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
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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

Ms ROSALINDA FOGLIANI
State Coroner of Western Australia, Coroner's Court of Western Australia, examined:

Mr GARY COOPER
Principal Registrar, Coroner's Court of Western Australia, examined:

The DEPUTY CHAIR: Welcome. Thank you for agreeing to come and give evidence to the committee. I will introduce ourselves. My name is Colin Holt; I am the Deputy Chair of the committee. Our Chair, Amber-Jade Sanderson, has just relayed her apologies; she will be here very shortly. To introduce the committee, I start with Mr Simon Millman; Hon Dr Sally Talbot; Mr John McGrath; our chief research officer; myself; Hon Nick Goiran, who will be here very shortly; Mr Reece Whitby; and Hon Robin Chapple.

The purpose of today's hearing is to discuss the current arrangements for end-of-life choices in WA and 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 that you might say outside of today's hearing. I advise that the proceedings of the hearings will be broadcast live within Parliament House and via the internet.

Do you have any questions about your attendance here today?

The WITNESSES: No.

The DEPUTY CHAIR: Before we begin with our questions, would you like to make a brief opening statement?

Ms FOGLIANI: No, thank you.

The DEPUTY CHAIR: Let us start with the question of voluntary assisted dying. Thank you for your very detailed and helpful submission outlining suggested requirements for your office if voluntary assisted dying is legislated. In your submission you recommend that a full investigation, including post-mortem, is warranted in each case of voluntary assisted dying. Why do you make this recommendation?

Ms FOGLIANI: I think the first starting point is to explain what is meant by post-mortem examination. Sometimes it is assumed to mean dissection or an autopsy, but a post-mortem examination is actually broader than that. It begins when the forensic pathologist conducts an external examination of the deceased's body, examines that with nothing further, and that may be all that is needed. The post-mortem examination starts from there and then continues to a point that is reasonably necessary in order to investigate the death. The forensic pathologist will look at a range of factors and then essentially tissue samples may be taken. It may not be necessary to proceed to a dissection because that may depend on what other evidence is available; for example, there may be quite good medical records. There may be CT scans or images that can be taken into account, in which case a recommendation will be made that an external examination is sufficient for that information, and that will go to the coroner or the principal registrar with delegated functions, and may be the end of the post-mortem examination. If it is necessary, it will proceed to a dissection in order to investigate the death, if it is reasonably necessary, and may proceed to the taking of certain samples and the retention of some organs.

That is the broad picture, first of all. In terms of why post-mortem examination is needed, if it is a reportable death, the coroner needs to make a finding on cause of death and how the death occurred. A post-mortem examination will be something that the coroner will want. The extent will simply be dictated by the circumstances.

To turn to your question, it is not a given that in a case of voluntary dying there would need to be an autopsy. There are bound to be medical records, for example, that are likely to establish the fact that there was a terminal illness. There will be toxicology available through the sampling process that will essentially reflect on the administration of any medication to end life. From that perspective, yes, there is a post-mortem examination, but it is done on a case-by-case basis. I cannot really say any more than that. I cannot say you will never have a dissection. I cannot say that it is likely that you would either.

Hon ROBIN CHAPPLE: Could you define what is a reportable death?

Ms FOGLIANI: A reportable death is in the Coroners Act, under section 3. It is an unnatural death or a death that occurs by reason of injury, directly or indirectly. It is basically defined in the Coroners Act.

Hon ROBIN CHAPPLE: I ask a hypothetical. If it was defined in the legislation—if legislation were to come about that it was not to be considered a reportable death—would it then preclude, as obviously the circumstances might vary from time to time, where you need to call it in, but if legislation were to be introduced and it defined the end of life as not being a reportable death, what would happen then?

Ms FOGLIANI: Then it would not come within the jurisdiction of the coroner by reason of the administration of the medication to end life. But if there was another aspect that brings it into the Coroners Act, it would be there.

Hon ROBIN CHAPPLE: I am not suggesting that would be the case. I am just trying to drill down into the legalities around that.

Mr J.E. McGRATH: Mine was along the same lines of reportable deaths. Could there be a circumstance possibly in which someone died as a result of voluntary assisted dying but there was some other factor in the death? Even if the legislation said that voluntary assisted dying did not come under reportable death, there could still be a factor in there that would mean that the coroner would need to do a post-mortem.

Ms FOGLIANI: Correct.

Mr J.E. McGRATH: What would that circumstance possibly be?

Ms FOGLIANI: I suppose in some ways, it is best to show by way of example. I can imagine an example in which it came to the coroner's notice that a family member had expressed a concern, for example, about the process. We might look into it. Essentially, when you look at these definitions of "reportable death", I would then have to match it up with whatever legislation excludes it. There is an example that I have here from Victoria. Essentially, we would want to look at whether there was a concern about the administration of the medication, for example. We would want to look at whether there was a concern about how voluntary it was, for example. Those sorts of things may actually then mean that it would fall within the ambit of the coroner's jurisdiction.

Mr R.R. WHITBY: Coroner, obviously there is always a concern amongst loved ones about the thought of a post-mortem, especially one that involves dissection. In the case of voluntary assisted dying, the patient would obviously be in a very advanced stage of a terminal illness. If they have taken advantage of a voluntary assisted dying situation, the cause of death to most people would

be pretty plain and obvious. Can you give us any indication of your thoughts on how often in this situation you might be required to proceed to a post-mortem that includes dissection? Would that be rare? Have you looked at examples of other jurisdictions that have this law and what happens in terms of post-mortems and dissections there?

Ms FOGLIANI: To answer your second question first, no, I have not looked at other jurisdictions. In relation to the conduct of a post-mortem examination, it is very hard and one does not like to give undertakings or anything like that but if the medical records are satisfactory, essentially, you are leaning towards not having to do a dissection. You are doing the dissection if there is a concern. If you have a medical record that is showing essentially the terminal nature of the illness—it matches up with the toxicology and everything that is known, the medication charts and so forth—you have to ask yourself: why does it need to proceed to a dissection? What is the dissection going to generate for the coroner that the coroner does not already have? Logic would suggest that you do not need to, other than in an exceptional or an unusual case in which you have concern. I do want to stress that they are on a case-by-case basis. Logic would suggest that if the medical records are there, you do not need to.

[9.10 am]

Mr R.R. WHITBY: Are you suggesting it would be an exceptional or rare occasion, although you cannot prejudge any specific case?

Ms FOGLIANI: I cannot judge it. I would not put it as exceptional or rare, but I would say it is unusual. It is not the usual procedure because, essentially, what one tries to do is use the least invasive method that is appropriate in the circumstances. You always have that as a guiding principle and then move from there.

Hon NICK GOIRAN: To the witnesses, my apologies that I was a few minutes late for this morning's hearing.

Coroner, you mentioned that when a death is reported to you, that you then need to identify the cause of death and how the death occurred.

Ms FOGLIANI: If possible.

Hon NICK GOIRAN: Is part of that process done in order to identify if there has been any mischief?

Ms FOGLIANI: Yes.

Hon NICK GOIRAN: When you undertake that investigation, are you able to assess whether the deceased had capacity prior to their death?

Ms FOGLIANI: That is part of the reason why you want them to be reported as a reportable death because, essentially, that would be an important consideration. You need to understand capacity. I have not seen any draft legislation, but voluntariness would be a very important component, so, yes, of course. That may involve looking at the medical records. If there is then a concern about voluntariness, that may involve evidence from clinicians and that may involve evidence from family members as well.

Hon NICK GOIRAN: Coroner, do not be concerned that you have not seen the draft legislation, nor have I. In terms of your investigation, you indicate that trying to determine capacity prior to death is an important factor.

Ms FOGLIANI: Yes.

Hon NICK GOIRAN: Would your investigation in the same way then also look at issues like whether the patient had been under duress or undue influence?

Ms FOGLIANI: That is all part of what you look at, essentially. On the assumption that the legislation will embed—it would have to—that it needs to be voluntary, a person has to have capacity and all those sorts of things; they all become factors that the coroner looks at to be satisfied that the legislation was complied with. You start looking and, if you have a concern, you keep looking.

Hon NICK GOIRAN: Very good. Would you also then be looking at whether the patient might have been misdiagnosed?

Ms FOGLIANI: One would have to look at that. One would have to look at, essentially, the diagnosis and then if there was a concern about misdiagnosis. I suppose in a coronial investigation, you proceed and you keep going until you are satisfied. You do not necessarily say, "This is where I want to end up." You start and you keep going to the point that you are satisfied.

Hon NICK GOIRAN: In some circumstances you might do all this investigation and find that there has been some breach, some mischief—there might not have been capacity, there might have been undue influence, there might have been a misdiagnosis—all spectacularly unhelpful for the person who is now deceased. You then make some recommendations, I presume, as a result of that investigation. Do those recommendations lead towards systemic changes?

Ms FOGLIANI: There are a number of components to that question. Depending on what the coroner finds, under section 27(5) of the Coroners Act, the coroner might report it to the police or the coroner might report it to the DPP. First of all, you may consider that. It is a discretion but that would depend on the facts. That would depend on what the coroner thought had happened. Bear in mind that the coronial process comes, normally, at the end of all of the other legal processes. If somebody was charged with an offence—we are talking about that type of situation where something has gone wrong and maybe there was not voluntariness or there was not consent, for example—under section 53, the coroner will have to wait for the conclusion of any of those proceedings before the coroner conducts an inquest, if the coroner determines that an inquest is desirable after, say, other legal proceedings, like a prosecution. Through that process, if the coroner thinks it appropriate, yes, recommendations can be made. There are quite a few steps before that, so, essentially, I think I would start by looking at section 27 and see whether it is appropriate to invoke that to begin with and then take it from there.

Hon NICK GOIRAN: When you say that it depends what the coroner thought, is there a standard of proof that is required for the coroner before making any findings?

Ms FOGLIANI: The coroner operates on the Briginshaw standard. There is a scale, essentially, that you apply. In relation to section 27(5), which is a report to the DPP or the Commissioner of Police, that really is if the coroner believes it to have happened. It is actually not as high a test, because the coroner is not making a determination that a criminal offence has happened; you have formed a belief and also it is a discretion.

Hon NICK GOIRAN: The coroner could believe that there has been some mischief but, ultimately, the evidence —

Ms FOGLIANI: It could turn out to be wrong.

Hon NICK GOIRAN: Or the evidence that is required for the prosecution is of a higher standard and unable to be sustained.

Ms FOGLIANI: Exactly right.

Hon ROBIN CHAPPLE: Just on section 27: could I ask what is defined as a simple offence?

Ms FOGLIANI: Yes, all right. That will be defined, basically, in the legislation; "simple" is not a layman's term essentially. So, "simple" are the less serious ones, basically. You are conducting them

or prosecuting them in, say, the Magistrates Court, by way of example, whereas an indictable offence is on indictment and it is in the District Court or the Supreme Court.

Hon Dr SALLY TALBOT: Under the definitional clause, we have the conditions relating to reportable deaths—paragraph (i). Do you recall that? That is where there has not been a death certificate issued.

Ms FOGLIANI: Yes.

Hon Dr SALLY TALBOT: This came up in a hearing earlier this week with some health providers. Could you just explain to us what would fall under that provision?

Ms FOGLIANI: The way I read that is that that is a catch-all provision. Essentially, if it does not fall into any of the others but the doctor just is not comfortable to issue a certificate, there may well be good reason for the coroner to have a look at it.

Hon Dr SALLY TALBOT: In your experience, is that used by doctors to ensure the intervention of the coroner? You said it is where the doctor is not comfortable or where the doctor is not at ease.

Ms FOGLIANI: I would not say doctors use it to ensure; I would say that a doctor is simply telling the coroner, "Look, I can't issue a death certificate here", not necessarily, I suppose, to give it to the coroner, but in the knowledge that when he or she says that, obviously, yes, the coroner will have to look at it.

Hon Dr SALLY TALBOT: How does that intersect with the provision—my colleague here has just shown me section 44 of the Births, Deaths and Marriages Registration Act, which does look as though the doctor has to decide that the death is reportable to the coroner rather than simply not issuing a death certificate and having an automatic referral.

[9.20 am]

Ms FOGLIANI: Yes. Essentially, I think one follows the other. If the doctor does not issue the death certificate, the doctor knows and the doctor is in discussion and these discussions are had sometimes with the Principal Registrar so I have asked him also to give you his views. Clearly, it is going to end up with the coroner. As to whether the doctor is saying—maybe I have misunderstood—I will not issue a death certificate in order for it to go to the coroner, which is a separate one, I am not in his or her mind. All I can say is that one follows the other.

Mr COOPER: There are a number of reasons under (i) why a doctor cannot or will not issue a death certificate. As you can appreciate, it is a very onerous responsibility and quite often doctors are unclear on why their patients died or they have not seen them for quite some time. We regularly meet circumstances where the regular doctor is on holiday and the practice partner is not confident in issuing a death certificate. As the State Coroner said, it is a catch-all because we cannot have a situation where we have a deceased person in this state where we cannot administer dealing with that body. It either comes to the coroner or it can be dealt with out in the community by issuing a death certificate. If you have not got a death certificate, it stands to reason and commonsense we have got to refer to the coroner to establish why that person died.

Hon Dr SALLY TALBOT: How many referrals to you under that definition "died" would you have in a year?

Mr COOPER: Best guess, they are quite frequent.

Hon Dr SALLY TALBOT: In the circumstances you have just described.

Mr COOPER: Yes, absolutely; they can occur on a daily basis. We have regular discussions with doctors and doctors' practices when there is a bit of a problem with the issuance of a death certificate.

Hon Dr SALLY TALBOT: My colleagues might want to follow-up. I have one more question about capacity, although I am happy to leave it till later if we are going to do a section on capacity. I think it was in response to a question asked of you by Hon Nick Goiran. You talked about assessing the capacity of the person who has died to maybe have made certain determinations—refused treatment, for example. In many of the cases, obviously, that we are considering in the context of voluntary assisted dying, the person who had died would clearly not have had capacity at the time they died. Could you elaborate a little more on that concept of capacity, the time at which you need to be assured or to reassure yourselves that the person did have capacity when they made a certain decision?

Ms FOGLIANI: Yes, all right. I predicate it by saying, first of all, having not seen the legislation, I do not know what the legislation will require of me if it comes into being. But, essentially, it is at the time the person makes the decision that they wish to end their life by this method and being fully informed of the consequences, and obviously I imagine logic would dictate that all of this is recorded in writing with witnesses. That is what the coroner would be looking at, together with the entire, I suppose, matrix of evidence so that you are satisfied that there was not duress. Essentially, that is where you are headed to be sure that the person had capacity and was able to make decisions properly informed.

Hon Dr SALLY TALBOT: That is very clear, thank you.

Mr J.E. McGRATH: Further to what you said about how the coroner would like these deaths under voluntary assisted dying to come under the category of reportable deaths, I am thinking of family members. Not all families stay together. Sometimes there might be a family member living Perth and their siblings are all around Australia and one of them finds out that this family member has died and is not happy with the circumstance under which they died. Where would they go to make a complaint about it? Would they go to the medical board? What pathway would a family member have who was not involved, who hears about the death and is concerned because even though they have drifted apart, they are still a sibling? Where would they go?

Ms FOGLIANI: I might have to qualify my answer to this. Essentially, I can comment most effectively from the coronial perspective. They can essentially go to disciplinary bodies if they think that a doctor, essentially, did something wrong. But I will start by saying this: family members do come to the Coroner's Court and we try to help them. Under section 16 of the Coroners Act I have a coronial counselling service that is attached to the court and, as far as possible, that service provides assistance to any person that comes into contact with the coronial system. If I have a concerned family member, I consider that to be a person that has come into contact with the coronial system if it is a reportable death. In terms of engaging with the Coroner's Court, it is staffed by three counsellors, psychologists, so the discussion will start there. In the normal course, that is who they will talk to—one of the grief counsellors. If it then transpired that there is reason for elevated level of concern, they would be brought to the attention of the Principal Registrar; it would be brought to the attention of the coroner. But, essentially, in terms of answering your question of where they would go, I expect that if they rang the Coroner's Court, the first contact would be one of the counsellors.

Mr S.A. MILLMAN: Coroner, just following up on some questions from Dr Talbot, in respect of the material that you provided in the tables provided in your submission and the 240 cases that were referred to —

Ms FOGLIANI: This is the NCIS report?

Mr S.A. MILLMAN: Yes, the tables, "Intentional Self-harm: fatalities of persons with terminal and debilitating conditions". They would fall into (a) of their reportable deaths subcategory, would they not—the violent —

Ms FOGLIANI: You are referring to table 3?

Mr S.A. MILLMAN: There are a number of tables that are extracted in the papers that the secretariat put together for the committee this morning.

The CHAIR: They are labelled. Is it table 3?

Mr S.A. MILLMAN: Yes, table 3.

Ms FOGLIANI: And table 6.

Mr S.A. MILLMAN: Also carrying through 4, 6, 7 and 9. These intentional self-harm deaths, are not category (i) deaths for the purposes of reportable deaths; these are much more likely to be —

Ms FOGLIANI: They are unnatural to begin with. Sometimes a reportable death is reportable for a number of reasons and another one would be the injury.

Mr S.A. MILLMAN: These 240 that are the subject of these tables —

Ms FOGLIANI: Are reportable deaths.

Mr S.A. MILLMAN: Are all reportable deaths, but are any of them reportable by virtue of (i) or are they predominantly reportable by virtue of (a)?

Ms FOGLIANI: I would say (a), yes.

Mr S.A. MILLMAN: Thanks very much. We have had a bit of evidence before the committee about palliated sedation or sedation given in the terminal phase. I think it is fair to say that the evidence in regard to this practice is that this does not hasten death; it is sedation that is given in the final phase of life. The evidence is that in those circumstances what is most commonly recorded on the death certificate is the underlying medical condition, not the sedation itself. If you have a death certificate in those circumstances, it is highly unlikely to come before you is it not?

Ms FOGLIANI: Correct.

Mr S.A. MILLMAN: Thanks very much.

The CHAIR: I apologise for not being here at the beginning of the hearing and my lateness. Thank you to the Deputy Chair.

We will continue with reportable deaths. I have a series of scenarios that I will walk you through. If you could indicate to me whether you would consider them a reportable deaths and a simple yes or no is fine or feel free to elaborate. Would a reportable death be a death potentially resulting from the refusal of life-sustaining medical treatment, including artificial nutrition and hydration by a competent adult, including by way of AHD or, alternatively, their substitute decision-maker?

[9.30 am]

Ms FOGLIANI: No; not a reportable death. A patient of sound mind has the right to refuse medical treatment.

The CHAIR: Would a reportable death potentially result from voluntary palliated starvation when a competent individual chooses to stop eating and drinking and receives palliative care to address pain?

Ms FOGLIANI: Yes. Again, a person of sound mind has the right to decide whether they eat or drink. To look at it on the other side, to forcibly administer a substance when a person has said that they do not want it could in fact be problematic on a number of levels.

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

Ms FOGLIANI: No. Essentially, the amount of medication that can be given by a doctor to relieve suffering, there is not a set amount, because it so depends on the individual, the nature of the illness and what is being administered. What is important is the intention of the doctor. If the intention is to alleviate pain and suffering, and you are administering it to alleviate the pain and suffering, that is not a reportable death.

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?

Ms FOGLIANI: Yes. These are decisions that doctors need to make all the time. Once death is inevitable and further treatment becomes futile, what happens is the natural progression of the illness; so, that would be a natural-cause death and would not be a reportable death.

The CHAIR: Would a reportable death be potentially associated with terminal or palliated sedation where artificial nutrition and hydration are withdrawn?

Ms FOGLIANI: To begin with, if you palliate, you are relieving or lessening suffering but you are not curing, essentially. If you are using sedating medications or pain medications to relieve suffering, you often get sedation as a consequence, obviously, of the person. Again, that is not a reportable death.

Hon COLIN HOLT: Coroner, you have used a couple of times in those answers "a person with a sound mind" can make those decisions. You talked a little while ago about voluntary assisted dying and making an assessment of capacity. Also, in your submission you suggested —

> Information that would be relevant to a coroner investigating such deaths would include:
>
> …
>
> 2. Medical records to establish capacity to make an informed decision;

In that list, there was a presumption that people had a sound mind and had capacity in refusing medical treatment or whatever the case may be; yet, when it comes to voluntary assisted dying, there is not that presumption of capacity, it seems, from your submission. Do you have any comments on that?

Ms FOGLIANI: Yes. I start by saying that I would need to look at what is embedded in the legislation. If that becomes one of the planks that you need to look at, then, yes, obviously, I would want to look at that.

Hon COLIN HOLT: We have heard quite a bit of evidence around presumption of capacity, even in alternative decision-makers, yet there is potential with VAD to raise that bar to not have that presumption of capacity. Would that be your view or would you just work within the constraints of the —

Ms FOGLIANI: I would work with the legislation. I imagine that voluntariness and capacity in the circumstances of voluntary assisted dying would be an important component; but, again, I would work with the legislation.

Hon COLIN HOLT: It is less about the presumption of capacity in that case; whereas, more of a proof of capacity would be the bar?

Ms FOGLIANI: Yes, evidence that goes to show it.

The CHAIR: You have stated that none of these, in your view, would fall under the reportable category. Have any of them been reported to your office?

Ms FOGLIANI: None have been reported to me, but I would like to invite Mr Cooper, the principal registrar, to also answer that question to see if he is aware of any.

Mr COOPER: Not aware of any that have been reported, no.

Hon NICK GOIRAN: Thanks to both witnesses. These types of deaths, or these types of circumstances, have not been reported. Are there matters that have come to your attention that should have been reported to your office and have not been? Does that happen from time to time?

Ms FOGLIANI: Do you mean matters of this nature or any sort of matters?

Hon NICK GOIRAN: Just generally, because I think it is useful for the committee to understand that it is all very well for someone not to report something to you—you can only investigate something if it is drawn to your attention.

Ms FOGLIANI: Correct.

Hon NICK GOIRAN: Are there circumstances where people should be reporting?

Ms FOGLIANI: That can happen. It can happen from confusion or people not understanding what their obligations are, and it creates difficulty when it happens. So then the pathways for the coroner to find out—well, there are many ways. Somebody will say something to the coroner and we start asking, and then it looks like that ought to have been reported. The difficulty that it creates is that at that point in time the body has been disposed of, so there are some very material and important things that the coroner can no longer do by way of investigation. Yes, it does happen. Mr Cooper can also provide you with some information on that.

Mr COOPER: Yes, it does happen on a fairly regular basis. As you can appreciate, there is no death that can occur in this state—it must be dealt with either by way of a death certificate or by way of coming to the Coroner's Court. What happens quite often is a doctor will issue a death certificate, the death certificate finishes up at the Registry of Births, Deaths and Marriages, who will then look at the cause of death and they automatically and regularly identify that this case should have been reported to the coroner. The most common occurrence is, for example, someone who has had a fall, sustained a fracture and then later died, and because there was an injury related to the death, whether or not it caused it directly or indirectly is of no consequence, but it should have been reported to us in that instance. As the State Coroner stated, quite often we are playing a little bit of catch-up, because there has been a funeral or cremation, so we can only look at the case on a purely documentary sort of basis. But it does happen quite regularly. Sometimes it is because there is ignorance of the Coroners Act—I say that in the sense that it is because they do not know what is and is not reportable. This is why we encourage physicians and medical practitioners, if they are not sure about a death, to contact us and have a talk to us about the case.

Hon NICK GOIRAN: So there are two circumstances there then, is there not? There is the mechanism of the Registry of Births, Deaths and Marriages receiving a death certificate and looking at it and then saying, "Well, there could be something here." What do they then do? Do they then bring it to your attention or go back to the practitioner?

Mr COOPER: They would refer it to us and then we would make due inquiries. If necessary, we can determine whether or not the case needed to be reported and we can accept the death certificate

or, alternatively, we will say, "No, we can't accept the death certificate," and then we would commence a coronial investigation.

Hon NICK GOIRAN: Then there is the other circumstance that requires someone to bring it to your attention outside of that certificated process to raise some concerns.

Mr COOPER: Yes.

Hon NICK GOIRAN: There needs to be a complainant.

Mr COOPER: We can also do that too. That happens fairly infrequently. But you may get a family member, as was discussed earlier, who may have only recently become aware of the death, and the death has been dealt with and, as the State Coroner said, the first port of call would be the counselling service and then we can make further inquiries and carry it on from there, if necessary.

Hon NICK GOIRAN: Is it difficult for individuals who are quite isolated, who do not have much community contact, to identify a complainant?

Ms FOGLIANI: You might have to give me the question again; I am not quite sure what you mean.

Hon NICK GOIRAN: The circumstances are that in Western Australia we have a huge geographical state; some people are very isolated. That might be a matter of geography, but it might also be a matter of their personal circumstances. A very isolated person may not have the community network around them to be a complainant, so in those circumstances it would be very hard to find a complainant who would bring to your attention any concerns.

Ms FOGLIANI: Yes. It could be. Everybody is an individual. You do not know what their support networks are. One might imagine that if you had somebody in an isolated area and they had a concern about a death, for example, one might imagine they would go to the local police who would know to come to us. They might go to the local hospital or a nurse. There are various pathways, but, of course, if people are in more remote areas, one could say that they could pick up the phone and call the Coroner's Court. But it is an individual thing about what choice somebody makes about who they want to talk to about it and how they want to raise it.

[9.40 am]

Hon ROBIN CHAPPLE: Just one, if I may. I have reviewed your supplementary submission and you talk about the 240 cases representing 13.9 per cent of all intentional self-harm cases reported to the Western Australian coroner. You provide a number of tables, and maybe I am just drawing a long bow, but you refer to tables 3, 4, 6, 7 and 9. Where there are other tables?

The CHAIR: Member, this is the summary of the tables. There were other tables in the original submission.

Hon ROBIN CHAPPLE: Okay, no worries, thank you. I do apologise; I will retreat!

The CHAIR: I want to put to you that we had the police commissioner give evidence earlier this week and we put the same questions to him for each of those deaths, and he was of the view that all of those deaths would be reportable deaths.

Ms FOGLIANI: Yes, that is interesting.

The CHAIR: Yes. Do you have a comment on that?

Ms FOGLIANI: All of the deaths that you spoke to me about are not reportable, but any death that is reported to a coroner, we look at. If, for example, the police reported the death, the first thing you would do is start asking questions. If it then turned out that it was within the scenario that you asked me about, the likely response from the coroner's office would be, "Thank you for raising it with us. It's very good that you raised it. I prefer people to raise things with me rather than not, but

in this instance it's not a reportable death." It is a very individual situation in each case. I guess the only comment I would make in relation to that is that if in doubt, please report, and we will look at it.

The CHAIR: Can I ask why the death of a person who had chosen to stop eating and drinking and underwent palliative care throughout that scenario and died as a result would not be considered self-harm, as a death from an act of self-destruction being an intentional act by a person knowing the probable consequences of what he or she is about?

Ms FOGLIANI: Yes. Look, from my perspective it is not, because a person of sound mind can decide not to keep eating and drinking. An act of self-destruction, suicide—which is essentially an act that you take with a view to ending life—is different. I do not regard it as essentially a suicide; I regard that as a decision to allow a natural illness to progress.

The CHAIR: Could it not be argued that some of these people, the individuals involved in these statistics who were faced with a terminal and debilitating condition, were of sound mind and chose to self-harm and self-destruct, if you like?

Ms FOGLIANI: Yes, indeed.

The CHAIR: So, there is almost an assumption that if you suicide, you are not of sound mind —

Ms FOGLIANI: Look, that is a very interesting area —

The CHAIR: — but if you choose not to eat and drink, you are.

Ms FOGLIANI: Yes, all right. It is a very interesting area. In relation to suicide there are two trains of thought. One is that if a person has taken his or her life, it must mean that they were not of sound mind. That is a bit old-fashioned. The other view is that that can happen; a person can take his or her own life and be of sound mind. I create a distinction between that act and the decision to essentially allow the progression of a natural illness.

The CHAIR: We will move to the causes of death and verdicts. Do you think that any of the kinds of deaths referred to in question (2) would be regarded as deaths that are not the result of an external source? You have probably covered this.

Ms FOGLIANI: No. I do not think any of them meet the criteria of a reportable death, so I do not regard them as being the result of an external source.

The CHAIR: Non-natural death includes verdicts of lawful homicide, which relate to deaths that would be justified or otherwise excused by law. Can you comment on why this outcome would not be applicable in a case, for example, in which the doctrine of double effect applied under the Criminal Code?

Ms FOGLIANI: I suppose if we go to the doctrine of double effect, we are starting with section 259 of the Criminal Code—that is the one you are looking at, yes—so a doctor is a person not being criminally responsible for administering medication in good faith. Homicide excused by law would not be applicable in a case of the doctrine of double effect because the primary intention is to relieve suffering and not to end life.

The CHAIR: Are you able to explain why these deaths are not considered to be deaths occurring under anaesthetic?

Ms FOGLIANI: Yes, they are not anaesthetic. Anaesthetic is one thing and sedation and analgesia is another, so yes.

The CHAIR: So, the coroner has a clear distinction between sedation and anaesthesia?

Ms FOGLIANI: Yes.

The CHAIR: With regard to death certificates, is it fair to say that it would be rare for a doctor not to complete a death certificate in relation to the kinds of deaths outlined in question (2) and report these deaths to your office? I think you have answered this in a different way earlier.

Ms FOGLIANI: Yes.

The CHAIR: Do you think there are clear guidelines about whether these kinds of deaths are reportable deaths?

Ms FOGLIANI: All right. These are the deaths that you have raised with me—those ones where essentially I am saying you allow the natural disease to progress.

Hon NICK GOIRAN: Yes, but can I just jump in there and say that I still would not mind you expanding that to not just being the circumstances described, but are there good guidelines for Western Australians generally with regard to what are reportable deaths?

Ms FOGLIANI: There are no published guidelines that go into it. Essentially, that is something that is on my mind and something I want to do. The Coroners Act was the subject of an extensive and comprehensive review by the Law Reform Commission of Western Australia, as a result of which a range of amendments, by way of law reform, were recommended. That is now in train and if those changes occur—which I expect they are likely to—then when I see the new legislation, I am tasked with writing up all of the guidelines in relation to it and that will be part of it.

Hon NICK GOIRAN: Is this the legislation that is before the Council at the moment and will enable, I think, you to use the CT scanner to speed up the process of investigation?

Ms FOGLIANI: That is part of it. That came from two of the recommendations by the Law Reform Commission, yes, but there were 113 recommendations, a number of which would result in law reform if they were implemented.

Hon NICK GOIRAN: I think in answer to the chair's question, basically the guidelines are in train and we will see them in the fullness of time?

Ms FOGLIANI: Yes.

The CHAIR: But at the moment it is just the act that people rely on?

Ms FOGLIANI: Yes.

The CHAIR: You have said that in cases of end-of-life you would not expect to see starvation or dehydration on a death certificate. Have you had death certificates reported with those causes of deaths reported?

Mr COOPER: Yes, it is quite common in dementia cases. It is a debilitating disease, as I am sure you know, and people do not eat, do not drink and do not take the medications. A recognised cause of death, which is permissible and accepted by the Registry of Births, Deaths and Marriages is inanition, and it is an old term basically meaning that a person has starved themselves to death, really, which is a known consequence of dementia.

[9.50 am]

The CHAIR: Are you able to provide some figures on that to the committee?

Mr COOPER: Sadly, no. I wish we could; our database is not fully searchable on that kind of data.

Ms FOGLIANI: I would not mind taking that on notice just to think about that. We have a case recording system but we do not have a case management system. That is on the way for the court. I would not mind having a look to see if we can and then letting you know.

The CHAIR: Yes.

Ms FOGLIANI: I believe that Mr Cooper is correct. We probably do not have the searching mechanism for it, but I am just interested myself in seeing that.

The CHAIR: That would be useful. Thank you. Are you confident that the adequacy and accuracy of death certification in WA is managed properly?

Ms FOGLIANI: That is a big question. I have no reason to believe that it is not.

The CHAIR: The national coronial information system—the Victorian coroner provided a report to the Victorian committee into end-of-life choices which was very specifically linked to Victoria. I understand that the WA office has some issues providing similar information. Are you able to explain why that is the case?

Ms FOGLIANI: Yes and I will begin by explaining why we have gone to the national coronial information system in order to produce this report. That is because we are under a licence agreement with them. This is not the Coroner's Court of Victoria; it is a separate entity. It is a database that relates to all of the coronial jurisdictions in Australia. We simply, at the Coroner's Court of Western Australia, would not have the capacity to produce a report like this. But as part of the licence agreement our data is entered. It feeds into the national coronial information system and then we can ask these sorts of questions. There is a second aspect to it. That is that in Western Australia the Coroner's Court is configured differently to Victoria. Basically, one of the main differences on the topic of your question is that we do not, essentially, have a death prevention branch. We are not staffed with people that can look at those sorts of issues. We do not have researchers embedded within the office. You might see within the transcript of the hearing with the Victorian coroners that they mentioned the prevention branch and how much it assists them in relation to undertaking all of that. Because of the workload of the court—we have a backlog—obviously I am going to prioritise operational work as much as possible. On the good news side, the Law Reform Commission did recommend—recommendation 83—a prevention branch. That is something that I would like to have and I very much support. But resources are not infinite. I know that they need to be shared around. It is certainly a goal and something that I raise from time to time, that it would very much assist the Coroner's Court if we could have something like a prevention branch with researchers to assist in compiling this sort of information to assist coroners with recommendations. It would be very helpful.

The CHAIR: Are you able to explain to the committee how the information you have provided for us through the NCIS is different to the information that was provided to the Victorian inquiry?

Ms FOGLIANI: I might not be able to, but I might be able to say this, which could assist: I could see that they raised in the Victorian inquiry a number of case studies. After I received this, which was in response to the direct questions on the statistics that were sought, I tasked the in-house medical adviser to do a bit of work for me. They are operational and they really need to focus on the operational work but they were able to help. I can make this available to you but I need to outline some factors beforehand. Bearing in mind that we do not have a case management system, basically what happened is that we searched with the search term pentobarbitone to see if we could get a number of cases where people had self-administered. A number of cases were identified between 2010 and 2017. I called for the findings on those to see what the circumstances were. That may be a little bit more like what was produced in Victoria, but it will not be as comprehensive because this is just entering a search term for pentobarbitone. It has to also be borne in mind that as a result of the coroner's investigation, administrative findings were issued. Administrative findings are confidential documents. We provide them to the senior next of kin and the next of kin of the family, but we do not publish them on the website. It is not like a public inquest. One way in which I may be able to assist you, if you wish, and I will take this on notice, is to de-identify some of those

findings. I also take into account that I am not in a position to voluntarily disclose information of the Coroner's Court. It would have to be under a compulsion, then I could look at that. I guess what I am saying is that I cannot sit here and give you all of those administrative findings. I could try to de-identify it. I could try to provide you with a summary that is very broad. There would be 10 cases. If you consider that that would assist you, on the understanding that we just entered the search term pentobarbitone and saw what came, I can provide that.

The CHAIR: Yes. I think that would be helpful.

Hon Dr SALLY TALBOT: Can you tell us how many—what was the search result?

Ms FOGLIANI: There were 10 cases within 2010 to 2017, but I would want to crosscheck that.

Hon Dr SALLY TALBOT: And that comes under that first category of substance for human use?

Ms FOGLIANI: Yes.

Hon Dr SALLY TALBOT: The drug you are talking about—can you de-technicalise it for us?

Ms FOGLIANI: Yes. The pentobarbitone is essentially the drug that is intended to take life. The drug that they are using —

Hon Dr SALLY TALBOT: So that would come under that first category—drug or toxicity.

Hon ROBIN CHAPPLE: That is including Nembutal?

Ms FOGLIANI: What I would like to do is have a look and see, essentially, the drug name, the tradename and join it together and provide you with something that is accurate. I can do that. Then what I can do is link it in to that report.

Hon Dr SALLY TALBOT: Can I just seek further clarification? I am not objecting to that course of action but I am wondering whether we can get a bit more. If you look at table 3, you can see that that may account, depending on what your further determinations are, for 30 per cent of those deaths. Can you suggest any way that we can get even close to some of the others? We have an equal number of people whose cause of death was asphyxiation.

The CHAIR: Would that information be available if we compelled it or provided a closed session for that information?

Ms FOGLIANI: I think the closed session would assist. Perhaps if I can take that on notice and consider the best way of providing it.

Hon Dr SALLY TALBOT: Yes. So we will wait for your advice about how to —

Ms FOGLIANI: How to best provide that—yes.

The CHAIR: The alternative is that the committee can issue a summons.

Ms FOGLIANI: Yes, so that is an alternative. If you do not mind, what I will do is I will think that through to see what the best way would be and provide the information.

The CHAIR: We will wait for your advice.

Ms FOGLIANI: Yes, good. Thank you.

[10.00 am]

The CHAIR: Just on the report—I know we are probably going to delve a bit deeper at some point in the future—would you draw any conclusions from this data and the association between terminal and debilitating conditions and suicide?

Ms FOGLIANI: To be frank, I am always very cautious about drawing conclusions from data. I know that it is a very valuable tool, but I do not think I have enough information at the moment to draw conclusions.

The CHAIR: Do you think that these suicides in these circumstances, where people were taking their lives in the face of a debilitating illness, would be particularly harrowing for the family members?

Ms FOGLIANI: Undoubtedly, yes.

The CHAIR: And those people obviously working in the coroner's office and police and first responders?

Ms FOGLIANI: It is a difficult job, absolutely, yes.

Hon COLIN HOLT: I think delving into the statistics would be very useful, if you could come back with some guidelines. I guess from my viewpoint, if some laws around voluntary assisted dying were introduced, what is the likely level of candidacy from the community of utilising that new legislation if it came about? It would be interesting, I think. Delving into some of your tables, does it mean that—I do not want to put words in your mouth and I am not suggesting that I have got this right either—potentially 48 people over the last five years from 2012 to 2016 were the people who were nearing the end of their terminal illness who decided to take their own life? But, again, I am just looking at it in a superficial way. It would be interesting, I think, to give some indications to the community of the potential. It all depends on what the legislation says for a start. I know this is very difficult, but if you had some legislation similar to the Victorian legislation that said they had to be close to terminal illness within the last six months and had to show capacity, and some of those other hoops of where people were, it would be interesting to know potential candidacy to utilise the Victorian laws or, in this case, Western Australian laws, if we could get to that point.

Ms FOGLIANI: I would like to take that on notice and give it some thought. In terms of answering, my answer will have to be based on the statistics that I have, because I have not seen the legislation so I do not know what the provisions are going to say.

Hon COLIN HOLT: There is none, really.

Ms FOGLIANI: Yes, there is none. I will take that on notice as well. One of the tasks that I have considered requesting of the NCIS is this: when I received the report, I called for the underlying information—meaning all of the cases that went into it—by way of a schedule. It is quite extensive. Essentially, I asked for a few case examples and they just did a random selection for me. What I would like to do is to confer with the NCIS to see if they are sufficiently resourced to be able to give me a more detailed report by reference to all of the underlying cases that make up the statistics. It might be a bit of a big ask, but I am happy to ask that just to see if I can give you a little bit more so that the statistics can be a little bit more meaningful.

The CHAIR: Yes, that would be very helpful.

Mr R.R. WHITBY: Coroner, I would like to go back to the doctrine of double effect. I know that it is all about intent, and the primary intent being the relief of pain and a secondary consequence might be hastening of death. I know this could be a grey area. Has your office ever investigated a complaint about an allegation in terms of the doctor's intent in that regard—whether there was a sense that maybe the intent was to cause death?

Ms FOGLIANI: As opposed to palliate? Yes; all right. Not to my knowledge, but I will just ask Mr Cooper.

Mr COOPER: Yes, we have had instances where family members are concerned about the amount of morphine, for example, that has been given. As a consequence of that, we will inquire into the

death and, through a process of toxicology, we will see what the levels were and then we can get back to the family and reassure them or otherwise that everything was okay. I hasten to add that there has never been an incidence where a doctor has deliberately overdosed anybody, to our knowledge anyway, in a case.

The CHAIR: Would a post-mortem be conducted in those circumstances?

Mr COOPER: It would have to be. Because we would have to rely on toxicology, it would probably be an external examination and then be proved on the toxicology.

Mr R.R. WHITBY: Given the issues that the coroner spoke about earlier about there is no set dosage, that everyone is different and that everyone is suffering different conditions, how on earth do you get to a point where you determine what the intent was?

Mr COOPER: That is a good question!

Ms FOGLIANI: That is all of the surrounding circumstances. Basically, the difficulty is that the coroner relies on deaths being reported. It is impossible to know if a death in those circumstances occurred if it never came to the attention of the coroner. It is simply impossible to know. The system, to my mind, is robust. The toxicologists do look at the administration of medication, particularly in elderly deaths and with palliation. So toxicology in those sorts of cases, if appropriate, will be looked at. In terms of morphine, there are some thresholds; there are some records that may show that, for example, hypothetically speaking, an overdose was given with an intention. That might be that. The sorts of things that you might look at are: there is the medication chart, here is the morphine and all of a sudden here is the medication chart and there is an entry with an anomalous amount, but how likely is the medication chart to say that? So you have to balance all of that up. What you do is you do the best and most thorough investigation you can do that is appropriate in the circumstances when a death is reported to the coroner.

Mr R.R. WHITBY: In the absence of any other contrary evidence, I guess you would make a judgement that the doctors always act in good faith.

Ms FOGLIANI: Essentially, it is this: we are not in the minds of the doctors. I am relying on people complying with their legal requirements, and their ethical duties as well if they are medical practitioners, to report a death to the coroner. If they do not, I suppose, as I said earlier on, there are numerous pathways. There could be a family member that expresses a concern. There could be another clinician that expresses a concern. We look at all of that.

The CHAIR: Are you able to indicate how often that instance occurs?

Mr COOPER: Very rarely. Obviously, I have been at the court a lot of years, so I have come across at least a couple of cases where that has been something. It is just to reassure the family that everything was done appropriately, because obviously when a person is in a great deal of pain and the longer it goes on, the more and more morphine and pain medication they need anyway. There comes a tipping point where it is doing you more harm than good. As the State Coroner said, and as the committee knows, the intention is to relieve the pain, not to end the life.

Ms FOGLIANI: And you probably know that is set out in *Halsbury's Laws*; you will have that as well. I do not know if you want the other case: R v Adams—Bodkin—[1957] CLR 365. You have probably got that—yes. The tests are all there. I suppose what I can say is that I have no reason to believe that there is the improper administration of medication to hasten death.

[10.10 am]

The CHAIR: There are a number of studies and surveys that have been submitted to the committee that indicate that significant numbers of doctors have admitted to intentionally hastening death. I am just interested to know if that flows on into your area of work. Clearly, it does not often.

Mr COOPER: No.

Mr R.R. WHITBY: No, and there would need to be a complaint from some party involved for it to come to your attention.

Mr COOPER: Indeed, yes.

Ms FOGLIANI: Indeed, yes; we cannot be there. We are not there.

Hon ROBIN CHAPPLE: In relation to the 18 plastic bag asphyxiations that you refer to in your chart, are you able to identify whether they were what we refer to as exit bags?

Ms FOGLIANI: Look, when I said earlier on that I can get some of the underlying information, if you wish, I can see if we have that.

Hon ROBIN CHAPPLE: I mean they are bags supplied by Exit International.

Ms FOGLIANI: Yes, all right. I will take that one on notice as well because whilst I said that it is a pretty big job to look at all of the underlying information, it should not be difficult—I hope; I do not know—to just ask that question and see whether that can be identified for you.

Hon ROBIN CHAPPLE: Thank you. I understand there is some sort of trauma about that in terms of family and all the rest of it. If a person suicides by hanging and it is not included in your area—this is a bit painful for me. My foster child hung himself as a result of him being a deaf-mute.

Ms FOGLIANI: I am sorry to hear that.

Hon ROBIN CHAPPLE: So it was the issue of being a deaf-mute that lead to the hanging. Would that be picked up by you or only if it was referred to you? Would it be included in those stats?

Ms FOGLIANI: First of all, picked up by you; that is a reportable death. I am sorry to hear that.

Hon ROBIN CHAPPLE: No, that is fine.

Ms FOGLIANI: In terms of whether it would be picked up here, what the NCIS has done, if you look three pages into the report, is list the key terms that they used in order to search. It is right at the very beginning of the document. So, the answer is no, because it is unlikely unless there was another feature in this list. You can see all the bullet points; they are the terms that were searched in order to identify the terminal or debilitating illness. But you also have to identify a range of other conditions because essentially, the selection of cases related to where the physical condition was the primary condition. But people are not one-dimensional and often, you will have a primary physical condition but they could have a mental condition as well. There are a range of things but the aim of this report was to identify where the physical condition was the primary condition.

Hon ROBIN CHAPPLE: I do not think it would have been because it was his frustration with his condition that led to the situation.

Ms FOGLIANI: Yes.

Hon ROBIN CHAPPLE: Thank you. I will come back to my perennial question, just for the satisfaction of my colleagues. Do not resuscitate: has it ever been brought to your attention in relation to directions based on a patient's "do not resuscitate" and the relatives have come along and said, "Oh! They did not resuscitate! Who put the DNR on?"

Ms FOGLIANI: Are you saying a situation where the individual himself or herself has signed and an advance health directive saying they do not want to be resuscitated?

Hon ROBIN CHAPPLE: There is that, but also prior to advance health care directives and still, currently, doctors and families come to the decision that a person should not be resuscitated because it is futile.

Ms FOGLIANI: Okay, and the person is incapable by then, are you saying, for this?

Hon ROBIN CHAPPLE: Yes. Has that come before you in terms of somebody sort of saying, "I didn't actually agree to Aunt Mabel not being resuscitated" or vice versa? Have you come across that?

Ms FOGLIANI: It has not come to my attention but Mr Cooper has been there longer.

Mr COOPER: Yes, it does occur from time to time, very occasionally, when there is a "not for re-sus" order and one family member says, "I didn't know and I didn't agree." But then, when we get the medical notes, it is quite clear that there is a notation in the notes that the doctor has discussed with family members, the daughter or son et cetera. So it might be one that is either not privy or they have been excluded, but certainly, there is consultation. There is also a copy of the "not for resuscitation" order, which we respect because, as I said before, if a person of sound mind has said, "Look, if anything happens, don't resuscitate me", we have to respect that.

Hon ROBIN CHAPPLE: In terms of family members or guardians, or whatever, agreeing with the doctor, is that ever tested against pecuniary interest?

Mr COOPER: In terms of?

Ms FOGLIANI: Standing to inherit?

Hon ROBIN CHAPPLE: In terms of family members standing to benefit by the death?

Mr COOPER: No, not from our point of view, because it is an area of law and death that we do not become involved with—with property issues. We have to just take things on face value and look at it purely from the circumstances surrounding the death, not if anybody has a pecuniary interest or is likely to inherit a stately home or something like that.

The CHAIR: You, coroner, indicated support for the law reform recommendations to establish a prevention unit, so you obviously have some views in this area. Do you think that if this legislation to introduce voluntary assisted dying were passed in WA that it would undermine suicide prevention in Western Australia?

Ms FOGLIANI: The answer is complex because the issue, as it appears that the end of my submission, is this: Are these deaths to be looked at as suicides? Is the verdict suicide, or is the verdict voluntary assisted dying? It is a different nature, a different type of death. Bearing in mind the confidentiality of these proceedings, I have not raised that at a national level yet, but now that I have had this hearing and I will be meeting my colleagues in the other jurisdictions, that is something I want to talk about because, from my perspective, if this does come to pass, then I think it is different to a suicide. You would want to be able to then collect those sorts of records and distinguish those deaths. They may not really be comparable to others.

Hon Dr SALLY TALBOT: Just for the record, could you tell us what has happened in Victoria? How are those deaths recorded by the coroner with the change to the law?

Ms FOGLIANI: I have not had the discussion externally because of the confidentiality of the proceedings, but that is something that I intend to now talk about.

Hon Dr SALLY TALBOT: Okay, so you are not sure what the Victorian practice is?

Ms FOGLIANI: No, I have not started with that.

Hon Dr SALLY TALBOT: Would the people in your NCIS list all have suicide on their death certificates?

Ms FOGLIANI: Yes.

Hon Dr SALLY TALBOT: For the cases you showed us where people have a terminal illness?

Ms FOGLIANI: Yes. This is essentially a question of terminology. In Western Australia, we use "suicide" and that can sometimes be recoded as "intentional self-harm". I believe the other jurisdictions use "suicide" but if they do not, they may be using "intentional self-harm". It is the same thing but we operate with the traditional verdicts.

Hon Dr SALLY TALBOT: When you say recoded, what does that mean? What would it actually say on the death certificate?

Ms FOGLIANI: On the death certificate, I would expect that it says "suicide".

Hon Dr SALLY TALBOT: So, what is recoded?

Ms FOGLIANI: It might be that when the NCIS receives that on the coroner's finding and those details, as I understand it, it is then called an "intentional self-harm" in the system.

Hon Dr SALLY TALBOT: Is it for data collection purposes?

Ms FOGLIANI: Yes.

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 of evidence. The committee will write to you with questions taken on notice during the hearing. There are a number of options available for us to request that information from you, coroner. I think Dr Jeannine Purdy will probably speak to your office in relation to what the best way to go forward and do that is. Thank you both very much.

Hearing concluded at 10.20 am