in fact the matter falls within a reportable matter for the State Coroner. All such deaths have to be reported to the coroner. The coroner is made aware of every single death, but as to whether that triggers an investigation by police would be another matter.

Hon ROBIN CHAPPLE: I am not sure whether you would have the information, but I wonder if you could identify as a question on notice whether any matters have been referred to you which arose from a do not resuscitate recommendation.

Mr DAWSON: I would have to take that on notice because I do not have the information with me.

The CHAIR: In relation to death certificates, are you confident that the adequacy and accuracy of death certification in Western Australia is currently managed appropriately?

Mr DAWSON: It is outlined for the State Coroner under section 8. Again, we follow the provisions of the Coroners Act as to those particular functions, so that really is a matter the state coroner is probably in a better position to answer than I am.

The CHAIR: I am going to ask you a few questions about suicides following an irreversible deterioration. During the Victorian parliamentary inquiry the Victorian coroner provided a submission which highlighted a number of suicides in the face of significant illness. Do you have a sense of whether these suicides occur regularly in Western Australia?

Mr DAWSON: The information I have from the national coronial information system is that over a six-year period between 1 January 2012 and 5 November 2017 there were reported some 240 deaths in Western Australia to the State Coroner, where the deceased has died as a result of an act of intentional self-harm and has been diagnosed with a terminal debilitating physical condition prior to death.

The CHAIR: As part of his evidence, Acting Commander Rob Wilson of Victoria Police described the effect of these violent deaths on first responders. Do you think there is any particular impact on police who deal with these cases?

Mr DAWSON: Yes, there is. Police officers suffer the same emotions and these are often very upsetting matters for all parties concerned. We take steps both from initial recruit training, through to those officers who are regularly attending such deaths from our coronial, homicide and the like squads. They may attend these as a far more frequent matter. We have appointed a clinical psychologist to assist police officers to ensure their wellbeing—particularly their psychological care—is being properly cared for. Yes, my answer is that it does have an effect on police officers.

Hon ROBIN CHAPPLE: Those deaths that are reported to you, is there a percentage of those which are actively reported—that is, the wife or the husband of somebody who has suicided—as opposed to an investigation which occurs later? Do you have any information as to roughly how many you might get who are people who are seemingly knowing a death has occurred and reported it immediately, rather than going through the normal process and reporting it to the medical profession?

Mr DAWSON: I do not have that information. I doubt whether that could be easily extracted. The circumstances by which police attend death by way of suicide is very broad—from searches for missing persons that might take several years before a deceased may be located to a most recent violent death. I have personally attended both of those scenarios and there is a very, very wide range of matters from persons maybe being present in a house when a suicide takes place, to those where persons take their lives when they are by themselves. So I do not think I would be able to easily extract that sort of response.

Hon NICK GOIRAN: When a suicide takes place, commissioner, would it ordinarily be the case in Western Australia that it would be the police who are first notified about that and it is then police who report it to the coroner?

Mr DAWSON: Ordinarily, police are advised in the first iteration. At times, first responders from St John Ambulance or other or a local doctor in fact may be notified. But my experience tells me that ordinarily police are usually the first responder to such matters.

Hon NICK GOIRAN: Say, for instance, an ambulance officer might report the matter directly to the coroner and not to WA police?

Mr DAWSON: We have a strong relationship with St John Ambulance. Our joint communication protocols are such that St John Ambulance will ordinarily advise us if there is a death and police would co-respond.

Hon NICK GOIRAN: Would it be common for them to report to both you and the coroner?

Mr DAWSON: Yes, that would occur. Ordinarily, because police do these inquiries on behalf of the coroner it is a general protocol that St John Ambulance would advise police if there is a sudden death of this nature. Police would be advised and we would attend.

Hon NICK GOIRAN: Once the matter has been reported to the coroner, either directly by the ambulance officer or by your office, is it then a matter for the coroner as to whether an investigation takes place or can WA police investigate regardless?

Mr DAWSON: We can investigate regardless if there are attendant suspicious circumstances which go beyond. For instance, if a person dies by way of a gunshot we would ordinarily investigate that matter to assure ourselves, and indeed on behalf of the coroner, that that death was either self-administered or was administered by some other person, so we will be attending to look for any suspicious circumstances. In both of those scenarios, the State Coroner would be immediately advised. Police may inform the State Coroner that there are circumstances which we consider are suspicious that we would then investigate as a suspected homicide. If that is the case, that can at times be a protracted investigation or it may be one that, depending on circumstances, we can more quickly come to a view and a person may be charged. But in both instances, the police would always advise the State Coroner.

[9.30 am]

Hon NICK GOIRAN: So once you have started an investigation either of your own motion or because the coroner has asked you to do that—this is in circumstances of suicide; I think the chair was asking about suicides following an irreversible deterioration—is it common commonly the case that police, as part of that investigation, will do an assessment on the deceased's medical diagnosis?

Mr DAWSON: Yes, we take, obviously, medical reports from particularly those that occur in hospitals. Our coronial investigation section is the area that ordinarily will do that. We have collocated our homicide squad and our coronial investigation under the command of the same area—so we have experienced homicide investigators through to detective superintendent and commander level—to ensure that all such matters are investigated, whether they are overtly suspicious in the first iteration or not, and that there is sufficient investigative experience to ensure that because the death occurred in a hospital setting, it would not necessarily automatically invite police to say, "Look, there is nothing suspicious here." We have a duty to investigate all such matters.

Hon NICK GOIRAN: Sure. I am just interested to know as to whether the investigation would drill down to the level of WA Police doing an assessment to ascertain if the person had been diagnosed with cancer, for example.

Mr DAWSON: We will be heavily reliant on the hospital authorities and the family medical practitioners in providing us with sufficient information, but as to whether the administration of, for instance, a medicine was of a prescribed amount and the condition of the person and what medicine may be administered, we are very heavily reliant, obviously, on medical practitioners because of the actual science of it. I think it is unreasonable to expect a police officer to have the medical scientific capability to determine whether, in fact, that is the right amount of not. So, we will obviously have to take that into account based on the medical reports provided to us.

Hon NICK GOIRAN: Yes, okay. But in terms of gathering the facts of the case, you would do that?

Mr DAWSON: Yes.

Hon NICK GOIRAN: So would one of the facts of the case be: did the person have a cancer diagnosis or not?

Mr DAWSON: They would ordinarily be provided by way of a medical report. The post-mortems that are conducted do require pathology to take samples. That occurs in all these instances and so the pathology report is very heavily relied upon, as indeed samples and toxicology reports and suchlike. These at times do take, in fact, months before you come to a more complete report.

Hon NICK GOIRAN: So you do find out whether the person has, for example, had a diagnosis of cancer. Do you then drill down to a further level to determine whether there was any delay in the diagnosis for that individual which may have contributed to their suicide?

Mr DAWSON: No. Look, I am unaware of the determination on both diagnosis and prognosis. They are matters that are generally provided for by way of the doctor's report. But we again have to rely very heavily on the pathology reports and the toxicology.

Mr J.E. McGRATH: Given the statistics that we have been provided, have you had to put more people into that section to deal with the support you are providing to the coroner and the support you are required to provide? Is that section of the police department under stress from time to time?

Mr DAWSON: Look, it is. We obviously have to investigate a lot of reportable deaths. We certainly have put a lot of effort into training. I think it is very important that we have placed both the coronial investigative section together with our homicide division so that we have a shared level of competency and capability there. Having them separated I think invites different responses. So we have intentionally physically collocated and put them under the governance of experienced investigators so that they are not easily sort of attributable as, well, that is a matter that is a coroner's file, versus that is a matter that should get the attention of homicide investigators.

The CHAIR: Just moving on, a number of studies and surveys have identified significant numbers of doctors who have admitted to intentionally hastening their patients' deaths. How often does this kind of conduct by medical practitioners come to the attention of your office?

Mr DAWSON: Rarely. We do at times get reports. We have had reports provided to us. One such matter that I have been briefed on was an allegation of a medical practitioner having administered a lethal injection. That investigation failed to identify sufficient evidence to substantiate the criminal charge. At the conclusion of that police investigation, which was in August 2016, we did refer the matter to the Health Practitioner Regulation Agency and provided information from that investigation.

The CHAIR: Given the high numbers of doctors identified in those studies, does it concern you that these are not being reported?

Mr DAWSON: Well, again I am unable to really quantify numbers of reports because we again are quite reliant on both the hospitals and the medical practitioners providing those.

Hon NICK GOIRAN: Commissioner, you mentioned that in that case there was insufficient evidence to sustain a charge, but then you referred it to the health practitioners body. What was the purpose of referring it to them?

Mr DAWSON: I do not have the particulars of that particular case in front of me, but if there are matters that turn on circumstances administratively, it may well be that—I do not want to speculate on this particular matter, but I would be surprised if it was a matter that was simply referred unless there was some particular regulatory area that our officers and investigators felt needed to be brought to the attention of a regulatory authority.

Hon NICK GOIRAN: They are looking at it from a disciplinary point of view and you are looking at it from a criminal law perspective?

Mr DAWSON: We are looking at it from both the coronial element to ensure the coroner is fully informed and/or whether if there is any criminality attached to it.

Hon NICK GOIRAN: Is there a difference in the standard of proof between what you require to conclude your investigation as compared to a disciplinary body?

Mr DAWSON: Ordinarily, disciplinary bodies do not go beyond the balance of a criminal responsibility threshold to that which is applied under a regulatory authority. I do not know about this particular one, what their threshold is, but I doubt it is on the threshold of criminal responsibility beyond reasonable doubt.

Hon ROBIN CHAPPLE: Just sort of touching on this and going back a little bit, what I think we are trying to find out is how many deaths or suicides are investigated, numerically. What I would like to know is how many of those have led to decisions to consider prosecution, not actual—so you have a death that has occurred for which your suspicions are raised. I would like to know in how many of those the suspicion is raised, as opposed to actually then going ahead and proceeding with a prosecution, because obviously you would have had a number come before you and you went, "No, we've looked at it. We've had suspicions but we cannot deal with it." Can you provide us with some stats around that?

Mr DAWSON: The number I gave you earlier was some 240 deaths over a six-year period. That is by way of intentional self-harm where they have been diagnosed with a terminal debilitating physical condition prior to death. That is not the totality of reported suicides. But in terms of suspicious deaths that we regard as homicides, they are roughly in the order of about 50 per annum. Over the last 25 years, the number of suspicious deaths which we consider are homicides, ordinarily, I would say, for well in excess of 95 per cent, criminal charges are preferred. It is quite uncommon these days to have a suspicious death which we regard as a homicide which does not result in a charge. There are some from time to time, but they would—again I am giving a rough answer to you. Ordinarily, two to five deaths per annum, I would state, would be unresolved homicides.

Hon ROBIN CHAPPLE: I think the problem we have most probably got is determining what is a homicide versus what is an assisted suicide or what is a suicide. I am trying to see if there is any way we can entice any figures out of you around those issues.

[9.40 am]

Mr DAWSON: I do not have sufficient particulars here to provide you with that because while I have outlined the 240 deaths over that six-year period, that is where the act of intentional self-harm is accompanied by a diagnosis of a debilitating illness or disease. That is somewhat different in my response to what we consider may be a homicide, because obviously if it is a suicide and it is investigated as a suicide, we do not consider that there is another party involved. It is not uncommon—I have attended these personally—where I have located a suicide note by a person who has expressed their intent to take their life because of their condition. That is not going to ordinarily invite us to record that as a homicide, so there I think we are talking about two different investigative streams. They both require investigation, but we will not adopt a homicide investigation per se because it is overtly reported or on all the circumstances it appears to be a self-inflicted death. It does not mean, though, that we simply close the file because there is a suicide note. It would be wrong for you to assume—perhaps it is the way I am responding to you—we have to give each of these matters full investigation and ultimately prepare a report to the coroner.

The CHAIR: For Ms Forrester and Commissioner Dawson, I want to move to offences under the Criminal Code. Can you indicate whether any of the following practices are lawful under the Criminal Code; and, if so, as a result of which provisions. I will go through each, one by one. The first is deaths associated with the doctrine of double effect, where medication is administered with the intention of relieving pain but must hasten death.

Hon NICK GOIRAN: "May".

The CHAIR: "May hasten death". Thank you.

Miss FORRESTER: Can I say in relation to all of these that the question is whether they are unlawful, not whether they are lawful, because the onus of proof is, of course, on the prosecution. A person is not criminally responsible for administering medical treatment in good faith, and that includes palliative care. So immediately we receive a death in any of these five categories, but I will limit myself to (a) at the moment, we would have to establish that the person medically treating them in those circumstances had acted otherwise than in good faith and with proper skill. That is the first issue. This particular question is very specifically worded and, under the law, if you are just intending to relieve pain, by necessity you are not intending to kill the person. So that is an issue. If you are medically treating them in good faith, then you are not criminally responsible for the death and so there is no unlawful death and there is no unlawful intention there. Under the way the question is phrased I would say no, but in all of these cases the trouble is working out the facts. It is all well and good for allegations to be made, and part of the problem is that there is only one person left, usually, to tell what happened, and that is the person who is under investigation. That is a real problem for us. That is why things like plans prepared by a patient, their own particular consent as to how their medical treatment goes and matters of that nature are so critical in assisting, I would have thought, WA police, but certainly us, in determining whether we would proceed any further or not.

Hon Dr SALLY TALBOT: Just a quick point of clarification: in answering no to all five, you have amended the question so that it says, "whether the following practices are unlawful" —

Miss FORRESTER: No, I am saying it should be. That should be the question because that is how the criminal law works—whether something is unlawful, not whether it is lawful. But it does not make much difference to the answer; under (a) —sorry; I see now what your point is. My apologies. The answer is, on the way that the question is framed I would say that is lawful.

Hon Dr SALLY TALBOT: So the answer is yes if it is unamended, and no if it is amended to unlawful.

Miss FORRESTER: Sorry, it is yes to the question as framed. My apologies.

Hon NICK GOIRAN: It is not unlawful.

Miss FORRESTER: Yes.

The CHAIR: So it is lawful.

Miss FORRESTER: They mean different things, sadly.

Hon NICK GOIRAN: Yes. Ms Forrester, you said something quite interesting there—that there is only one person left and they are the one usually under investigation.

Miss FORRESTER: If you have a situation where you have a doctor administering this treatment and the patient who says, "I want you to administer this treatment", it depends on whether that is recorded and how it is recorded, but at the end of the day it is one person's say-so and that is the person administering the treatment. The patient, of course, is deceased.

Hon NICK GOIRAN: Sure.

Miss FORRESTER: That is a problem we routinely encounter in these situations. The one person who says, "Well, that person wanted to die", is the person who is alleged to have killed them.

Hon NICK GOIRAN: What capacity is there for you to compel that person to give evidence?

Miss FORRESTER: Zero. The coroner has different capacities, but they could not be used in a criminal setting, obviously.

Hon ROBIN CHAPPLE: You just used the words "routinely encounter". Is this a very common occurrence?

Miss FORRESTER: In any homicide there is usually only two people who are participants in it, and you have to —

Hon ROBIN CHAPPLE: Yes, but we are actually dealing with the doctrine of double effect.

Miss FORRESTER: True, and there will be medical notes in some circumstances or things of that nature, or there might be nurses that assist. But my point was that subject to the facts being as I stated there, then it would be lawful.

Hon ROBIN CHAPPLE: No, the point I was actually trying to get to was that you were saying "routinely", so this is a very common occurrence?

Miss FORRESTER: No, these would not generally be referred to my office. We have not seen cases like this.

Hon ROBIN CHAPPLE: When it actually comes again to my pet subject, which is "do not resuscitate", do you deal with those?

Miss FORRESTER: No. I have not seen much of those, and I would not expect to.

Hon ROBIN CHAPPLE: So when it actually comes to a decision to not resuscitate, up until the time we actually started having living wills, that was usually written on the treatment sheet by a doctor. That doctor is doing it in a lot of cases without the knowledge of the patient. I am surprised that you have never seen one.

Miss FORRESTER: That is all I can say. I have been in my office now for 20 years and I have never heard of one.

Hon ROBIN CHAPPLE: Just as an overview, if a person were to establish that a patient was not to be resuscitated, would you consider that an issue that you would need to look at?

Miss FORRESTER: We need to go back a step, first of all, but failure to resuscitate a person is not necessarily a homicide. A failure to resuscitate them does not —

Hon ROBIN CHAPPLE: They are making a deliberative act, though.

Miss FORRESTER: No, you are not. You are making an omission.

The CHAIR: It is withholding medical treatment.

Miss FORRESTER: Yes, but you have, first of all, section 259, so whether that is even reported in some instances—it does not come to me until after the police have investigated it and found sufficient evidence upon which to consider a prosecution at the least. If a matter came to me and there was a do not resuscitate issue, I would want to see all that documentation, but, as I say, it has never come to me because—I would be surprised in those circumstances if we were looking at a homicide.

Hon COLIN HOLT: So it would be complaint-driven, wouldn't it, either reporting to police or the DPP?

Miss FORRESTER: We do not investigate, so it would only come to us through WA Police. If someone complained to me, I would say, "You should go to the coroner or WA Police", and we would not even record that complaint.

Hon COLIN HOLT: So it would be complaint-driven, really, from a source that says actually, "They should have resuscitated", or, "I was expecting them to, and they didn't."

Mr DAWSON: The facts are that there are many people in palliative care every day, so police have to then investigate any such death that is reported; you are correct. We do not routinely investigate

every single death in a hospital, but if there is a complaint generated that death has been hastened or caused by another person, we will investigate it.

[9.50 am]

The CHAIR: I want to move to discretion for Miss Forrester and the commissioner in relation to investigating and prosecuting. The committee received a submission from former New South Wales DPP Nicholas Cowdery that outlines the discretion available to New South Wales officers. Does WA have a similar limited discretion in relation to charges laid and prosecutions respectively?

Mr DAWSON: In the circumstances that have been outlined by Mr Cowdery, on the face of that in the scenario that has been put here—if a husband has suffocated his wife with a pillow—we would ordinarily investigate that matter with a view of whether it is or is not regarded as a murder under section 279 of the Criminal Code.

The CHAIR: Can you comment on whether there is any reason that the DPP, in liaison with WA police, could or should not issue a policy here similar to that in the UK which provides prosecutorial guidelines on assisted suicide?

Miss FORRESTER: I think that would be, with respect, a terrible idea. The UK is, as is pointed out in the question itself, of some distinction in this regard because of the particular framework under which they operate. The courts in the UK under the European framework have actually decided that there is some room for judicial review of the DPP's decisions, which is not the case here. There is no room for judicial review of my decisions at the end of the day. That is not particularly the reason why I say that a guideline should not be issued, but the DPP is an independent prosecuting agency. Parliament sets the laws; Parliament represents the people and sets the law. The DPP's job is to administer those laws, not to decide when it feels like doing it and when it does not, even if it does that under guidelines. We have guidelines which apply to all our prosecutions and they say that if there are reasonable prospects of conviction on the criminal charge and it is in the public interest to do so, then we prosecute. It would be very difficult for me to say that it is not in the public interest to prosecute something which remains on the statute book as a criminal offence. I do not really see how the two can operate together, particularly in the case of an unlawful death. Life being sacrosanct under our Criminal Code suggests that you should apply the law until Parliament says that the law should change.

Hon NICK GOIRAN: Maybe slightly going off topic here, I would just be interested to know is that a consistent view from the office of the DPP or is that the view of Amanda Forrester, Senior Counsel, as DPP?

Miss FORRESTER: I am the DPP and that is therefore the view of my office.

Hon NICK GOIRAN: Let me rephrase it. Because you have been there for 20 years, has that been the consistent position of the DPP during your 20-year tenure?

Miss FORRESTER: It has certainly been the consistently proclaimed view. There is still a remaining discretion and what people say is in the public interest; for example, if you consider whether to charge someone with murder or manslaughter because the evidence is a bit each way, some people might say, "I don't have any reasonable prospects of conviction on this because of the way the evidence is and the way that the jury will react to it, so I'm going to prosecute it for a manslaughter", but we would never discontinue it. If it is an unlawful death, it will be prosecuted as an unlawful death. That is the difference. One is about not prosecuting at all and one is about prosecuting and letting the justice system exercise its discretion in terms of merciful sentencing. Even murderers can get non-custodial sentences. They are still branded a murderer.

Hon NICK GOIRAN: There was one recently.

Miss FORRESTER: Yes, and there are more.

The CHAIR: I think you have probably answered this question, but Professors Ben White and Jocelyn Downie reviewed the UK policy and have suggested that a form of euthanasia and assisted dying could be introduced through the issue of DPP guidelines. Have you any view on which approach has more merit?

Miss FORRESTER: Which approach has more merit—as in legislative?

The CHAIR: Or if this approach has merit?

Miss FORRESTER: I think the whole framework of having a Parliament that sets the laws and a DPP that administers them is completely contrary to a prospect that I should set a guideline as to when I choose to prosecute what is proclaimed to be an unlawful death. I do not see that being appropriate.

The CHAIR: In relation to voluntary assisted dying for both the commissioner and Miss Forrester, do you agree with the coroner that should voluntary assisted dying be introduced, any ensuing death would become a reportable death?

Mr DAWSON: In my view, yes.

Miss FORRESTER: It does not have a great deal of relevance to me, but yes.

The CHAIR: Given that in the case of a VAD, if legalised in Western Australia, the identity of the deceased, how death occurred, the cause of death and the particulars needed to register a death would presumably be fairly apparent, would you nonetheless agree with the coroner that a full investigation is warranted in each of the voluntary assisted dying, including a post-mortem?

Mr DAWSON: Yes. Post-mortem examination would be critical in the investigation, and clearly the purpose of the police investigation would be to negate any suspicious conduct or any criminality associated with the death.

The CHAIR: They are all my questions.

Miss FORRESTER: Madam Chair, there was a matter raised earlier about omitting to provide medical treatment or "do not resuscitate". The omission has to cause the death. In order for a person to be liable for killing another person, which is the only way under which you become liable to the criminal provisions of the code, you have to cause their death directly or indirectly. If you just fail to resuscitate someone, you are not necessarily causing their death. That is the first issue. The second problem is that you would have to be failing to provide the necessaries of life and you would have to grossly breach that duty to even be considered to be liable under the Criminal Code, and even then you have got the protection of section 259. A civilian who does not resuscitate a person who has a heart attack in the street would never be considered liable in those circumstances because they do not have charge of the patient. It would primarily arise in a doctor's setting.

Hon ROBIN CHAPPLE: What I am trying to drill down to there is the actual writing of the words "do not resuscitate". Somebody is making a decision, with or without the patient's knowledge, that they have determined that this person should no longer live if they go into a coma. That is my issue. Does the person who writes "do not resuscitate" need to provide a reason to the coroner or to yourselves that they have made that decision?

Miss FORRESTER: Not to me, but the forensic pathologist does obtain all the medical records, particularly the most recent medical reports. So if somebody has been hospitalised and then they die and they have a post-mortem, the pathologist will get all those medical records and they will go through them and they will make those sorts of assessments of the medical records. If it came to us in the long run, I would certainly want to know how that came about.

Hon ROBIN CHAPPLE: I am going to hypothesise again if I may. We have a patient who is in a very poorly state. They are being administered significant doses of medication to control pain and alleviate suffering and at the bottom of the bed they have got "do not resuscitate". The addition of this extra medication leads them to stop breathing. I am trying to work out at what point that "do not resuscitate" becomes party to the extra medication that has been provided, and is it a deliberative act?

Miss FORRESTER: This probably highlights how it is each individual case, but when you say "becomes party to", do you mean that they might be potentially criminally liable as a result of having that "do not resuscitate"?

Hon ROBIN CHAPPLE: Yes.

Miss FORRESTER: You are also saying that someone has deliberately administered medication which has resulted in the patient stopping breathing.

[10.00 am]

Hon ROBIN CHAPPLE: Not necessarily deliberately. They —

Miss FORRESTER: They have deliberately administered medication. But they —

Hon ROBIN CHAPPLE: There is that fine line between deliberate and a dose that is suitable to alleviate the person's suffering.

Miss FORRESTER: I am sorry; I have not made myself clear. They have deliberately administered the medication. The effect is not deliberate, is what you are saying.

Hon ROBIN CHAPPLE: Yes, but there's this note on the bottom of the bed that should the person get into that comatose state or whatever, they will not be resuscitated.

Miss FORRESTER: Well, the person who wrote "do not resuscitate" before that drug was administered would have had to know that the drug was then going to be administered and intend that the person die as a result of it before they could become criminally responsible for the "do not resuscitate" order, because that intervening act —

Hon ROBIN CHAPPLE: But quite often that patient has a DNR on the bottom of their bed the whole time they are in that situation.

Miss FORRESTER: But you cannot be liable—that is what I mean. You have to cause the death; you have to have some involvement in the cause of the death and if you put in a "do not resuscitate" and then someone else causes the death, you cannot be a party to that unless you —

Hon ROBIN CHAPPLE: But if it was the same person.

Miss FORRESTER: Yes, well then you would be the person liable by reason of the administration of the drug not the "do not resuscitate". Other people then who do not act to resuscitate would be pulled into it. I understand what you are saying but that is the doctrine of double effect—the administration of the medication. There are so many defences and failures of the Criminal Code to pick up that conduct that you do not get to how the person who put the DNR on there is liable because the death is not unlawful in the first place. So you have to have —

Hon ROBIN CHAPPLE: I really appreciate the explanation.

Miss FORRESTER: No, it is a difficult one. The way the Criminal Code works is someone has to cause the death. The death has to be unlawful. Then there has to be an intention and in order to prove a death to be unlawful, you have to not be in breach of section 259 or section 262 and they are very significant protections for doctors. That is why I have never seen any of these cases because I would expect that if I got them, we would not proceed. I suspect that the police see that.

Hon ROBIN CHAPPLE: That is useful, thank you.

Hon COLIN HOLT: We have been talking a little bit about discretionary powers and police portray discretionary powers all the time and you have also said that you believe the doctrine of double effect when a death occurs should be a reportable death. If one of those comes to the police and an investigation happens, at some point in time, you must make a discretion about whether to report it to the DPP or the coroner—I assume the DPP for prosecution. Do you have any idea how often that occurs where you get a reportable death from the doctrine of double effect that does not go much further than that?

Mr DAWSON: I do not have the statistics but I would say it would be rare.

Hon COLIN HOLT: It would be rare, so if a death that occurs by the doctrine of double effect comes to the police and they investigate it, most often would it go further to the DPP?

Mr DAWSON: No.

Hon COLIN HOLT: No, would it not make it that far?

Mr DAWSON: No, it would not make it that far. The numbers of hospital reported deaths under medical care—obviously, that is where most people die; in hospital and increasingly, in recent years, more in their homes under medical care. But in both those circumstances, they will be reportable, they will be subject of an investigation, and they ordinarily will be subject of a pathology report. At times, if the doctor has provided a medical certificate, as I outlined earlier—there may not be—the coroner has the power to conduct his or her investigation including whether a post-mortem is taken. That ordinarily does occur. We are very informed by that, obviously, in terms of whether any suspicion is attached to that death.

Miss FORRESTER: They would not be reported to us. What the police would do is gather an investigative brief and send it to us. My experience is, particularly with homicides, if the investigators are not certain as to the way that they should exercise that discretion, they will refer it to us for advice.

Hon ROBIN CHAPPLE: Following on from what Hon Colin Holt has just asked, we have heard previously that medication is administered based on the weight, the frailty of the person and their whole demeanour, so there seems to be quite a variation in what levels of medication can be applied. That must make it quite difficult for you in determining what is a dose of double effect and because the levels of medication can be widely varying to create that situation. Have you come across that issue?

Mr DAWSON: Matters do get reported from time to time, ordinarily by grieving relatives or carers. We must and do investigate any matters that are reported to us to be suspicious. So, at times, family ordinarily may report that the medicine has not administered properly, but again, as my colleague here has outlined, there are very strict provisions under the Criminal Code under those two particular provisions that do provide a backdrop—backdrop is probably too flippant a term, but they are very important provisions which we must take into consideration before we would further a matter to the DPP by way of a brief. We do not ordinarily consult the DPP unless our investigation reaches a point where we are seriously considering whether or not to prefer a charge of murder or manslaughter. Ordinarily, the DPP would not receive any such files. They would go straight to the coroner.

Hon ROBIN CHAPPLE: Would your investigation in that area be looking for medical advice —

Mr DAWSON: Yes.

Hon ROBIN CHAPPLE: — as to the weight of the person, their disposition, whether the dose that was there was over and above what was necessary? How do you define that?

Mr DAWSON: We are very much guided by the pathology reports and the toxicology reports. We cannot be expected to have that medical expertise, and nor do I contend that we should. In that case, we are very heavily reliant on the medical reports. But, of course that is incumbent upon the pathologist to actually make an assessment.

Hon ROBIN CHAPPLE: And that must be fairly subjective anyway.

Mr DAWSON: Well, it is again a matter for the pathologist to determine whether in fact that is a reasonable application of medical procedures.

Miss FORRESTER: That is why that question at the start so important, whether it is lawful or whether it is not unlawful, because we have to prove it beyond reasonable doubt. If a pathologist cannot say, then there is no prospect that we are going to be able to say to the standard required to charge someone with a serious criminal offence and there is no prospect that a jury would decide that that person was guilty on the basis of "I'm not sure." Of course, there is not just the measurements, weight and things of that nature; some people deal with medication better than others and there are so many imponderables in that. You are looking for a medical report that says, "This patient was definitely killed by that dose", to get there.

The CHAIR: Thank you for your evidence before the committee today. A transcript of this hearing will be forwarded to you for correction of minor errors. Any such corrections must be made and the transcript returned within 10 working days from the date of the email attached to the transcript. If the transcript is not returned within this period it will be deemed to be correct. New material cannot be added via these corrections and the sense of your evidence cannot be altered. If you wish to provide additional information or elaborate on your evidence, please provide this in an email for consideration by the committee when you return your corrected transcript. The committee will write to you with questions taken on notice during the hearing. Thank you very much, both of you, for your time this morning.

Hearing concluded at 10.08 am

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