CORONERS AMENDMENT BILL 2017

Committee

Resumed from an earlier stage of the sitting. The Deputy Chair of Committees (Hon Dr Steve Thomas) in the chair; Hon Sue Ellery (Leader of the House) in charge of the bill.

Clause 1: Short title —

Committee was interrupted after the clause had been partly considered.

Hon NICK GOIRAN: Prior to the interruption for the taking of questions, we were considering clause 1. Specifically, we are looking at recommendation 55 in the Law Reform Commission of Western Australia's "Review of Coronial Practice in Western Australia: Final Report". We are looking at this recommendation because, in its second reading speech, the government indicated that the Coroners Amendment Bill will give legislative effect to recommendations 55 and 56 in that report. We learnt earlier that recommendation 55.1 is given effect by virtue of clause 5 of this bill inserting new section 25(1A) in the act, because that new section in the legislation will, effectively, dispense with section 25(1)(b) in certain circumstances and those circumstances are outlined in recommendation 55.2 in the Law Reform Commission of Western Australia's final report. In effect, the chamber is being asked to agree to the fact that in the primary act, the coroner will make findings on the identity of the deceased, how the death occurred, the cause of death and the particulars needed to register the death under the Births, Deaths and Marriages Registration Act 1998. The coroner will ordinarily do that following an inquest, but in certain circumstances it will not be necessary for the coroner to identify or set out how the death occurred. We learnt earlier that that is what is referred to as the narrative findings.

Recommendation 55.2, of course, limits recommendation 55.1 of the Law Reform Commission's report in certain circumstances. Circumstances when this should not occur are when the deceased was a person held in care. If the person was held in care, these provisions should not apply. That is my understanding of what the Law Reform Commission is saying in recommendations 55.1 and 55.2. Prior to the interruption for the taking of questions, the minister indicated that we can be satisfied that that is indeed the case because there is a duty to hold an inquest for a person in care and the duty is set out at section 22 of the primary act, which states —

> (1) A coroner who has jurisdiction to investigate a death must hold an inquest if the death appears to be a Western Australian death and —
>
> (a) the deceased was immediately before death a person held in care; …

The minister was indicating to us, as I understand it, that we can be satisfied that recommendations 55.1 and 55.2 are captured by clause 5 in the bill before us but it must be read in conjunction with sections 22 and 25(1) of the primary act. For my part at least, I am satisfied that the bill before us is giving legislative effect to recommendation 55.

I would like to turn to recommendation 56. I note that it has three sub-recommendations. The theme of recommendation 56 is that the coroner should have the power to discontinue investigations in certain cases. Indeed, I am particularly interested in this recommendation. I was also interested in recommendation 55 to make sure the government was doing what it said it was doing. I am especially interested in recommendation 56 because, as I outlined in the second reading debate, my concern over the last few years is that certain matters have not even been reported to the coroner. The last thing I want to do is find that we can now have these matters reported to the coroner only for the coroner to discontinue them. That will defeat the very purpose of the work that I have been trying to achieve for many years, started by the revelations of Hon Ed Dermer in the thirty-eighth Parliament.

Recommendation 56 in chapter five of the Law Reform Commission's final report states —

> That a provision modelled on s 17 of the *Coroners Act 2008* (Vic) be inserted into the Coroners Act to provide that in cases where a forensic pathologist has examined the body of a deceased and has expressed an opinion that the death was consistent with natural causes and the coroner determines that, other than the fact that the death of the person was unexpected, the death is not a reportable death, a coroner may discontinue the coronial investigation into the death and report the particulars required to register the death to the Registrar of Births, Deaths and Marriages.

That is the first of the recommendations at 56. The second states —

> That a coroner may not discontinue a coronial investigation in cases where the deceased was a person held in care or a person held in custody or where the death was during or following and causally connected to a medical procedure.

The third states —

> That the power to discontinue a coronial investigation into a death in the circumstances described above may be delegated by the State Coroner to the Principal Registrar.

Which clauses of the bill give effect to recommendations 56.1, 56.2 and 56.3?

Hon SUE ELLERY: Recommendation 56.1 states —

> That a provision modelled on s 17 of the *Coroners Act 2008* (Vic) be inserted … to provide that in cases where a forensic pathologist has examined the body … and has expressed an opinion that the death was consistent with natural causes … other than the fact that the death of the person was unexpected, the death is not a reportable death, a coroner may discontinue the coronial investigation …

I take the member to proposed section 19A(1)(a) in the bill before us and recommendation 56.2, which states —

> That a coroner may not discontinue a coronial investigation … where the deceased was a person held in care or a person held in custody …

Again, I take the member to proposed section 19A(3)(a), which refers to a duty to hold an inquest. Let us then go back to those provisions that I referred to earlier—that is, part 3 and section 22 of the substantive act—and recommendation 56.3, which states —

> That the power to discontinue a coronial investigation into a death in the circumstances described above may be delegated by the State Coroner to the Principal Registrar.

I take the member back to the principal act and the delegation provisions set out in section 10.

Hon NICK GOIRAN: Let us take each of those one at a time. Let us start with the last one—recommendation 56.3. I understood that this bill was giving effect to recommendations 55 and 56. When Hon Michael Mischin asked earlier to what extent have we decided not to proceed or were there any differences between the bill and recommendations 55 and 56, he was told that the government does not accept the premise of the question, or words to that effect. It seems to me that there is nothing in this bill that gives effect to recommendation 56.3. I think the minister is saying that it is already covered in the primary act. Why then did the Law Reform Commission put it in its recommendation?

Hon SUE ELLERY: The member will need to ask the Law Reform Commission.

Hon NICK GOIRAN: Would it not have been preferable for the minister to indicate that to Hon Michael Mischin when he asked the question? Would she not have been able to say to him that the government is giving full effect to recommendations 55.1 and 55.2 and 56.1 and 56.2 but it is not giving full effect to recommendation 56.3 because it is already covered in the primary act and this bill is not giving effect to recommendation 56.3?

Hon SUE ELLERY: That is one way of answering the question. However, if we take the view that it is already encompassed in the primary legislation, why would we need to add it to the bill? In any event, if the member wants an acknowledgement that the way he has described the circumstances is at odds with how I answered the earlier question, I will cop it, but the provision set out in recommendation 56.3 is already set out in section 10 of the primary act.

Hon MICHAEL MISCHIN: I think it is a bit more than that, minister. The question I asked was about to what extent recommendations 55 and 56 were adopted in this amendment and to what extent the amendment departed from what was recommended. The minister told me that she did not accept the premise that there was any departure, so it is a question of the reliability of the information we are receiving. I understood from what the minister said that the Coroners Amendment Bill reflects all elements of those two recommendations but the minister is telling us now that it reflects the two recommendations in combination with the principal act. It may not matter much in the scheme of things in this case, but it is a question of how much we can rely on the minister's responses at face value. I had assumed, subject to what Hon Nick Goiran might explore and tease out, that the intention was to pick up recommendations 55 and 56, translate them into law, and introduce them through this bill. The minister is now saying that is not quite right.

Hon SUE ELLERY: Let us look at the end point here. Are recommendations 55 and 56 going to be reflected in the laws applying to coronial inquiries in Western Australia as a result of this legislation and the existing legislation? The answer is yes. I just said to Hon Nick Goiran that if he wants to say that I did not adequately answer the question when asked before, I will cop it. I am sorry; I apologise to the chamber. The outcome, however, is that recommendations 55 and 56 of the Law Reform Commission's report are given effect. That particular part of recommendation 56 is in the substantive act and the other components are picked up in the amendments before the house.

Hon NICK GOIRAN: Having dealt with recommendation 56.3, I indicate at this point that I do not have any issue with recommendation 56.1. I agree that it is captured by clause 4 of the bill, specifically by the insertion of new

section 19A in subsections (1), (2) and (4). It is my view that those three subsections will give effect to what is set out at recommendation 56.1 of the Law Reform Commission's report. However, I want to take the minister to recommendation 56.2. The minister will remember that, during my contribution to the second reading debate, I flagged that this recommendation was troubling me somewhat. Recommendation 56.2 states —

> That a coroner may not discontinue a coronial investigation in cases where the deceased was a person held in care —

That is one scenario. The second scenario is for "a person held in custody" and the third scenario is —

> … where the death was during or following and causally connected to a medical procedure.

The minister indicated earlier that this provision is covered by clause 4 of the bill, specifically by the insertion of new section 19A(3). A couple of things trouble me and I ask for some clarification. As I said, there are three scenarios in recommendation 56.2. The first is that the deceased was "a person held in care". I concede that that is covered by the insertion of new section 19A(3)(a). As the minister indicated earlier, it states that is where —

> there is a duty to hold an inquest into the death under this Act;

The minister kindly referred me to section 22(1)(a) of the primary act, but it is not readily clear to me where it captures "a person held in custody"; that is the second scenario. The third scenario I want the minister to look at is the Law Reform Commission's statement —

> … where the death was during or following and causally connected to a medical procedure.

New section 19A(3)(b) of the bill before us talks about a death occurring "during an anaesthetic". It strikes me that the insertion of new section 19A(3)(b) is a subset of the scenario outlined by the Law Reform Commission. If a death has occurred during an anaesthetic, it is a subset of a death that occurs "during or following and causally connected to a medical procedure" but a death could occur "during or following and causally connected to a medical procedure" that does not involve an anaesthetic at all. In any event, that section talks about it occurring during an anaesthetic; it does not talk about it following or being causally connected. Can we get some clarification to ensure —

Hon Sue Ellery: By interjection, can the member go back to paragraph (a) in the definition of "reportable death"? The advice I have been given is that it is captured in the provision of paragraph (a), an "unexpected, unnatural" death.

Hon NICK GOIRAN: Is the minister talking about section 3 of the act?

Hon Sue Ellery: Yes. I am saving myself standing up and sitting down; I am sorry, Hansard.

Hon NICK GOIRAN: Section 3(a) of the Coroners Act includes, as the minister identified, that a reportable death means a death that appears to have been unexpected or unnatural. They are two of the various scenarios in which a death is reportable. However, the Law Reform Commission is asking —

> That a coroner may not discontinue a coronial investigation in cases where the deceased was a person held in care —

We have dealt with that, but I am asking about a person held in custody. Let us deal with that one first, then we will come back to the medical procedure.

Hon SUE ELLERY: I should have listened more carefully; I thought the member was asking me about the medical element.

Hon Nick Goiran: I was asking about both.

Hon SUE ELLERY: Okay. In respect to a person held in care, again if the member goes to section 3 of the primary act, a "person held in care" means —

> (a) a person under, or escaping from, the control, care or custody of —

Subparagraph (i) of that provision effectively captures children in the care of the state; subparagraph (ii) refers to the Prisons Act; and, for completeness, subparagraph (iii) refers to someone escaping from a member of the police force.

Hon NICK GOIRAN: I take it that the government is saying that, for the purposes of the Coroners Act 1996, a person held in custody is a person held in care.

Hon Sue Ellery: Correct.

Hon NICK GOIRAN: Let us deal with the final scenario in the recommendations, which is a death that occurred "during or following and causally connected to a medical procedure". The Law Reform Commission asks that a coroner should not be able to discontinue an investigation in those circumstances. In other words, if a death has

occurred during or following and causally connected to a medical procedure, the coroner must investigate. I agree with that. As I outlined earlier, I think that is absolutely crucial, but which part are we referring to in this bill? Again, this goes back to what was said to Hon Michael Mischin earlier—that we are giving effect to all these provisions. I want to be clear: is it a proposed section in the bill before us or a section in the primary act that gives effect to that final portion of recommendation 56.2 dealing with medical procedures?

Hon SUE ELLERY: The link is made in two places. Proposed section 19A(3) states —

> However, a determination cannot be made under subsection (1) about a reportable death if —
>
> (a) there is a duty to hold an inquest into the death under this Act; —

I will go to that duty in a minute, which is when we go back to sections 3 and 22 of the act. It continues —

> or
>
> (b) the death occurred during an anaesthetic.

In the first instance, there is a reference in the bill to "the death occurred during an anaesthetic". Secondly, if we unpick proposed subsection (3)(a), we go back to duty under section 3 of the act. I am advised that if it was not during an anaesthetic, it would be captured under the definition of "reportable death" in section 3 of the act, which states —

> ***reportable death*** means a Western Australian death —
>
> (a) that appears to have been unexpected, unnatural …

"Unnatural" is where it would be captured. The advice provided to me is that there are two places in which recommendation 56.2 and that particular bit relating to medical procedure is captured; that is, in the bill before us in proposed section 19A(3)(b), and then, under proposed subsection (3)(a) where it refers to a duty, we go back to the definition of "reportable death" in the act. I also make the point that the advice to me is that the coroner's view is that the existing act allows the types of death to which the honourable member has referred to be reported, and that it is the current coroner's view that nothing in the bill before us would have the effect of preventing or being an obstacle to that reporting.

Hon NICK GOIRAN: I thank the minister for that additional clarification. I did appreciate those same remarks in the minister's reply to the second reading debate. I want to clarify a couple of things on that in due course. Just before we get there, clause 4 of the bill before us will insert a new section 19A into the act. Proposed subsection (3) states —

> However, a determination cannot be made under subsection (1) about a reportable death if —
>
> (a) there is a duty to hold an inquest into the death under this Act; or
>
> (b) the death occurred during an anaesthetic.

I gather, from what the minister indicated earlier, that the reason recommendation 56.2 of the Law Reform Commission report is being given effect is that a death that occurs during or following and causally connected to a medical procedure is already captured by the fact that there is a duty under our act to investigate reportable deaths and, specifically, deaths that appear to have been unexpected, unnatural, violent or have resulted directly or indirectly from injury. I am hearing from the minister that the circumstance set out in recommendation 56.2 is already captured by the act, because a definition of "reportable death", and specifically paragraph (a), is already in the primary act. There is a duty to hold an inquest for those types of deaths. Therefore, because there is a duty, the coroner is not going to be able to discontinue such investigations. That is okay, but the thing that is slightly confusing about it is that proposed section 19A(3)(b) says —

> the death occurred during an anaesthetic.

That is virtually word for word the same as paragraph (b) of the definition of "reportable death". If it is the case that the coroner has a duty to hold an inquest into all these deaths outlined under "reportable death"—that is, paragraphs (a) through to (j), which includes paragraph (b) when it occurs during an anaesthetic—why does this bill then seek to additionally enshrine and put completely beyond doubt that we definitely want deaths that occur during an anaesthetic to be captured? I am not troubled by it, but it does at the very least seem duplicative.

Hon SUE ELLERY: Proposed section 19A(3)(b) specifies that the determination not to hold an investigation—this is a kind of double negative—cannot be made when a death occurred during an anaesthetic. Section 3 of the Coroners Act provides a list of "reportable deaths". With the exception of those provisions under "reportable deaths" that are related to a person held in care, which we have already established includes a person held in custody—we cannot get around that—we cannot get around a death occurring during anaesthetic. Proposed section 19A(3)(a) already provides for what we know is covered by "reportable death"—which we cannot get

around—including "in care", which includes "in custody". Proposed section 19A(3)(b), which is "the death occurred during an anaesthetic", spells out those two provisions effectively all listed under "reportable death". We cannot get around conducting an investigation into those two.

Hon NICK GOIRAN: What I am really driving at is contained in proposed section 19A(3)(a), which states —

> there is a duty to hold an inquest into the death under this Act;

Is that not for all the reportable deaths contained in paragraphs (a) through to (j)?

Hon SUE ELLERY: Just because we like to have complicated legislation, some of them are, but some of them are discretional. The ones that are not discretional right now are the ones that are related to held in care—that is, where it has been caused by a member of the police force or a person that is in custody. This bill now adds "the death occurred during an anaesthetic". It is those in the bill before us that we have now added to the ones contained under "reportable death" in paragraphs (a) through to (j), which are not discretionary—you must.

Hon NICK GOIRAN: I want to be absolutely crystal clear here. Recommendation 56.2 of the Law Reform Commission states that the coroner should not be able to discontinue in three scenarios. Scenario 1 is that the deceased was a person held in care and scenario 2 is that the deceased was a person held in custody. We have established that is all one and the same and that that is captured by proposed section 19A(3)(a). Recommendation 56.2 of the Law Reform Commission report, the final scenario, states —

> … where the death was during or following and causally connected to a medical procedure.

It is my concern that that is wider than a death occurring during an anaesthetic. If the minister then says to me, "That is covered by the fact that there is a duty to hold an inquest into the death," that is where the problem will arise, because the only way in which the duty to hold an inquest into a death can occur is if it is one of those reportable deaths. It is not presently clear. I wonder, in order to take us forward, whether it would be helpful for the minister to indicate to the chamber for which of the reportable deaths contained in paragraphs (a) through (j) there is a duty to hold an inquest, and which ones are discretionary?

Hon SUE ELLERY: The policy provision of the bill goes to early resolution of deaths that occur by natural causes. Right now, under the act, the "reportable deaths" contained in paragraphs (e), (f) and (g) of section (3) of the act state —

> (e) of a person who immediately before death was a person held in care;
>
> (f) that appears to have been caused or contributed to while the person was held in care;
>
> (g) that appears to have been caused or contributed to by any action of a member of the Police Force;

Right now, they must be reported. They must be investigated. It is mandatory that they are reported.

Sitting suspended from 6.00 to 7.30 pm

Hon SUE ELLERY: Before we broke for dinner, I was on my feet responding to a question from Hon Nick Goiran about how recommendation 56.2 of the Law Reform Commission report is given effect in the bill before us. The object of proposed section 19A is to facilitate the early resolution of natural cause deaths only, if there is no duty to hold an inquest or no public interest. Reportable deaths are prescribed in paragraphs (a) to (j) of section 3 under "reportable deaths". "Reportable" means that the death is reported to a coroner and is investigated. Of the reportable deaths listed in paragraphs (a) to (j), only (e), (f) and (g) require a mandatory inquest. In all the other cases, the holding of an inquest is discretionary. That power is set out in section 22.2 of the Coroners Act. Anaesthetic-related deaths are reportable and are investigated, but it is a matter for the coroner whether an inquest is held. Proposed section 19A(3)(a) means that the coroner cannot cease the investigation when there is a duty to hold an inquest. Proposed section 19A(3)(b) means that the coroner cannot cease the investigation when the death occurred during an anaesthetic. When a death is investigated and/or the coroner holds an inquest, the coroner will issue a narrative finding, except if the death occurred by natural causes. A coroner's finding contains: first, the identity of the deceased; second, the cause of death; and, third, the manner of death. However, under section 25.1, there is no need to issue a narrative finding if the circumstances permit. The term "medical procedure" is used in the Victorian act, but not in the Western Australian act. The Western Australian act uses the concept of anaesthetic. Those concepts are not synonymous. I think the honourable member made the point that "medical procedure" is obviously broader than "anaesthetic".

Deaths due to a medical procedure that does not involve an anaesthetic—my discussions with the advisers used the example of a chiropractor; no anaesthetic is used but somebody dies—are not listed as exceptions in proposed section 19A(3), but they would be required to be investigated because they would not be deaths by natural causes. For the chiropractic example, that is not a natural cause. Proposed section 19A(1) provides that an investigation can be discontinued if the death is due to a natural cause.

Hon Peter Collier: Surely, the minister said that before the dinner break.

Hon SUE ELLERY: It is much more eloquently put now because we have all had something to eat.

Hon NICK GOIRAN: The chiropractic death that the minister referred to is not one that has occurred due to natural causes, but nor is a death that occurred during an anaesthetic. Why do we draw a distinction between the two?

Hon SUE ELLERY: It is possible that a death has a natural cause even though an anaesthetic may have been applied. Someone may have a heart attack and the medical practitioners might need to apply an anaesthetic to do some investigation. Ultimately, the cause of that death may well be found to have been the heart attack that the person had in the first place, even though an anaesthetic might have been involved.

Hon NICK GOIRAN: I think that by the end of this exercise, both the minister and I will have become experts in the Coroners Act. This has been most valuable, and I thank the minister and the chamber for their ongoing indulgence in this matter. This is a matter that I have been pursuing for a long time. As I indicated to the chamber in my second reading contribution, this was first identified by Hon Ed Dermer in 2011 and I have been pursuing it since then. In my experience, amendments to the Coroners Act come up very infrequently, so I do not want to miss this opportunity to make sure that we have dotted every "i" and crossed every "t", lest we find ourselves in a situation in which another coroner determines the act and its provisions in the same way as the former coroner.

I will leave further questions about this matter until we get to clause 4 because I think I have exhausted the latitude available about this issue under clause 1. I ask the minister to advise us of the status of the other recommendations that arise from the Law Reform Commission's final report "Review of the Coronial Process in Western Australia". In the second reading speech, the minister said that this bill seeks to give legislative effect to recommendations 55 and 56. However many recommendations there are in the report, I do not expect the minister to take us through them all this evening, but might there be some table or document in the possession of the government that might let us know the status of the various recommendations?

Hon SUE ELLERY: I am somewhat constrained in the information that I can give the member. I responded to this in my second reading speech. Work is being done on preparing a response by government on all the recommendations. Not all the recommendations require a legislative response. That work is being done and will be presented to cabinet, but I am not in a position to give the member any more detail than that.

Hon NICK GOIRAN: Is the minister constrained because those matters are currently before cabinet?

Hon SUE ELLERY: I am advised that the work is being done and that a submission to cabinet is being prepared. I cannot tell the member any more than that.

Hon NICK GOIRAN: Is there a time frame for when the people of Western Australia might be in a position to know the status of the recommendations arising out of this Law Reform Commission report?

Hon SUE ELLERY: I am not able to answer that. I am happy to take that on notice and I can tell the member that subsequent to this debate, but I do not have the information here.

Hon NICK GOIRAN: Just to tidy that one up, is that something that the house might be informed of by the end of the week?

Hon SUE ELLERY: I can take it on notice. I cannot guarantee what answer I will get. I can try, but I cannot guarantee that.

Hon NICK GOIRAN: Moving to a different topic then, does the minister have before her, with the advisers, an indication of the number of deaths in Western Australia last year?

Hon SUE ELLERY: I cannot provide a definitive answer. I can advise that reportable deaths were around 2 450.

Hon NICK GOIRAN: Were those approximately 2 450 deaths reported, or were they 2 450 reportable deaths in Western Australia?

Hon SUE ELLERY: It is the deaths that have been reported.

Hon NICK GOIRAN: Does the coroner's office have a sense about the difference between how many deaths are reportable in Western Australia and how many are routinely reported? Is there a gap between what should be reported to the coroner's office each year and the number that is actually reported?

Hon SUE ELLERY: No, I am advised that the office would not know if they were not reported.

Hon MICHAEL MISCHIN: There is a little confusion in my mind. When we received a briefing on this last year, we were told there was something like 14 000 deaths in Western Australia, of which about 3 500 were reported by the police, 10 500 had a death certificate issued, 2 400 were investigated and several others. But the minister has just told us that 2 450 deaths were reported last year. That seems to be a remarkable survival rate down from 14 000 deaths the year before. Is the minister talking about reportable deaths, which is a term of art in the act, or reported deaths?

Hon SUE ELLERY: Firstly, if the member was given that information in the briefing, I am sure the officers were sitting there with the relevant information. I have already said, I put a caveat on the answer that I gave, that we do not have the information here.

Hon Michael Mischin: That is fine, I understand that.

Hon SUE ELLERY: However, the 14 000 that the member referred to, I am advised, is most likely the total number of deaths. Not all deaths go to the coroner. The 2 450 is an estimate of those that are reported. It does not include those for which a death certificate is issued.

Hon MICHAEL MISCHIN: Reported as in reportable deaths or just reported? Presumably we have the figure of 14 000 people because they have been reported by someone. I am just trying to get the terminology correct so that we have some precision about what we are talking about.

Hon SUE ELLERY: I tried to make it clear—I put the caveat on it—that we do not have the information here. I can take it on notice and provide the member with the accurate number subsequent to this. We do not have it here. In an effort to answer Hon Nick Goiran's question, I provided advice about reported deaths. I have to say the language of the advisers is interchangeable with reportable and reported, but that is what it was referring to.

Hon NICK GOIRAN: Yes, I think what the minister is probably saying is that they are the reportable deaths that were reported. What professions report these deaths to the coroner?

Hon SUE ELLERY: Part 3, section 17 of the existing act refers to the obligation to report death. I am advised that those who predominantly report deaths are members of the police force or doctors.

Hon NICK GOIRAN: Section 17(3) of the primary act just refers to the doctor.

Hon Sue Ellery: Section 17(1) refers to the police force.

Hon NICK GOIRAN: Are doctors and police officers the only two professions that can report deaths to the coroner? Otherwise the coroner cannot receive a report of a reportable death.

Hon SUE ELLERY: As I said, under the heading "Obligation to report death", section 17(1) states "a person." That person could be anyone but, as I said, the most common are police officers or doctors.

Hon NICK GOIRAN: If a person within the Department of Health is aware of a reportable death, must they then report that death to the coroner otherwise there is a penalty of $1 000?

Hon SUE ELLERY: Yes, and if the member reads section 17(1), he will see that it states —

> A person must report a death that is or may be a reportable death to a coroner or a member of the Police Force immediately after he or she becomes aware of the death, unless the person has reasonable grounds to believe that the death has already been reported.

Then the penalty, as the member described, applies.

Hon NICK GOIRAN: Is there a system by which the office of the coroner identifies whether there have been some reportable deaths in Western Australia that have not been reported to the office? In other words, is there some auditing done by the coroner's office to ensure that the obligations to report death, as set out in section 17 of the primary act, are being fulfilled?

Hon SUE ELLERY: I am advised that if the Registrar of Births, Deaths and Marriages becomes aware of a death they believe could be reportable, they refer it to the coroner's office. I am advised that happens quite regularly.

Hon NICK GOIRAN: I appreciate the minister will probably not have the precise number before her, but is the number of matters referred to the coroner's office from the Registrar of Births, Deaths and Marriages something the coroner's office keeps a record of? Are there some data or statistics to say, "On a calendar year basis, X amount of these things are referred to us"?

Hon SUE ELLERY: Yes. I am advised that a database is collected of that information.

Hon NICK GOIRAN: So from time to time—in fact it is quite common—the Registrar of Births, Deaths and Marriages refers matters to the coroner, noting that they should have been reported but were not. Who then prosecutes these matters that have a potential penalty of up to $1 000, as set out in section 17? Is the coroner's office likely to do that?

Hon SUE ELLERY: I am advised that in the living memory of the advisers at the table with me—I suspect that might be a while but I do not want to make judgements—it has never been done. But, in any event, it would not be the coroner's office that did the investigation; it would refer it to the State Solicitor's Office.

Hon NICK GOIRAN: This is indeed interesting, because the State Solicitor's Office cannot possibly prosecute anything if it is not aware of it in the first instance. So we have a strange situation in Western Australia, whereby deaths are, as I understand it, commonly not being reported to the coroner's office—this is happening on a common basis. It is so common that the coroner's office actually keeps data of how many of these matters are referred from the Registrar of Births, Deaths and Marriages, but that is as far as it goes. The law of Western Australia, in section 17 of the Coroners Act, says there will be a penalty of $1 000 if people fail to report these deaths, but nobody is doing anything about it. The coroner's office says, "Sorry; it's not our responsibility. The prosecution would be done by the State Solicitor's Office." How could the State Solicitor's Office, with all due respect to it and in fairness to it, possibly know this is happening if no-one tells it? Then we wonder why we are in the situation—since 2011, when Hon Ed Dermer discovered and revealed that at that time 14 Western Australian babies were born alive and left to die—of nothing having been done about it. Here we are in 2018, and nothing has happened about it. Now I know why: because paper has been pushed between agencies, until the Western Australian Parliament from time to time decides to say, "This is a sufficiently important law that we are going to set out a penalty if Western Australians do not comply with this law." It is absolutely pointless because nobody is auditing, nobody is prosecuting and nobody is monitoring.

Hon MICHAEL MISCHIN: Just picking up on the point that Hon Nick Goiran raised about failure to comply with obligations under the act, who would be the prosecutor for any of these offences of failing to report and of failing to provide relevant information and so forth under sections 17 and 18 of the act? I might clarify it. Someone must present the complaint or at least sign the prosecution notice.

Hon SUE ELLERY: The provisions around who prosecutes are not set out in this bill. Equally, before, when I was answering Hon Nick Goiran's question, I made the point that it has never been done in the memory of the advisers with me at the table. Their advice to me was that if that circumstance arose, they would refer it to the State Solicitor's Office—with due respect to Hon Nick Goiran—not necessarily for the State Solicitor's Office to do the prosecution but to get advice. So maybe that was my shorthand that was being used. So I cannot answer that question with the advisers here tonight. It is not a provision set out in the substantive act we are amending tonight, and it is certainly not in the bill that we are supposed to be debating.

Hon MICHAEL MISCHIN: Yes. Thank you. But I think there was mention in the Law Reform Commission report or section 57 review of the act—at least there was in the Law Reform Commission report—of penalties. I take it that will be part of the supposed larger package being dealt with by the government and that we are still waiting to see something of. Is that the idea?

Hon SUE ELLERY: I have said this probably three times, but I will say it again. The government is working on the rest of the recommendations set out in the Law Reform Commission report and preparing a submission to be considered by cabinet. I cannot give the member any more details than that.

Hon NICK GOIRAN: The minister will be pleased to know that I am coming to the conclusion of my questions on clause 1. Before I ask these questions, I acknowledge that the minister made some helpful clarifying remarks during her second reading reply on those types of circumstances and the particular types of deaths I outlined in my second reading contribution. But I want to make sure that we have this absolutely crystal clear on the record, and that there is no prospect in due course of someone from the Department of Health or anyone else saying to me, "Sorry; you've misunderstood these circumstances. Those particular types of death are not reportable." The reason this is particularly important and why I am spending the time to do this now, is that members will be aware that there is a supplementary notice paper before the house. The supplementary notice paper related to the Coroners Amendment Bill 2017 has a potential new amendment flagged by me. That amendment seeks to insert an additional definition under "reportable death". Section 3 of the Coroners Act 1996 sets out the terms used in the act, and one is reportable death. We have spent some time during the consideration of clause 1 dealing with matters arising from the definition of "reportable death". The purpose of my amendment, if moved, is to insert an additional definition to ensure that a reportable death in Western Australia, amongst all the other things that it includes, would also include the death —

> of an infant who was born alive that occurs during, within 28 days after, or as a result of, the performance on the infant's mother of an abortion, within the meaning of the Health (Miscellaneous Provisions) Act 1911 section 334(1);

The shorthand for all that is simply to say that for any baby who survives an abortion and is born alive in Western Australia and subsequently dies, at least within 28 days, that would be a reportable death. That would be the purpose of the amendment. It has been put to me that that amendment is unnecessary, and I understand that that is the position of the government because it is already captured as a reportable death in Western Australia. I want to make sure that we get this absolutely crystal clear, not only for the benefit of further work that needs to be done but also to ascertain whether it is necessary to move the amendment on the supplementary notice paper; it may prove not to be necessary. My question to the minister is: is the death of an infant who was born alive that

occurs during, within 28 days after, or as a result of the performance on the infant's mother of an abortion, a reportable death in Western Australia?

Hon SUE ELLERY: The answer to that is yes. I already did this in my reply to the second reading debate, and I think I have done it already, but I will do it again. I will start off by making this point: I do not speak on behalf of the Department of Health, so in respect of the debate that we are having now, it is in respect of the powers that exist within the State Coroner's office. The advice provided is that section 3 of the Coroner's Act defines "reportable death". Section 8 of the act prescribes the functions of the State Coroner, and includes at paragraph (c) —

> to ensure that all reportable deaths reported to a coroner are investigated;

Paragraph (a) of the definition of "reportable death" defines a Western Australian death and states —

> that appears to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from injury;

The government's advice from the State Solicitor's Office confirms that the circumstances of the death of such an infant as described in the member's proposed amendment—that is, an infant born alive that occurs during, within 28 days after, or as a result of the performance on the infant's mother of an abortion within the meaning of the Health (Miscellaneous Provisions) Act 1911, section 334(1)—would come within the definition of "reportable death" in the Coroners Act 1996 at paragraph (a), unnatural, or directly or indirectly from injury, and therefore already comes within the definition of "reportable death".

Hon NICK GOIRAN: I thank the minister for that very clear response. If that is the case, I want to ask why these have not been reported. However, in light of the minister's earlier remarks indicating that she cannot speak for the Department of Health, she is not going to be able to tell me why these deaths have not been reported, despite the fact that it is clear from tonight's proceedings that that is the law in Western Australia. These deaths are reportable deaths, but the minister will not be able to tell me why they have not been reported. That is no criticism; that is just the situation we find ourselves in. Can I ask the minister, however: has the Coroner's office received reports of any such deaths?

Hon SUE ELLERY: No. The member might recall that in my second reading reply I referred to the jurisdictional issue raised with the State Coroner when she gave evidence to the Community Development and Justice Standing Committee in October 2016. The State Coroner advised that none had been reported to her since her appointment and I am advised that, subsequent to that, it is still the case that none has been reported. She undertook to seek information and did so, and I am advised that the Department of Health advised the Coroner that medical practitioners had been unaware of their obligations to report such deaths and would do so in the future.

Hon NICK GOIRAN: But, minister, this cannot possibly be correct because during my second reading contribution I quoted in this chamber letters that had been penned by the State Coroner of Western Australia in 2012, acknowledging that these types of deaths had been reported to the Coroner's office. It was the conclusion of that particular coroner, the former coroner, and I quote from the letter of 14 August 2012, in the penultimate paragraph —

> In the above circumstances it appears that the deaths were not reportable and I have no jurisdiction to take the matter further.

That is a statement we now know, from tonight, was incorrect, but it is actually the fact that some of these deaths have been reported to the Coroner's office, so it does not sound correct to me to say that these have never been reported. This particular correspondence from 2012 was the reporting of the deaths of 14 infants. On what basis can we maintain that these had never been reported to the Coroner's office?

Hon SUE ELLERY: I just advised the house that the current State Coroner—I cannot speak on behalf of the previous coroner—at that committee hearing in 2016 was asked how many of those deaths were reported to the office of the State Coroner. She advised that none had been reported since her appointment. She undertook to seek information, and she did so. I then said that the Department of Health advised the State Coroner that medical practitioners had been unaware of their obligation. The honourable member may be right; I do not know whether he is or is not. He may be right. The advice that I am being given is from the current coroner and that advice is the answer she gave to a committee hearing in 2016. Between then and now, I am advised, none of the deaths that the member describes has been reported to the existing coroner.

Hon NICK GOIRAN: The minister has just indicated to the house that the Department of Health advised the State Coroner that medical practitioners had been unaware of their obligation under the Coroners Act to report such deaths and would do so in the future. Are we able to tell the house when that advice came to the State Coroner's office from the Department of Health?

Hon SUE ELLERY: No. We do not have that information here.

Hon NICK GOIRAN: But since that time, whenever that time was that the Department of Health advised the State Coroner that it was unaware of its obligation and it would report in future, the evidence in the chamber tonight is that it still has never happened. Even though the Department of Health now knows that it needs to report them, it still has never reported.

Hon SUE ELLERY: Correct.

Hon NICK GOIRAN: Has the Coroner's office ever gone back to the Department of Health to say to them, "This is highly irregular; this is highly unusual. We know that these deaths do occur in Western Australia and you said to us that you were unaware of your obligation. You now know that you have this obligation and you said you would do so in the future. We, the Coroner's office, find it very strange that we are not catching any of these reports from you." Has there been any conversation like that between the Coroner's office and the Department of Health?

Hon SUE ELLERY: I am advised not.

Hon MICHAEL MISCHIN: Hon Nick Goiran said that it was highly irregular. It is actually a little more than that, because section 17(3) of the Coroners Act 1996 states —

> A doctor who is present at or soon after the death of a person must report the death immediately to a coroner if —
>
> (a) the death is or may be a reportable death; or
>
> (b) the doctor is unable to determine the cause of death; or
>
> (c) in the opinion of the doctor, the death has occurred under any suspicious circumstances.
>
> Penalty: $1 000

Derisory as a penalty of $1 000 may be nowadays, it goes beyond simply a difference of opinion or uncertainty on the part of the Department of Health, its officers and its medical practitioners as to whether or not it is a reportable death; it says "is or may be a reportable death". There is a positive obligation, backed by criminal sanction, against doctors who fail to report these matters. Whatever one may think of the merits of the idea that these sorts of deaths ought to be investigated and the like—I will not get into that—it is not up to medical practitioners to decide that they will or will not comply with the Coroners Act; or, if they have any doubt about the matter, take an interpretation that suits themselves. The minister has told us the State Coroner has informed the Department of Health. Is the minister able to assure us, or is the State Coroner able to assure us through the minister and her advisers, that the Department of Health is aware of its responsibilities; and, if these offences are being committed, they will be reported and dealt with? It seems to me unsatisfactory that although the Department of Health has a positive obligation, and there is a history, patently, of these sorts of deaths occurring and not being reported, all of a sudden none of these deaths are being reported at all. Either things have improved enormously, or the Department of Health and its medical practitioners are not complying with their obligations.

I want to go back to the point I made in my earlier questioning about the ability of medical practitioners to kill their patients, in the noblest of causes, of course, and the coroner not being able to find out about that. I also go back to the point about whether the provisions that are being introduced in this bill, which would expedite cases, but would rely entirely on the opinion of a pathologist, without going through some of the detailed investigation that may be unnecessary but is gone through now, will allow more of those sorts of cases to occur. Is the State Coroner satisfied that medical practitioners—doctors—are complying with their obligations, at least within the state health system, and do not require further reminders?

Hon SUE ELLERY: Chair, I ask for some assistance here. In my second reading reply, and in response to questions asked by Hon Nick Goiran, I have addressed this issue. I put a caveat on my second reading reply. I understand Hon Nick Goiran's issue well. There are actually two agencies that manage the information that Hon Nick Goiran is interested in. I cannot speak on behalf of the Department of Health here tonight. That is not who the advisers are. This is not their bill. This is a coroner's bill. Therefore, the advice that I can give, and have given in good faith and as much as I am able to, comes from the coroner's perspective. However, we did seek advice, and I have provided it to the chamber I think five times now, that the coroner undertook to the committee back in 2016 that she would raise that issue with the Department of Health, and she did. What the Department of Health advised the coroner, and what I have been advised—which the member can choose to believe or not—is that medical practitioners were not aware of their obligations. Beyond that, I am not able to provide any further information. I have provided as much information to Hon Nick Goiran as I possibly can. I am not in a position to go further than what I have already said a number of times.

Hon NICK GOIRAN: Minister, I understand this is exasperating, and that the minister has said she has said certain things five times. That may well be the case, and we can go back to *Hansard* and count how many times

that has happened. However, I have been pursuing this matter since 2011, which is more years than the number of times the minister has said it tonight, so, minister, please understand if we do take a few moments to make sure that we get this absolutely right. Given that we now know that these deaths are reportable deaths and that they have not been reported to the coroner's office, is there anything that would prevent me from writing to the State Coroner tomorrow to report to her those 27 deaths, and is there anything that would prevent the coroner from investigating those deaths?

Hon SUE ELLERY: There is absolutely nothing that would prevent the member from writing to the coroner in the terms he has just described. What detailed advice the coroner might require from the member in order to respond to the letter remains to be seen, but there is nothing to stop him from writing that letter.

Hon NICK GOIRAN: I take it from the earlier advice the minister has given to the chamber that, of course, albeit these types of deaths are reportable, an inquest is not mandated by the coroner, and it remains discretionary should she want to investigate these matters, should she receive a letter from me.

Hon SUE ELLERY: That is correct. When we came back into the chamber at 7.30 pm, that is the bit that I set out. I outlined which provisions in paragraphs (a) to (j) are mandatory.

Hon NICK GOIRAN: The minister's evidence to the chamber, on the basis of the expert advisers whom the minister has before her at the moment, is that there is no provision in this bill before the chamber that will change any of that. It will remain the case, as it is now, that babies who are born alive, survive an abortion and subsequently die are reportable deaths today and will be reportable deaths even if this bill passes in its current form.

Hon SUE ELLERY: I would not describe what I am doing as giving evidence, but I am providing the chamber with advice and trying to respond to the questions the member has asked. I am doing that based on the advice I am given. Yes, what the member has described is correct. The advice I am given is that there is nothing in the legislation as it exists now, and there is nothing in the bill, that would preclude the deaths that the member has described from being reported. That is the view of the current coroner.

Hon NICK GOIRAN: It is customary when we are considering clause 1 of a bill to range over the bill and the various clauses, and also the supplementary notice paper. As I indicated earlier to members, I have a proposed amendment on the supplementary notice paper. On the basis of the information that has been given to the chamber by the minister, on the basis of the expert advice that is available to her, it is not my intention to move that amendment this evening. I am persuaded, on the basis of the information to the chamber, that it is unnecessary to do so. I indicate and underscore for the benefit of members that we have been told tonight that the 27 Western Australian babies born alive and left to die are reportable deaths, and they were always reportable deaths. It is, therefore, open to me to write to the coroner's office as early as tomorrow, and it is then at the discretion of the coroner to determine whether that investigation will take place. That would be the case irrespective of the content of this bill that is before the chamber and would be the case whether or not that amendment was moved. For those reasons, I am persuaded that it is not necessary to move the amendment; the advice that has been provided to the government from the State Solicitor's Office confirms that the circumstances of the death of such an infant born alive would come within the definition of "reportable death" as set out in the act, specifically paragraph (a), which reads that a reportable death means a Western Australian death —

> that appears to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from injury …

I will have a further set of questions when we get to clause 4, but otherwise I am minded to support clause 1.

Hon MARTIN ALDRIDGE: Minister, I have a couple of questions. I do not think it will detain the chamber very long. During the course of the briefings that we received on this matter, which goes back a number of months, so I am testing my memory, we received advice from the Attorney General's office about some government amendments that would be introduced to this bill. It appears from the supplementary notice paper that no notice has been given of any such government amendments. Can the minister confirm for me the government's intention with respect to amendments to this bill?

Hon SUE ELLERY: There are not any.

Hon MARTIN ALDRIDGE: If I read from the advice that we received from the Attorney General's office, it might assist the minister in providing a response. We received an email on 21 August 2018 following, I think, a briefing from the Attorney General's office by an adviser by the name of Leesa Markussen. The email says —

> As discussed, the Government will be moving an amendment to the Bill currently before the Council.
>
> As the amendment, outlined below, is outside the scope of the Bill agreement from the House (on motion) is required for it to be considered in Committee of the Whole.
>
> The Government is seeking to clarify the Coroners powers to disclose coronial records to Government agencies and bodies with a demonstrable interest in the information (i.e. their statutory powers and functions).

> It will provide for the Coroner to disclose and release coronial records, regulate and authorise disclosure and create confidentiality provisions relating to the disclosure of such information.
>
> The proposed amendments, to be circulated with an supplementary EM, will outline the proposed provisions.
>
> I anticipate this will be finalised by midday and am happy to provide further briefings to Members.
>
> As this bill is listed on the weekly notice paper I anticipate debate will resume in the coming week.

This email was dated 21 August 2018. I do not know whether that will assist the advisers in providing some clarity around this matter of urgency that requires addressing by government amendment.

Hon SUE ELLERY: Honourable member, there are not any amendments on the supplementary notice paper. I have no intention of moving any amendments, so I cannot add anything further for the member.

Hon MARTIN ALDRIDGE: Does the minister not have an adviser with her today who is from the Attorney General's office?

Hon Sue Ellery: No.

Hon MARTIN ALDRIDGE: So the advisers with the minister have no knowledge of these government amendments to clarify the coroner's powers in relation to the release of coronial records.

Hon SUE ELLERY: I am advised that there was discussion about amendments. I know nothing about the email that the member is referring to. I am advised that a decision was made not to proceed with any amendments.

Clause put and passed.

Clause 2: Commencement —

Hon MICHAEL MISCHIN: I note that clause 2 provides that the bill will become law on the day after the day it receives royal assent. Are there any preparatory matters that the coroner has to undertake to be ready for the new regime? Has that been done in the last 12 months that this bill has been before Parliament un-enacted? Normally, we get told that the bulk of the operative provisions in legislation need to come into operation by proclamation because there are forms to prepare and procedures need to be established. The minister has mentioned that there will be a learning curve once a computerised tomography scanner is obtained and the like, but are we to take it that the State Coroner, other coroners under the State Coroner's supervision and staff are all ready for the new processes that will be introduced once this legislation becomes law?

Hon SUE ELLERY: There are some procedural matters that need to be settled—for example, the nature of the forms. There are no regulations, but there are some procedural matters and administrative matters that need to be developed.

Hon MICHAEL MISCHIN: We have the Coroners Regulations, and they contain a variety of forms that are currently used within the coronial jurisdiction. I take it that the minister is saying that none of that needs to be addressed before the new regime under this legislation comes into effect and can be effective.

Hon SUE ELLERY: There is no change to the regulations. There are some administrative things that need to be done.

Clause put and passed.

Clause 3 put and passed.

Clause 4: Section 19A inserted —

Hon NICK GOIRAN: Clause 4 refers to the term "unexpected". How is an unexpected death defined?

Hon SUE ELLERY: There is no definition in the act. It is the common usage—common understanding—of the word "unexpected".

Hon NICK GOIRAN: I trust that the common understanding of the term "unexpected" will not include the circumstances of an infant survivor of an abortion who is left to die.

Hon SUE ELLERY: I have already set out that in the view of the current coroner, there is nothing in the act, nor in the provisions of the bill before us, that impedes the death that the member described being deemed reportable.

Hon NICK GOIRAN: Yes, I understand that, but this is why I want to make sure that we are very precise with our language. We have been told—a point that I agree has been argued for several years—that such deaths are covered by paragraph (a) under the definition of "reportable death" in section 3 of the Coroners Act. We have to be careful of the language here, because the language used in paragraph (a) is —

> that appears to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from injury…

There are four different scenarios, one of which is "unexpected". I do not want us to get down the path and somebody from the coroner's office to say to me, "Sorry, honourable member, the deaths of those 27 babies that you have reported are reportable deaths, but guess what? Under this particular section, we have determined that they are unexpected. The death is a reportable death solely because it appears to have been unexpected and therefore we are going to discontinue the inquiry." That is what I want to avoid. I want to have no suggestion whatsoever that that is a possibility.

Hon SUE ELLERY: I know what the honourable member is seeking. I do not know how to say it another way. Paragraph (a) under the definition of "reportable death" in section 3 includes the word "unexpected". The coroner's view is that there is nothing in the existing legislation that includes that word "unexpected" as undefined; nor is there anything in the bill before us that includes the word "unexpected" as undefined. The coroner's advice to me is that there is nothing in either the current legislation or the bill that will prevent the kinds of deaths that the member has been describing from being reportable deaths.

Hon NICK GOIRAN: By way of further explanation, during my contribution to the second reading debate, I referred to the inquest into the death of baby Jessica Jane in the Northern Territory in which the term "unexpected" was dealt with by the Northern Territory coroner. The findings were released on 10 April 2000 and with respect to the term "unexpected", the coroner gave this explanation at paragraph 3 of that inquest's report —

> "What was expected was the delivery of a normal foetus, unexpectedly there occurred the delivery of a live baby human being; that being unexpected, her death 80 minutes later was also unexpected."

Even though in that particular case the coroner used the word "unexpected" and said that therefore this particular death was unexpected, the coroner also went on to say that the death was unnatural. In the Northern Territory inquest case, we have a view of the world that these types of deaths are both unexpected and unnatural. This particular clause in this legislation deals solely with the scenario in which a death is unexpected. My view, of course, is the same as that of the Northern Territory coroner that not only is the death unexpected, but also it is unnatural. In actual fact, I also agree with the State Solicitor's Office, which says that it is directly or indirectly from injury. I actually think there are three scenarios and, frankly, one could even make a case for saying whether it was violent, but let us leave that one aside.

My view is that "reportable death" covers all those terms but it definitely covers unnatural. I seek to confirm whether there is a view from the coroner's office that it is only a reportable death at the moment because it is unexpected. As I understand it, it is the view of the coroner's office that it is more than unexpected and that the coroner's office agrees with the State Solicitor's Office that the reason these deaths are reportable is that they are unnatural or that they are directly or indirectly from injury. If that is the view of the coroner's office, that is the view that I share. That is clearly the view of the State Solicitor's Office. For whatever reason, the Department of Health is doing its own thing, but that is a matter for me to pursue another day. I just want to make sure that we are all 100 per cent on the same page here.

Hon SUE ELLERY: As I read out before, the coroner's office received advice from the State Solicitor's Office. I am advised that the coroner's office accepted that advice that the circumstances of the death of such an infant born alive would come within the definition at paragraph (a) as unnatural or directly or indirectly from injury and therefore already comes with the definition of "reportable death".

Hon NICK GOIRAN: I will finish on this point because I have no further questions and I am not intending to detain the chamber any further on this clause. I want to thank the minister for her cooperation throughout today on this particular matter, not just this clause, but the entirety of the bill. I think it has been most profitable that her expert advisers have been in the chamber and I thank whoever chose the advisers, because they have definitely brought us substantially further forward. Considering that debate on this matter started in 2011, here we are in 2018 finally getting to the bottom of the matter. I certainly support the passage of not only this clause, but also the bill. It will surprise no member to know that I intend at my earliest opportunity to write to the coroner's office.

Hon MICHAEL MISCHIN: I have a question about proposed section 19A(2), which is at the heart of the new process proposed in the legislation. My concern, which I think has been made clear, is that although I am entirely supportive of anything that will be more efficient and expedite the determination of causes of death and the disposal of cases that might otherwise involve a lengthy, but unwarranted, inquiry by the coroner, I have a concern that deaths might slip through the net, or be unnoticed, because of the paucity of evidence and a truncated investigation. Can the minister outline for me a bit of the mental process that one goes through having regard to proposed subsection (2)? In its context, proposed section 19A(1) states —

> A coroner is not required to investigate, or continue to investigate, a reportable death if the coroner determines that —

(a) the death is due to natural causes; …

Proposed section 19A(1) then gives another qualification to that. Proposed subsection (2) states —

> For the purposes of subsection (1)(a), a coroner may determine that a death is due to natural causes …

That is a positive finding in that regard. For the purposes of that —

> … a coroner may determine that a death is due to natural causes if a pathologist informs the coroner in writing that, in the pathologist's opinion, the death is due to natural causes …

So far, so good. That is an expert opinion from a suitably qualified medical practitioner who is skilled in that area. The proposed section goes on to state "or consistent with natural causes". So, the coroner has the ability to make a positive determination that a death is due to natural causes on the basis of only an opinion that it is consistent with natural causes. Why is that the case? Should it not be that the pathologist's opinion goes so far as to give that expert advice to the coroner that it is due to natural causes. If the pathologist is not prepared to go to that standard and say, "Yes, it is due to natural causes", but says, "Look, I can't tell, but it's consistent with it", the coroner can then take the intellectual leap and say, "Well, I'm satisfied that it is." Does that not undermine the certainty that we are hoping for from a decision of the coroner and a finding of cause of death?

Hon SUE ELLERY: I have a couple of points. Recommendation 56 states —

> … in cases where a forensic pathologist has examined the body of a deceased and has expressed an opinion that the death was consistent with natural causes …

That language is straight out of the Law Reform Commission of Western Australia report, but in terms of the mindset—I will not describe my mindset right now—and the process, all cases are triaged and they look at the full circumstances. Obviously, the police are involved at the beginning. The medical examiner conducts an external examination, information may well be provided as a result of the computerised tomography scan, there is a review of the medical notes and the pathologist must provide an unqualified opinion that the death is due to natural causes or consistent with natural causes.

Hon MICHAEL MISCHIN: The minister is telling us that although the coroner is empowered to make a positive finding that a death is due to natural causes on the basis of an expert opinion that it looks like it is natural causes—it is consistent with it—there is an expectation that the coroner would take other evidence into account. Is that correct?

Hon SUE ELLERY: That is what I just outlined.

Hon MICHAEL MISCHIN: I detect a bit of tension there, minister. I am just trying to understand this legislation of which the minister has carriage. Is there anything in the body of the principal act that requires the coroner to have regard to something other than just the pathologist's opinion that death is consistent with natural causes? It is like saying that something is a duck because it is consistent with looking and acting like a duck; therefore, it must be a duck. We are looking for something with a little more certainty when we are looking at the potential for a death due to mischief rather than natural causes.

Hon SUE ELLERY: There is nothing further in the act. There is a set of standard operating procedures as to how the work is conducted in the coroner's office, and it includes all the things that I have already outlined.

Hon MICHAEL MISCHIN: Does that procedure include taking toxicology reports and the like or are we dealing with potentially the use of a CT scan, as envisaged by the Attorney General, to expedite these things? Perhaps the minister can outline what the procedures will be after the passage of this provision so that we can be satisfied that they will not be compromised for the sake of expediency.

Hon SUE ELLERY: All sorts of medical information is relied upon, including toxicology reports if they are relevant to the particular circumstances.

Hon MICHAEL MISCHIN: Relevant to the pathologist's opinion or submitted to the coroner separately? We are talking about a provision that allows the coroner to discontinue an investigation or decline to hold an investigation on the basis of a pathologist's opinion—it does not say based on what—that the death is either due to natural causes or, and this is my concern, consistent with natural causes without being able to say that it is.

Hon SUE ELLERY: When the member asked me a few minutes ago to outline the mental process of what happens in the coroner's office when these kinds of judgments are made, I said at the outset that all cases are triaged and all the circumstances are looked at by the coroner, including, for example, when members of the family raise particular issues. The police are involved at the outset and a medical examination is done externally. A CT scan may be relied on. There is a review of all the medical notes. Additional tests and assessments are made by the coroner if the coroner deems fit, and the pathologist informs the coroner in writing that in their opinion—it has to be an unqualified opinion—the death is due to natural causes or, as is consistent with the language and the recommendation of the Law Reform Commission of Western Australia, is consistent with natural causes.

Hon MICHAEL MISCHIN: To tease this out a little further, clause 5, which we will get to —

Hon Sue Ellery: Why don't we deal with clause 4?

Hon MICHAEL MISCHIN: Because it is relevant to clause 4. Under clause 5, the coroner will not be under a duty to make a finding as to how death occurred, even if it is possible to do so, if the coroner determines that no public interest will be severed in making a finding as to how death occurred. We can have a situation in which a deceased person is brought in and a pathologist will do what pathologists do—either an autopsy or a CT scan after one is organised—and they come to the view that it is natural causes or they cannot tell but it is consistent with natural causes. The coroner does not have to go any further and work out how the death occurred if he or she is simply satisfied that it is not in the public interest to make a finding about how the death occurred or to explain how the death occurred, but is satisfied that it is natural causes and there is no public interest in going any further. That is a possibility, is it not? Someone might be killed by their doctor and buried or disposed of and no-one will ever be any the wiser because there has not been a full process of investigation as is currently required. Is that a possibility?

Hon SUE ELLERY: In clause 5, under proposed subsection (1A), paragraphs (a) and (b) have to be read together. There is an "and" between them. The coroner is not under a duty to make a finding as to how death occurred, even if it is possible to do so, if there is no duty to hold an inquest—we have already been through paragraphs (a) to (j), the reasons that constitute a duty—and the coroner determines that no public interest will be served in making a finding as to how the death occurred. The member must recall that the policy principle is that this is about expediting processes and making it easier for families to have quicker resolutions if the death is related to natural causes. We are not talking about a circumstance in which there is any reason to believe that somebody's body has been dug up from a grave and, therefore, we can probably conclude that that was not a natural cause. That is the example the member just gave.

Hon Michael Mischin: No, it's not.

Hon SUE ELLERY: The member referred to a doctor and the body being buried. That is the example he just gave.

Hon MICHAEL MISCHIN: I said after the coroner has done his or her thing. Perhaps I did not make myself clear enough. We are not talking about an inquest. If there was a requirement for an inquest, none of this process that the government is putting in place would apply. If there is a requirement for an inquest, there is an inquest. We are talking about a reportable death and a question as to whether the death is due to natural causes. As it currently stands, the coroner has to investigate it, work out how the death occurred and report on how the death occurred, as well as make a finding as to whether it was natural causes. The point that I am making is this: let us say that a doctor kills their patient. It is reported to the coroner, who relies on the pathologist's opinion, and the pathologist says, "I don't know whether it's natural causes; I can't tell you. I'm not prepared to give an opinion that this was due to natural causes but it looks consistent with natural causes." On the strength of that, the coroner can say, in this expedited process to give comfort to the family, "Well, the pathologist thinks it looks like natural causes but can't say it is. I'm not going to investigate it any further and, what's more, I don't have to go through all the trouble of making an investigation of the circumstances leading up to the death as to how death occurred, because I can be satisfied on that opinion that it is natural causes, and I make a positive finding that it is natural causes, even though the opinion I've been given is that we cannot tell but it's consistent with it." That is the bit that I am concerned about. I am not talking about finding bodies in graves out in the bush. Of course there would be an inquest or an investigation into that. I am talking about the ones that we are trying to expedite, for very worthy causes and ends, in this process. I am concerned that one of the prices of expedition is that mischief and criminal activity might go unnoticed because there is no strength of evidence behind it; there is simply a consistency that is required to allow a coroner to make a positive finding that a death has been due to natural causes. Is the minister able to assure us that that is not a prospect?

Hon SUE ELLERY: Proposed section 19A states that a coroner is not required to investigate. It does not state that a coroner must not investigate. Proposed section 19A(2) states that for the purposes of subsection (1)(a), a coroner may determine that death is due to natural causes if a pathologist provides a report in writing that it is due to natural causes or consistent with natural causes. The words "consistent with natural causes" are directly taken from the recommendation in the Law Reform Commission report. I have already set out the other circumstances that must apply in the mind of the coroner when determining whether to investigate or continue to investigate. The coroner will not be prevented from investigating in these circumstances; this legislation will remove the mandatory obligation. In addition to all the things I have set out already that the coroner needs to take into account in making that decision, this legislation adds that the coroner must also take into account information received from the forensic pathologist about whether, in their opinion, the death is due to, or consistent with, natural causes.

Hon MICHAEL MISCHIN: Plainly, we are not going to get any further with that. As I say, I support the intentions. I have concerns about the checks and balances to ensure that certainty and that the purpose of having a coroner charged with the responsibilities under this act may be sacrificed with having too much discretion about circumstances. Nevertheless, as the minister has said, it is consistent with the Law Reform Commission report.

But that is why governments sometimes do not accept entirely what law reform commissions and others might recommend. The minister is not prepared to give an assurance, but I suppose she has gone as far as she feels she can. I have no further questions on clause 4.

Clause put and passed.

Clauses 5 and 6 put and passed.

Title put and passed.

Report

Bill reported, without amendment, and the report adopted.

Third Reading

HON SUE ELLERY (South Metropolitan — Leader of the House) [8.55 pm]: I move —

That the bill be now read a third time.

HON MICHAEL MISCHIN (North Metropolitan — Deputy Leader of the Opposition) [8.55 pm]: I will not take up much of the house's time, but I would like to make a few points about the history of the Coroners Amendment Bill 2017. I am grateful to the minister for having acknowledged that what is before us today and has finally been passed builds on the work of the previous government. As Hon Alison Xamon has pointed out, it is true that this has been a long time coming. Over the years, this has probably been the most comprehensive reconsideration of the manner in which our coronial system ought to work since the principal act was passed in 1996. As I recall, the previous legislation dated back to 1920. Over the years, the manner in which the coroner goes about his or her task and what we expect from the coroner have evolved. The two elements to it are that, broadly speaking, the law has to be suitable for the purposes for which we enjoin having a coroner; and, also, the administrative practices and resources need to be adequate. It was all explored in the Law Reform Commission report, with its 112-odd recommendations; the section 57 review; and the structural review conducted under the previous government and which this government now tells us it is working on.

There is more than a little irony in the manner in which this bill has progressed to this place. We had the usual headlines from the Attorney General announcing this great reform that was going to help out people and bring them comfort earlier. He trumpeted himself on several occasions. He made a big announcement in July last year about how the reform was going to be facilitated by the purchase of a computerised tomography scanner. An announcement was made in December last year about how $1 million was going to be spent on that machine. Earlier this year, we had an announcement about it. We now find that, in fact, it is going to be something like $3.6 million and will be a work in progress until, hopefully, February next year. We also had a lot of talk in the other place about how urgent this bill was. On 17 August last year, apart from the usual talk about how nothing had been done under the previous government et cetera as an alibi for this government's greatness, there were a couple of revealing passages from the Attorney General in the other place. At one point, he said —

> As has been mentioned, these are but two reforms plucked out of the Law Reform Commission report on the Coroner's Court. They were plucked out because a more comprehensive response to that report will be engaged by this government in due course.

Point of Order

Hon SUE ELLERY: I would not mind, Mr Acting President, advice on whether the commentary we are receiving on media releases and comments in the other place reflect a third reading speech, which is meant to be a canvassing of the bill as it has come through the procedures in the Legislative Council.

The ACTING PRESIDENT (Hon Matthew Swinbourn): I bring to the member's attention the terms of standing order 141, "Scope of the Third Reading Debate", and the necessity to keep the third reading debate confined to matters that are the contents of the bill. Members shall not introduce new arguments or otherwise expand the debate, including canvassing matters that are outside those things. If the member could perhaps confine his third reading contribution to the four walls of standing order 141, that would be appreciated.

Debate Resumed

Hon MICHAEL MISCHIN: Thank you. I appreciate the reminder about standing order 141. I am not introducing new arguments or otherwise expanding the debate. This is much of what I had said or alluded to at an earlier stage. It is relevant to two elements of the bill that is being passed: one is the desire for an expedition of the processes for the benefit of those who are grieving for lost loved ones, and the other is the commencement of the bill.

As I was pointing out, the Attorney General said that the purpose of these two pieces of an extensive report being plucked out was to get things moving, to speed up the process and, he finished to say, that there was no delay in the other place. There was about three hours of debate. He said that it is a relatively short bill and he thanked the

opposition for allowing the bill to pass through that chamber that evening to be transmitted to the Council so that these much-needed reforms could be brought about at the earliest opportunity. That was on 17 August last year.

Hon Sue Ellery: Do you have a sense of irony?

Hon MICHAEL MISCHIN: There is a sense of irony, because the debate on this bill commenced then within a month. On 12 September 2017, this bill came before this place, and I had started to address the matter then. We have not seen it since then. It has come up more recently, as in about a week or so ago, but that is it—these much-needed reforms. The two bits, the low-hanging fruit, had been plucked out of that tree of the Law Reform Commission report and thrown into the Assembly to get things going and to get a headline for these much-needed reforms. Let us race it through. It came up here and it gathered dust. That is not the opposition's fault. That is the manner in which the government has managed this legislation, this much-needed reform. We find that one of the key pieces of it, a practical piece of equipment that was touted on two separate occasions last year as being important, still has not been purchased or installed. We are still going through a tender process with a preferred tenderer and it is not getting there until perhaps February.

The one good thing that comes out of this is that the government has at least provided for the bill to come into operation and to become law upon royal assent and the day after royal assent, so there will be no delay there. Even that is remarkable, because apparently the coroner still needs to prepare some forms and a few other things. But at least it can get going. I will be interested to know how much time will be taken in producing the rest of the recommendations after all the stick we have had about how long it has taken. This government has been in a position to do something about it for 18 months and we do not seem to be any closer to seeing any of the other matters addressed that were important at the time and for which work had been done, not even to make sure that the penalties in the Coroners Act, the derisory $1 000 or $2 000—$1 000, I should add, that should be the incentive for doctors to do their duty under section 17(3)—have been updated to anything worthwhile. Nevertheless, I am pleased that the bill has finally passed through all stages in this place, with very little thanks to the government, I should add, in the way that it has managed this legislation, and now will probably get on to something else that has been sitting around for about half a year. On that note, I commend the government for at least taking some action in this regard, but I suspect that not much will be achieved in efficiency and effectiveness until this much touted CT scanner, which we would have had in the first budget after the election because we had done some work in the area, is finally going to be acquired, installed and put into operation.

HON NICK GOIRAN (South Metropolitan) [9.05 pm]: I rise briefly to support the third reading of the Coroners Amendment Bill 2017. During the second reading debate I indicated that the bill had my support, subject to two concerns. In my view, we are better placed now as a result of having gone into the Committee of the Whole House and exposing a number of matters. Because of the work done in the Committee of the Whole House, we now know that the bill gives effect to recommendations 55 and 56 of the Law Reform Commission's final report, as asserted by the government, with one clarification being that recommendation 56.3 was unnecessary to be pursued in the bill before the house because it is already captured in the originating act.

We also know that the expert advice from the Coroner's Court and the State Solicitor's Office is that there is nothing in this bill before the house that would make the deaths of infants who survive an abortion procedure any less reportable than they are now. It is the case, because of the advice given by the experts today, that we know that these deaths were always reportable from the day that Hon Ed Dermer exposed this matter in 2011 in the thirty-eighth Parliament. It was reportable then; it was reportable in the thirty-ninth Parliament, when I further asked questions about this matter and the deaths of those infants rose from 14 to 20; and it was still reportable last year when I asked questions on this matter and 27 babies born alive were left to die in Western Australia. It has always been reportable and that has always been my position. The position of the former State Coroner was clearly that it was not reportable. The position of the so-called experts in the Department of Health at that time was also that it was not reportable, as I quoted earlier today. It troubles me immensely that when Hon Ed Dermer exposed this matter in 2011, urgent action was not taken within government agencies at that time. How exasperating must it have been for ordinary citizens, in the form of the Coalition for the Defence of Human Life, to have to take it upon themselves to report to the coroner of the day and then be told, "Sorry; this is not within my jurisdiction"? These ordinary Western Australians have a heart for infants who cannot talk for themselves. There was nobody there to support those infants who were left to die at that time, so the Coalition for the Defence of Human Life wrote to the only place it could to report this matter—the State Coroner—and was told, "Sorry; it's not within our jurisdiction." We found out in the course of this debate, thanks to the work of the Committee of the Whole House, that that was wrong. That was not the state of the law at the time.

Thankfully, the record has now been corrected. We now have it crystal clear that these are reportable deaths, and nothing prevented any Western Australian from reporting those 27 deaths to the coroner. I indicated to members during the Committee of the Whole House that I certainly intend to take that up. At the outset, I thank Hon Ed Dermer for exposing this matter in 2011. I thank the advisers who were here today, and the minister, for their patience. I acknowledge that I quite intentionally wanted to ensure that no stone was left unturned. I do not

want to come back to a situation of people being left exasperated again. The whole purpose of having these laws in place is so that the most vulnerable Western Australians are protected by them. It has always been the case that a Western Australian baby born alive, irrespective of the circumstances that they find themselves in—it does not matter if they are in the wealthiest home in Cottesloe or the poorest home somewhere else in Western Australia—is a Western Australian citizen who attracts the same rights and privileges as you or I if we were to go to a hospital in Western Australia. We are very fortunate to live in this state, where we have access to first-class health care. So many places in the world do not have the luxury, benefit and blessing we have of being able to have that level of health care, and 27 Western Australian infants were not given that care.

The answers repeatedly given in Parliament—not just to me, but also to Hon Ed Dermer; to both of us—were that no medical treatment was provided to these Western Australians. That is especially shocking because we know that in Western Australia excellent work is routinely occurring at King Edward Memorial Hospital for Women. People there are routinely saving children at gestational ages of 23 weeks and onwards. I outlined earlier that we know that at least six of those Western Australian babies I have referred to were at a gestational age of 26 weeks or older. We do not know much other information. Why? Because the Department of Health has refused to provide that information. But it is going to have to provide that information to the coroner now because I am going to write to the coroner, and the coroner will have the power to get that information from the Department of Health.

We also know, as a result of the work done and what the government told us during the Committee of the Whole House, that the Department of Health, which is responsible for these things, advised the State Coroner that medical practitioners had been unaware of their obligation under the Coroners Act 1996 to report such deaths, and would do so in the future. It is staggering to think that medical practitioners in this state would be unaware of their obligations under the Coroners Act. That is what we found out tonight in the Committee of the Whole House. Thank goodness we went into the Committee of the Whole House so that we were able to find that out. Had we stopped at the second reading debate and proceeded forthwith to the third reading, we would never have found out that information. Now we know that that is the situation. The Department of Health—the so-called experts—advised the State Coroner's office that medical practitioners were unaware.

But what defies belief is that the same officials told the State Coroner that such deaths would be reported in the future. How many have been reported to the State Coroner's office? Nil. After all this time—since 2011, when this matter was first raised; we are in the eighth calendar year of raising and talking about this matter—we still have a situation whereby health officials are not reporting to the State Coroner's office. We found out tonight, because of the work done in the Committee of the Whole House, that they are under an obligation, if my memory serves me correctly, under section 17 of the primary act, and that there is a penalty for people who do not do that of up to $1 000. Most probably $1 000 is neither here nor there to a wealthy health practitioner. Maybe $1 000 means nothing to them. I do not know. But the point is that lives have been lost that have never been investigated. These are unnatural deaths—that is not my language; that is the language in the act. That is the language of the Northern Territory coroner. That is the language that has been confirmed by the experts here tonight—these are unnatural deaths. Unnatural deaths get reported to the coroner's office—well, they should do—but it has never happened, despite the fact that Parliament has been told on multiple occasions.

I can cite at least three occasions. In the thirty-eighth Parliament, we were told there were 14 deaths; in the thirty-ninth Parliament, we were told there were 20 deaths; and now there have been 27 deaths. How many more of these infant deaths will it take before Department of Health officials finally decide to take their responsibilities seriously? They are not responsibilities that certain members might think the Department of Health has. That is the law of Western Australia. How serious are we about the rule of law in our state? Does the rule of law apply to health officials in Western Australia, or only when they choose to comply with the law?

They should have complied from the instant that Hon Ed Dermer exposed this matter in 2011. That is when it should have started, and nothing has been done since then. Instead, we have this ridiculous situation of the former State Coroner saying, "It's not my jurisdiction", and he said so based upon advice from the then director general of Health. Thank goodness we now have a new coroner who has a proper understanding of the law. Thank goodness we have a principal registrar at the Coroner's Court who understands the true state of the law. I hope I will be in a position in the not-too-distant future to report back to the house on the progress of the report that I will make to the Coroner's Court, and the progress made by the coroner in this matter.

I certainly thank all members for their patience in what has been an unusual matter. I accept they have probably heard far too many speeches from me on this matter, but I hope that they will equally accept that it has been necessary. Unless we are prepared to continue to persevere and pursue these matters, unfortunately we will be left in the situation that people were in in 2012, when the State Coroner of the day said to the Coalition for the Defence of Human Life, "Sorry; not my jurisdiction." That was wrong. He should have taken it on then and investigated those 14 deaths, and I trust that the new State Coroner will investigate these 27 deaths.

So that members are absolutely crystal clear, I have no interest in seeing any of the health practitioners involved pursued and prosecuted and so on and so forth about these matters. I talked about $1 000 fines and penalties for these people who have not reported the deaths, but I actually have no interest in that. My interest in this matter is to get to the situation that the people in the Northern Territory were fortunate to be in in 2000, when their coroner investigated the death of Jessica Jane, which I reported earlier. Greg Cavanagh, the coroner at the time, was then able to make recommendations to see systemic improvements so that there was not a situation of a nurse being left with a baby, saying, "Oh my goodness, what do I do in this situation? A baby has been born alive, and I don't know what to do." That was what happened in the Northern Territory. That has to have been the case at least 27 times in Western Australia, all because there has been no inquiry into these things. We need to make sure that protocols are in place so that health practitioners know exactly what to do in that situation, and the very first thing they need to understand is that that human being is a Western Australian citizen and they have the same rights and privileges as any of the rest of us here. The 36 members of this place have no additional right to health care than those 27 Western Australian babies. We are all treated the same before the law; we are all entitled to the same level of health care. That should have happened, and it has not.

I am gratified that we have been able to finally get to the bottom of this matter and have confirmed in the Legislative Council of the Parliament of Western Australia the true state of the law. This clarification can now be sent to the relevant agencies and it will no longer be possible for them to say, "Sorry; we've got a different view of the world." No; this is the view of the government of Western Australia, as confirmed today in the Parliament.

Question put and passed.

Bill read a third time and passed.